

U.S. 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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BUSINESS MEETING

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TUESDAY  
JULY 8, 2014

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The Task Force met in the DoubleTree by Hilton Hotel Washington DC-Crystal City, Commonwealth Ballroom, 300 Army Navy Drive, Arlington, Virginia, at 8:00 a.m., VADM Matthew L. Nathan, DoD Co-Chair, and Suzanne Crockett-Jones, Non-DoD Co-Chair, presiding.

PRESENT

VADM MATTHEW L. NATHAN, DoD Co-Chair  
SUZANNE CROCKETT-JONES, Non-DoD Co-Chair  
CSM STEVEN D. DEJONG, Member  
RONALD DRACH, Member  
TSGT ALEX J. EUDY, Member  
LTCOL SEAN P.K. KEANE, Member  
KAREN T. MALEBRANCHE, Member  
STEVEN J. PHILLIPS, Member  
DAVID REHBEIN, Member  
CAPT ROBERT A. SANDERS, Member  
RICHARD A. STONE, Member  
LTCOL THEODORE L WONG, Member

**ALSO PRESENT**

**DENISE F. DAILEY, Executive Director**

**JOHN KUNZ, Research Director**

**SUZANNE LEDERER, Deputy Research Director**

**AMBER BAKEMAN, Research Team**

**ASHLEIGH DAVIS, Research Team**

**MICHAEL INMAN, Research Team**

**MATTHEW MCDONOUGH, Research Team**

**ASHLEY SCHAAD, Research Team**

**JOHN BOOTON, Staff**

**STEPHEN LU, Staff**

**DAVID C. MCKELVIN, Staff**

**HEATHER JANE MOORE, Staff**

**JOSEPH NAGORKA, Staff**

**JOHN OTI, Staff**

**LAKIA THOMAS, Staff**

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

(8:03 a.m.)

CO-CHAIR CROCKETT-JONES: Good morning, everyone. Thank you all for attending our July voting session meeting for the 2014 annual report, our last meeting with the Task Force.

Before we continue, I ask that we go around the table and conduct introductions. Start with you, Mr. Drach. Can you introduce yourself?

MR. DRACH: Yes, good morning. Ron Drach. I am a non-DoD member of the Task Force, retired from the Department of Labor and Disabled American Veterans wounded in Vietnam in 1967.

MR. REHBEIN: Dave Rehbein, civilian member and recently retired, very recently retired from Iowa State University Research Laboratory.

LT COL WONG: Lieutenant Colonel Wong, United States Marine Corps

1 representative, currently holding the vote of  
2 Wounded Warrior Regiment Liaison Officer at  
3 Marine Forces Reserve.

4 CSM DEJONG: Command Sergeant  
5 Major Steve DeJong, representing National  
6 Guard Bureau.

7 CO-CHAIR NATHAN: Is Karen going  
8 to be here?

9 I'm Matt Nathan, the DoD co-chair,  
10 Navy SG.

11 CO-CHAIR CROCKETT-JONES: I'm  
12 Suzanne Crockett-Jones, civilian co-chair,  
13 spouse of a wounded Army officer.

14 DR. STONE: Rich Stone, civilian  
15 member.

16 LT COL KEANE: Lieutenant Colonel  
17 Sean Keane, representing the reserves.

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

21 CAPT SANDERS: Captain Robert  
22 Sanders, JAG Corps, United States Navy,

1 representing the Navy.

2 DR. PHILLIPS: Steven Phillips,  
3 non-DoD member, physician. I work at the  
4 Department of Health and Human Services.

5 CO-CHAIR CROCKETT-JONES: Thank  
6 you everyone. And I note that Major General  
7 Richard Mustion will not be attending either  
8 day of this business meeting. That kind of  
9 bummed me out.

10 I'll turn it over to you.

11 CO-CHAIR NATHAN: Thanks. Okay,  
12 well as we head to the stables here, as we  
13 prepare for voting, I would like to review the  
14 voting session guidelines, which are located  
15 on the inside pocket of the briefing books.  
16 While discussing and voting on recommendations  
17 over the next two days, the aim is to provide  
18 clarity regarding each recommendation, to keep  
19 comments focused on the critical issues, and  
20 to publicly record an accurate vote. When  
21 identifying grammatical changes or  
22 clarifications, they should be introduced as

1 a point of order for administrative change,  
2 not as a motion. A motion should be made only  
3 to introduce substantive changes. In general,  
4 the co-chairs will read an item in question  
5 without the findings. Then, another member  
6 must move to adopt them as read, stating: "I  
7 move that the recommendation be adopted as  
8 read." A third member seconds the motion,  
9 stating: "I second the motion," "I second  
10 it," or, "Second." Then, discussion on the  
11 motion may occur.

12           Once discussion is completed, a  
13 co-chair will say, "The question is on the  
14 adoption of the motion as read. Those in  
15 favor of the motion, signify "Yea" by raising  
16 their hands and keeping them raised. The co-  
17 Chair then asks for the nays and then for the  
18 abstains. A co-chair will then announce the  
19 final vote, which will be noted on the screen.

20           Please take some moments to read  
21 over the insert, which also addresses amending  
22 a motion and reconsidering an item already

1 discussed. All recommendations will be shown  
2 on the screen. As we conduct our discussion,  
3 any changes will be made in real time and will  
4 be properly displayed for the final vote. All  
5 draft recommendations and findings can be  
6 found under Tab B.

7 So, I think most, if not all of  
8 us, who have done all of this before but don't  
9 let standing on ceremony intimidate you if you  
10 believe you have a change or a concern with  
11 something that is up for a vote. We will get  
12 the hang of the Roberts Rules of Orders as we  
13 go along, but don't let that stop you if you  
14 think you need to ask questions about it or  
15 have concerns.

16 CO-CHAIR CROCKETT-JONES: Okay, we  
17 will now discuss a recommendation focused on  
18 the Department of Defense redesigning the  
19 Integrated Disability Evaluation System  
20 process. This recommendation states that the  
21 Department of Defense should design a new  
22 approach to replace the current disability



1 evaluation system. The hallmarks of the  
2 redesigned approach should include simplicity,  
3 incentivization of work and wellness, patient  
4 and family-centered, and standardization  
5 across the Department of Defense.

6 I invite anyone to move to adopt  
7 this recommendation for discussion. Somebody  
8 has got to, so that we can discuss it.

9 CAPT SANDERS: So moved.

10 MR. REHBEIN: Second, Rehbein.

11 CO-CHAIR CROCKETT-JONES: All  
12 right, then. Let's look at the language.  
13 Does anyone have thoughts that they have  
14 prepared for this? Because I think that we  
15 are close on this but I am not sure we have it  
16 right yet.

17 MR. REHBEIN: Madam Chair, I have  
18 one concern. As I read the recommendation and  
19 the findings, I find it to be a very complete  
20 description but my concern is that too often,  
21 all that gets read is the recommendation. And  
22 I am wondering if that first bullet point,

1       simplicity, is not specific enough, leaves too  
2       much room for misinterpretation, if we should  
3       add, and I don't know the words. Please don't  
4       think I do. I don't know the words to make  
5       that more descriptive of what the task force  
6       was discussing at the last meeting. And I  
7       don't know the words, mostly, because I wasn't  
8       at that meeting. So, I don't have a good  
9       grasp of that conversation.

10                   DR. STONE: Yes, I think you are  
11       correct. In its simplicity, it fails to  
12       really stand on its own as a recommendation.

13                   The discussion we had last time  
14       was to move to a system of compensation, you  
15       know a workers' compensation type model, and  
16       that that workers' compensation type model is  
17       not about long-term disability. It is about  
18       loss of income, based on the fact that service  
19       in uniform broke the person. And it is also  
20       not about long-term health-related acquired  
21       problems. If you get sleep apnea during the  
22       time of your services, not necessarily a

1       compensable issue that was caused by your  
2       service but it was about the creation of  
3       separation and workers' comp versus long-term  
4       disability which is a responsibility of the  
5       veterans' benefit system. It is about  
6       compensation for lost income and it is about  
7       transitioning the employee to an opportunity  
8       for future employment. And, therefore, there  
9       is a lot of pieces that go into that I think  
10      that are not captured within the  
11      recommendation itself.

12                   CO-CHAIR NATHAN: Yes, I think the  
13      gist of much of this was where we discussed  
14      the genesis for the disability system as it  
15      currently exists. You leave the service and  
16      you either have service-connected or service-  
17      acquired disabilities/illnesses. The current  
18      system, theoretically, pays you because you  
19      are either going to not be employable, fully  
20      employable, or statistically, you are going to  
21      suffer health issues as a result of what you  
22      have, sleep apnea being the classic case. You

1 can go out to work tomorrow if you have sleep  
2 apnea. There should be no reason why you  
3 can't work doing almost anything you want to  
4 be, unless you work in the sleep lab, I  
5 suppose but you can do anything.

6 Theoretically, people with sleep  
7 apnea have a higher morbidity and mortality as  
8 they age than people without; higher incidence  
9 of stroke and don't live as long.

10 Theoretically, that is what the actuaries  
11 would say.

12 So, those that argue that DoD is  
13 paying you for something that is going to  
14 either shorten your life span or eventually be  
15 a problem to it by the workman's comp issue,  
16 which is you can't work, you can't put food on  
17 the table, and so let's give you a payout for  
18 that.

19 We sort of landed on the idea of a  
20 payout, rather than a chronic check because  
21 the payout then, you get your money and there  
22 is no incentive for you to either maintain the

1 illness or maintain the vestiges of the  
2 illness or maintain the appearance of the  
3 illness. You have just got your money and  
4 whether you don't work for five years or  
5 whether you don't work for five minutes, there  
6 is no reason that you wouldn't want to go on  
7 and do other things.

8 Any other comments, Denise, from  
9 you're the staff on the background of this?

10 MS. DAILEY: So, we have captured  
11 in the findings what is the discussion. So,  
12 Mr. Rehbein, we captured in the findings  
13 discussion from last time. If we have missed  
14 something, Dr. Stone, I need to know what it  
15 is.

16 And this where the hard work  
17 begins. You can say no on this  
18 recommendation. You can say yes on this  
19 recommendation and then or the hard work is we  
20 sit here, and Suzanne has got your notes here,  
21 we'll re-craft in this meeting this  
22 recommendation.

1 CO-CHAIR CROCKETT-JONES: I think  
2 that it seems what --

3 MS. DAILEY: We do not have the  
4 option to come back later, come back in a  
5 month, come back in a time later to do this.  
6 It is now or not.

7 CO-CHAIR CROCKETT-JONES: I think  
8 that what everyone is saying, you know, the  
9 findings, I think, do hit everything that we  
10 have said. I think what is being indicated is  
11 that just we need another line, basically, we  
12 need just a little more language from the  
13 findings to say in that what that redesigned  
14 approach should include. Instead of just  
15 saying simplicity, it should say, perhaps, or  
16 add a bullet that says compensation for lost  
17 pay or for lost employment ability but not --  
18 we don't need to rework everything, since the  
19 findings are good. I think we just need to  
20 pull that concept up from the findings to be  
21 another bullet up there in the --

22 DR. STONE: Suzanne, I think you

1 have this right. I think the weakness is in  
2 that it is captured within the findings but  
3 the recommendation does not stand on its own.  
4 Now, we have discussed this every year for the  
5 four years that we have all been here. The  
6 recommendations should stand on their own and  
7 be supported by the findings. I don't think  
8 it does so now.

9           So, from my standpoint, simplicity  
10 needs to be changed to workers' compensation  
11 type model and can certainly accommodate, as  
12 a single payout system, that doesn't incentive  
13 long-term disability; that it should recognize  
14 lost income based on length of service. It  
15 should be modeled after other high-risk  
16 employment situations, whether that be the  
17 mining industry, the firefighters or the  
18 police. It should approach the fact that we  
19 are concerned about diseases of aging that  
20 might cause problems with long-term  
21 survivability or complications that we don't  
22 find within the workers' compensation type

1 model. It should have within it a discussion  
2 of our complete linkage to the GI bill, which  
3 would allow retraining of an employee for  
4 future employment. It should reference tax  
5 incentives to future employers. And it should  
6 also emphasize a complete separation from  
7 long-term disability.

8 And it should begin at some  
9 defined period of time after we are assured  
10 that the service member is given the  
11 opportunity to recover maximum functionality.  
12 So, whether it begins at six months or twelve  
13 months, but I think all of those need to be  
14 included in a defined recommendation that sets  
15 the debate for future discussion well beyond  
16 what you have in D1 today.

17 DR. PHILLIPS: I agree. And it  
18 may be a small point but on the order of the  
19 bullets, I would suggest putting  
20 standardization across DoD as the first  
21 bullet, not the last bullet.

22 MR. DRACH: The four bullet



1 points, I don't really have any problem with.  
2 I think my problem is comparing military  
3 service to civilian occupations. When  
4 somebody joins the military, they do it by  
5 choice, the same as if they go into the mining  
6 industry. But when they go into the mining  
7 industry, they go home at night. They do what  
8 they want to do. They are there. They are  
9 not uprooted. Their families are not uprooted  
10 every couple of years if they are making a  
11 career out of that, as they do in the  
12 military.

13                   And how do we know, how much  
14 science do we have to say, for example, the  
15 general talked about sleep apnea, what  
16 experiment, and I am not a doctor so I have no  
17 idea, but what external factors contribute to  
18 somebody getting sleep apnea or diabetes, or  
19 cancer, or heart condition, or high blood  
20 pressure? Is there something external that we  
21 have placed this military person into that  
22 might be a factor in contributing to that

1 diabetes, that sleep apnea, et cetera, et  
2 cetera, that he or she might not have been  
3 exposed to, had they not been in the military  
4 and been stationed in Guam or some other  
5 foreign country that may not have the same  
6 level of protections or maybe more susceptible  
7 to diseases in certain areas that, if they  
8 were working in the mine, they would have  
9 never gotten? So, who are we to say that they  
10 did or did not get it as a direct result of  
11 service in the military? And this is where my  
12 bias comes in because I have been working in  
13 this field so long, is what was the causation?  
14 And historically, the law says incurred in or  
15 aggravated by military service.

16 So, I don't know where the balance  
17 is here. I understand the need to try to  
18 simplify, incentivize, and so forth and so on.  
19 But to just kind of say that we should not or  
20 we should compensate on a workers' comp basis,  
21 I am just not comfortable in saying that  
22 military service comparable to civilian

1 service in the mining industry, in the steel  
2 industry, whatever.

3 DR. STONE: So, Ron, I guess my  
4 response to that is, I just spent part of last  
5 week working on behalf of the Agent Orange-  
6 exposed Vietnam veteran who now has prostate  
7 cancer, there are systems in place for the  
8 long-term effect of diseases related to  
9 service. And those in no way should my  
10 comments mean I am supportive of reducing  
11 those benefits through the VBA system but they  
12 aren't part of a compensation system. And so,  
13 therefore, if I am exposed to some sort of  
14 metal that releases an agent that gives me a  
15 higher cancer risk in the future, if,  
16 therefore, my service is found in the future  
17 to give me higher rates of other diseases, we,  
18 today, are still adding issues to the VBA  
19 system for our great Vietnam veterans. That  
20 system stays in place but must be de-linked to  
21 a system for loss of compensation. And that  
22 is the basic point.

1                   Now, there are some other new  
2 instances, as you and I have talked about, the  
3 new instance of access to commissary  
4 privileges, access to healthcare, those will  
5 all have to be worked into a new system in  
6 order to make sure that this is not a  
7 negative. But is an untenable situation today  
8 for the employee and moving the employee to  
9 sort of their next employment and to  
10 incentivize their recovery, as well as for the  
11 management of the Services, the way the system  
12 is integrated today.

13                   CO-CHAIR NATHAN: I think the  
14 challenge is --

15                   MR. REHBEIN: Madam Chairman, now  
16 that --

17                   CO-CHAIR NATHAN: Let me just add  
18 one thing, if I could.

19                   MR. REHBEIN: I'm sorry. Go  
20 ahead.

21                   CO-CHAIR NATHAN: You all are  
22 talking to some extent about eligibility for

1 healthcare from service connection through VA  
2 and eligibility for compensation. Service  
3 connection means because you are in the  
4 service, this happened to you. You fell off  
5 the truck as it was going over the bridge. As  
6 a result, you had a disc, you broke a disc,  
7 you ruptured a disc in your back. You cannot  
8 do any heavy lifting or working. You will be  
9 entitled to VA care for that, service-  
10 connected disability. The VA cannot send you  
11 away. That is service-connected. Whereas,  
12 opposed to you develop diabetes while you are  
13 on active duty, there is nothing that tells us  
14 yet why that diabetes in the military, as you  
15 would if you were working at Walmart or IBM,  
16 but you still receive a disability rating for  
17 that diabetes. That is our challenge. You  
18 may not be followed in the VA system for your  
19 diabetes because it is not service-connected.  
20 But as you leave the military, you are given  
21 a rating for a certain percentage of  
22 disability because you have diabetes,

1 presumably because the diabetes is going to  
2 eventually limit your ability to work and/or  
3 live a normal life.

4           So, the argument that you are  
5 having is the central theme over the DES  
6 system, which is is the government responsible  
7 for paying you for developing diabetes, simply  
8 because you happen to be on active duty when  
9 it was discovered. IBM does not do that.  
10 General Motors does not do that.

11           So, and the other problem we have,  
12 and this one of the reasons that the genesis  
13 of this discussion along the way, this  
14 recommendation was we all know people who are  
15 pretty fit and they are out there gainfully  
16 employed who are 90 to 100 percent disabled in  
17 the disability system. That is why it is  
18 different than workmen's comp. If you have a  
19 90 percent workmen's comp, you can't work,  
20 unless you are fraudulent, unless you are  
21 putting a neck brace on only when the cameras  
22 are around. But you can't work.

1                   You can be 90 percent disabled in  
2                   the VBA system and you could still go out and  
3                   work a construction job tomorrow because if  
4                   you have had a hysterectomy that is 50  
5                   percent, you had sleep apnea that is 50  
6                   percent, if you develop some diabetes, that is  
7                   20 percent, all those things.

8                   So, I think it comes down to the  
9                   central theme of do we or do we not subscribe  
10                  to a system that pays you for, I am going to  
11                  use the term incidental, I don't mean that to  
12                  be flippant or disrespectful to people who  
13                  have illnesses, but do we pay you for  
14                  incidental illnesses that develop during your  
15                  service in the present format? That is, I  
16                  think, the theme here.

17                  CO-CHAIR CROCKETT-JONES: I think  
18                  you are right. I think that is the theme. I  
19                  think that -- I don't think we know as a  
20                  system what the rates are for the kind of  
21                  dissident rating versus ability. I know we  
22                  all know people who have high ratings and are

1 quite able but what we don't know is how  
2 common that is. We have no way to adjudicate  
3 that. And although I think we need a  
4 different system and while I think it would be  
5 beneficial to separate VA ratings and  
6 processes from DoD, in order to get DoD to  
7 simplify theirs, and to keep both  
8 organizations sort of moving at a reasonable  
9 pace, I would say it may be wrong to base our  
10 view of the average veteran on something that  
11 maybe rarer than we think.

12 I mean, this Task Force, when we  
13 first began, we encountered the same kind of  
14 generalized views of wounded, ill, and injured  
15 service members being largely uninjured,  
16 having had no combat service. And when we  
17 first started, the impression of what the  
18 rates were for combat injuries or people who  
19 had injuries or illnesses and had never served  
20 in combat, these were all really misconceived.  
21 And when a nose count was done, we got a  
22 different view and it was more accurate. And



1 I am concerned that as we approach this and we  
2 are solving the problem of the 100 percent  
3 disabled but fully capable of work veteran,  
4 that we are going to throw some folks under  
5 the bus, based on a minority of problems.

6 So, I want us to be a little  
7 cautious as we move forward in what our  
8 assumptions are what we actually have evidence  
9 for.

10 I think that asking DoD to  
11 standardize, simplify, focus on compensation  
12 and employability to do more work to  
13 transition and encourage it to include  
14 families and to focus on patient recovery  
15 before the process finalizes, I think all  
16 those are good concepts. I think that we can  
17 pull more language about compensation into the  
18 recommendation. I think that we should be  
19 very careful and stick to only those things  
20 for which we have very clear evidence.

21 MR. REHBEIN: I look at this  
22 recommendation as not being something that DoD

1 can take our recommendation and immediately  
2 implement it. I look at this as a  
3 recommendation to create a group that would  
4 thoughtfully and deliberately design a new  
5 system. And so I think we need to be very  
6 careful not to try to do their work for them.

7 I think the words here, where we  
8 use words like incentivization of work and  
9 wellness, I look at that as being  
10 expectational. We expect that system to allow  
11 that, to promote that. I look at the word  
12 simplicity as being aspirational, where it has  
13 a multitude of meanings.

14 And so, if we could -- I am going  
15 to argue against too many words being added to  
16 this. But if we can, somehow, find a phrase  
17 or a sentence that would define what we mean  
18 by simplicity, I think that would, in my mind,  
19 that would be enough to add to this  
20 recommendation.

21 CO-CHAIR NATHAN: I think we are  
22 in violent agreement. To me, it gets back to

1 the central theme of this. If each of us were  
2 asked by somebody at a social gathering do you  
3 think the Disability Evaluation System, as it  
4 exists today, is a good system or needs to be  
5 fixed, you have to answer that first in your  
6 mind. If you believe that it is okay, most of  
7 us, the majority did not, otherwise, we  
8 wouldn't have this recommendation there. In  
9 other words, if we all thought there is  
10 nothing wrong with the DES. But obviously,  
11 the central theme here is that most of us feel  
12 there is a problem with the DES.

13 Then, the next question you has to  
14 be asked in a social gathering for your  
15 informal thoughts, is well, what would you  
16 change about it. What is it that you don't  
17 like about it? If you have said, okay, I am  
18 not wild about the DES system; I don't think  
19 it is a good system, we all agree it is  
20 probably too complicated. And that is where  
21 simplicity came from.

22 Now that is, as I think, Rich, you

1 said, and others said, that is a pretty  
2 generic term. I mean, fix it. How are you  
3 getting along with the Ukraine these day? Not  
4 very good. Well, make it better. That is our  
5 recommendation. Okay, well somebody is going  
6 to say well, how. What specifically are you  
7 going to do?

8                   So, we know it is too complicated.  
9 So, that is where simplicity came from. We  
10 know that, and this is to Suzanne's point, we  
11 know that there are people who are deserving  
12 who are being left out and we know that there  
13 are people who are not deserving who are on  
14 the dole getting paid. And so, is there a way  
15 that we can fix that or do we just simply call  
16 that to the attention of Congress and the VA  
17 and say that? Now, if we do that, I have a  
18 feeling Congress and the VA is going to go,  
19 duh. We have been hearing this for year. You  
20 guys are just now getting on the train of the  
21 DES system needs some sort of fine tuning.  
22 What are your specifics, Task Force? You have

1       been meeting. You have talked to people. You  
2       have talked to veterans. You have talked to  
3       VA personnel, DoD. You have talked to  
4       providers who are doing the physicals. What  
5       would you do to change it? And is there  
6       traction there?

7                   And I have often said, there is  
8       room on Mount Rushmore for one more face. And  
9       it is whoever figures out the right IDES or  
10      DES system because it is very complicated. It  
11      is very tough.

12                   But that is how I look at it.  
13      Because if somebody said to me, do you like  
14      the current DES system, my answer is I don't  
15      really like it. I think it is cumbersome and  
16      I think that it causes people to try to figure  
17      how to game the system, to game the system.  
18      I am in my last tour in the military, and  
19      Rich, I am sure you went through this and  
20      others, as you get ready to retire, my primary  
21      care provider is saying okay, well, let's line  
22      you up with all the specialists now. I go,

1       why? Well, we want to document that knee that  
2       bothers you a little bit and we want to  
3       document those headaches. And don't forget  
4       this and that because we want to make sure  
5       that you get every penny when you retire that  
6       you have coming to you.

7                       And so I am thinking gosh, I don't  
8       know that that is fair or right. Why should  
9       I be trying to do that? And when I sat down  
10      with an individual who works in the VA and  
11      said why do you give such a high percentage  
12      for sleep apnea, because everybody in the  
13      world gets a sleep apnea test now before you  
14      leave the service to try to prove that you  
15      stop breathing at night, it is worth money to  
16      you when you retire. And so we are not paying  
17      for compensation for work. We are paying for  
18      morbidity and mortality increases that you are  
19      going to suffer. And you develop your sleep  
20      apnea while you are in the military, so we are  
21      responsible for taking care of you for it.  
22      That is the current philosophy.

1                   So, that is what you have to ask  
2                   yourself. If you think the DES system is as  
3                   good as it is going to get and we can't do  
4                   much to it, then we should vote this down.  
5                   Let's vote against this recommendation. If  
6                   you think the DES system needs work, what work  
7                   does it need? And we can be as general or as  
8                   specific as we want, recognizing that if we  
9                   stay simple, I don't know how much anybody is  
10                  going to really take that to heart.

11                  Congress goes, simplicity? Yes,  
12                  tell me something I already don't know.  
13                  Incentivize work and wellness? What a great  
14                  bumper sticker. How? This is what I think we  
15                  have to determine because this is world  
16                  hunger. Of all the things we are going to  
17                  look at in the next couple of days, the DES  
18                  system is probably the most world hunger piece  
19                  that we are taking on right now changing.

20                  Clearly, I think what I have  
21                  everybody say along the line is  
22                  standardization is critical. I mean we sort

1 of have got that crossed out but we have all  
2 said, I think, why should a Soldier and a  
3 Marine who have similar issues land in  
4 different disability systems or be subject to  
5 different benefits, depending on their  
6 service.

7 So, there are some things, I  
8 think, that we can come down hard on. I like  
9 standardization. I think there should be no  
10 service parochialism in the disability system.  
11 But those are my two cents.

12 DR. PHILLIPS: I don't know.

13 MR. DRACH: Is it the DES system  
14 that is broken or is it the DES process that  
15 is broken? I think, in part, the  
16 standardization is part of the solution  
17 because I think DoD and the Services have made  
18 the system or the process more complicated  
19 than it needs to be.

20 Now, I have not gone through this  
21 DES process but I did get through the process  
22 47 years ago. I think, in an attempt to not



1 repeat what we did 50 years ago with Vietnam  
2 veterans, that the Services have made this  
3 process so convoluted in an attempt not to do  
4 the wrong thing, that they end up doing the  
5 wrong thing, which is the unintended  
6 consequence. So, I think standardization  
7 might be one way to address that.

8           The other concern that I have, as  
9 I read the recommendations and findings, and  
10 maybe I am misinterpreting, you could have,  
11 possibly, a combat wounded service member who  
12 loses a leg below the knee in Afghanistan, 40  
13 percent VA or military, as it stands right  
14 now. Are we saying that that amputee will get  
15 workers' comp as opposed to the DES process  
16 and be retired, et cetera, et cetera?

17           I know he or she would go to the  
18 VA and get the compensation but are we  
19 treating that amputation the same as we would  
20 under workers' comp for a miner who loses a  
21 leg below the knee in a mining accident? I  
22 don't think we should.

1 DR. PHILLIPS: Let me -- I don't  
2 know if this will help and I don't know if we  
3 can connect the dots. But going back to Dr.  
4 Stone's workman compensation model or  
5 something like that, and I don't know what the  
6 present rules are, exactly, but when I was in  
7 my practice, we had two types of disability  
8 policies. One was own occupation and one was  
9 general disability. So, my own occupation as  
10 a cardiac surgeon, if I could not function as  
11 a cardiac surgeon or I could not function as  
12 a tank driver or as a paratrooper, that was  
13 one type of disability which some folks in my  
14 practice couldn't perform any further for a  
15 variety of different reasons. The other type  
16 was a general disability, if you develop heart  
17 disease, diabetes, or whatever. And I don't  
18 know if we can connect the dots but I was  
19 thinking along what Dr. Stone mentioned about  
20 workmen's comp model, whether or not something  
21 like that could apply to what we are trying to  
22 do.

1           I mean it goes along with a lot of  
2 things we have been saying. If you can't work  
3 as an MOS XYZ, then perhaps you can move on to  
4 something else. But perhaps, to me, that is  
5 a simple model, and perhaps we can adopt  
6 something like that. I don't have a specific  
7 language or answer yet but I throw that out  
8 for though.

9           DR. STONE: So, Ron, I think that  
10 is the exact answer to the question you posed,  
11 which is right. Is this something that  
12 happened as part of your service or is this a  
13 disease process that was incidental? And I  
14 think it approaches that.

15           Now, that is the framework I think  
16 you put in and then you allow the discussion  
17 of that to really vet out what is fair and  
18 what does the government want to do.

19           I think we all recognize, today,  
20 as providers, that there are things that we  
21 don't know about service and long-term effect  
22 of service. And going back to your comment,

1 Suzanne, the default is always to the service  
2 member. And there are things that if I pull  
3 out the academics of the relationship to  
4 previous Agent Orange exposure to some of the  
5 disease processes we are compensating, I can't  
6 create firm linkage but policy is that the  
7 default goes to the service member. That is  
8 entirely okay.

9           What this does, though, is falls  
10 within really about 75 or 80 years of workers'  
11 compensation experience across all industries.  
12 I am just not sure why DoD needs to firmly  
13 identify itself as separate from what grew up  
14 at the end of the depression, as an effort to  
15 compensate industrial workers during the  
16 industrial revolution. And we have learned  
17 75, 80 years now, you can jump and down and  
18 say yes, but there are different injuries.  
19 Okay, we can default to the service member.  
20 But this system, we have to give some  
21 structure. And I would submit to you that as  
22 I look at the debate across DoD and the

1 government, your debate here is probably more  
2 sophisticated than we have seen in almost any  
3 other area of discussion, except for a few  
4 think tanks. And I would not, in any way,  
5 downgrade the level of expertise that you are  
6 bringing to this discussion in creating what  
7 Admiral Nathan has suggested and that is the  
8 framework for a future solution to this.

9 MR. REHBEIN: I think as we  
10 discuss workmen's comp industrial situations,  
11 the similarities and differences, there is one  
12 fundamental difference between the military  
13 and industry that we need to keep in mind.  
14 That miner goes through life-threatening  
15 experience today and this afternoon, as he  
16 leaves the shift, he goes to the personnel  
17 office and says that's it. Cut my last check.  
18 I am done. The sergeant can't do that. And  
19 so I think there is a fundamental difference  
20 there that we need to keep in mind as we talk  
21 about these sort of disability or compensation  
22 systems, whichever it is. We are going to put

1 that military member back into jeopardy,  
2 whether or not they agree.

3 MR. DRACH: One final comment and  
4 I will shut up.

5 When you look at the workers' comp  
6 system and the idea of return to work, I am  
7 all for return to work. That is what I am all  
8 about. I have been doing it for many, many,  
9 many years. Getting back to work, that is  
10 what it is all about. One of the critical  
11 factors, which I don't think DoD or the  
12 Services are prepared to do or are willing to  
13 do, and that is immediate intervention. As  
14 soon as that person is medically stabilized,  
15 they need to start working immediately with  
16 the mindset that we are now providing services  
17 to you that is going to make you ready, able,  
18 and willing to go back to work as soon as  
19 possible.

20 Under the system, we have seen  
21 service members in some of our focus groups  
22 have been three years' post-injury still on

1 active duty, still being tossed around. And  
2 I think this is where the simplicity and all  
3 the consistency needs to be looked at. Why is  
4 somebody being held for three years post-  
5 injury? Now, that person is probably never  
6 going to go back to work because we have  
7 incentivized him or her to stay disabled.

8 So, somewhere along the line, the  
9 idea, the culture has to change that we are  
10 coming in immediately with a return to work  
11 policy and procedures that is going to help  
12 you through the rehab process and get back to  
13 work as soon as possible.

14 CO-CHAIR CROCKETT-JONES: Okay, I  
15 just want to jump in, Ron, and say that we  
16 also saw places where medical limitations were  
17 not respected and folks were being pushed back  
18 into work that was not appropriate. So, I  
19 think that in some ways this mission, the  
20 mission of recovery and transition is so very  
21 different from the rest of the military  
22 mission that it might be best to minimize how

1 much of it the DoD does and to shift more of  
2 that to the VA, which does it -- which has  
3 that as part of its mission. But I think that  
4 is finer grains of sand than we can put into  
5 this recommendation.

6 I want to say that I think what  
7 everyone experiences when you are getting  
8 ready to retire and doctors are encouraging  
9 you to start recording everything, the current  
10 system is confrontational. It encourages  
11 people to game the system because it is  
12 confrontational.

13 Service members repeatedly tell  
14 us, everywhere we went, you get into IDES and  
15 it is you against the system. And the system  
16 is trying to keep you from getting compensated  
17 and you have got to be your own advocate to  
18 try and get your compensation. And it takes  
19 a long time and it is frustrating. And I  
20 think we all know it is broken. It is not  
21 working to the best outcomes for either side  
22 of the equation.



1  
2 I know that we really would love  
3 to put in every single descriptor and tell the  
4 DoD how to redesign IDES. They are not going  
5 to do it based on our recommendation. I think  
6 that the reality is we are adding our voice to  
7 the weight that says the current system has  
8 got to go. A new system should be created.  
9 And I think we need to let our findings speak  
10 for themselves and we should do, in the  
11 recommendation itself, just the framework that  
12 we talked about. I think that our discussion  
13 and the amount of nuance and fine grains of  
14 sand that we have got going here is why after  
15 this happened before, we came down to a set of  
16 bullets of hallmarks of what we would expect  
17 to see because as soon as we try to expand any  
18 one of those bullets, we have got lots of  
19 nuance and lots of grains of sand.

20 And if we tried to put that all  
21 into a recommendation, I think it would not be  
22 heard how clearly we are saying get rid of

1 IDES, burn it to the ground is, I think, the  
2 language we might have considered at one  
3 point. Start over again. Do something new.

4           And DoD is not going to throw out  
5 IDES and just follow our five bullets because  
6 we said so. But we are lending our voice to  
7 the -- we are not the first body to say IDES  
8 is not working. I think that our bullets,  
9 though, should be more clear and perhaps more  
10 than a word or two. Our bullets can be full  
11 sentences so that simplicity can be expanded  
12 or changed to something that captures our  
13 intention better.

14           I think compensation for lost pay  
15 or lost employment should be one of the  
16 bullets because I think that we clearly see  
17 that as a more viable method for disability  
18 evaluation. And I think otherwise, we have  
19 hit the right bullets. I don't think we can  
20 add anymore. I think five is good.

21           I think if we start adding too  
22 much, it will just, it won't add anything to

1 the recommendation itself. I don't think it  
2 will have any more impact. And I don't think  
3 that anyone is going to rely on our  
4 recommendation to create a new system. They  
5 are going to study it themselves. And perhaps  
6 the only other thing that we might want to put  
7 in there is a call that it should be evidence-  
8 based that they need to base the system not on  
9 the assumptions. I mean we have all made them  
10 here. We hear it everywhere we go. There are  
11 tons of assumptions made about the people who  
12 are in the system that don't always pan out to  
13 be evidentiary. So, we want them to use data  
14 and evidence to create a system, not  
15 assumptions.

16           If we want simplicity, when we say  
17 patient- and family-centered, if we want to  
18 expand that to say that the service member,  
19 the tie goes to the runner language, I can't  
20 think of how to put it. When we say patient-  
21 and family-centered, that is really what we  
22 mean.

1           The only bullet there that we  
2           can't seem to find the right words for is  
3           simplicity. We don't want it to be  
4           convoluted. We don't want it to be long. We  
5           want to minimize the confrontationality. But  
6           simplicity isn't adequate to describe what we  
7           want. Yes, we know the current system is too  
8           confusing and too complex but, in what ways?

9           Otherwise, I think we should stop  
10          messing with it.

11          CSM DEJONG: Let me make a quick  
12          suggestion here. Simplicity, I understand and  
13          I am listening to this conversation, what if  
14          we would just take what we have here and prior  
15          to the findings put the paragraph that General  
16          Stone has put together, which we might have to  
17          refine that paragraph, as a summary explaining  
18          simplicity prior to the findings. Because if  
19          the concern is that they only read the  
20          recommendation and they read the bullets, they  
21          might pick up on a summary of what it is prior  
22          to the findings, which is very clearly

1 articulated here with the paragraph that  
2 General Stone had made. We would leave that  
3 in there and --

4 CO-CHAIR NATHAN: Well, why don't  
5 we do this to try to get to the finish line?

6 We currently have, and Suzanne I  
7 think well said, I think you encapsulated the  
8 concerns very well, we currently have five  
9 bullets there. So, standardization across  
10 DoD. I am sort of adulterating the Roberts  
11 Rules of Order here but I am trying to get us  
12 to something that we can all agree on or agree  
13 to disagree on.

14 Standardization across DoD,  
15 comments, concerns about that bullet. People  
16 who feel viscerally that it should be removed  
17 or people who feel viscerally that it needs  
18 more, as opposed to looking in the findings,  
19 that it needs more substance as a bullet. Or  
20 are you okay with it? If I don't hear  
21 somebody say remove it or if I don't hear  
22 somebody say I like it but it needs to be

1 longer, then I am going to assume that we  
2 leave it. Going once.

3 CO-CHAIR CROCKETT-JONES: Can I  
4 ask a question of the folks who are actually  
5 in the service? When DoD hears that phrase  
6 standardization across DoD, do they know that  
7 we mean no service differentials, that we mean  
8 standardization across the Services?

9 CO-CHAIR NATHAN: I think that is  
10 a good point. I think that is what we mean.  
11 That is where it came from in our discussion.  
12 So, you could add standardization across DoD,  
13 there should be no service variance in DES  
14 processing.

15 CO-CHAIR CROCKETT-JONES: Is that  
16 good?

17 CO-CHAIR NATHAN: We will come  
18 back to simplicity, I think, because that is  
19 the one that I think has the most angst with  
20 it. Let's get that for a second.

21 Compensation for lost pay or lost  
22 employment ability. Is there anybody who

1 feels that that is inappropriate to be here or  
2 it should be here but isn't articulate enough?

3 MR. REHBEIN: I would argue that  
4 there may be one more thing that goes into  
5 that and that is quality of life. Because a  
6 disability may not affect your employment  
7 ability but it certainly can affect the things  
8 that you do outside of your job.

9 And I am holding Mr. Drach up here  
10 as an example. He has lived a very productive  
11 employment life but that prosthetic leg has  
12 certainly affected the things that he can do  
13 outside of that employment. And so I think  
14 maybe quality of life belongs in there.

15 CO-CHAIR NATHAN: It works for me.  
16 It is just it is difficult, I think, one  
17 person says potato, one person says potato.  
18 Once you start trying to figure out how to  
19 compensate for quality of life, I just think  
20 it is difficult do to that but that has to be  
21 in the mix.

22 So, concerns with that?

1 DR. STONE: Yes, I am concerned  
2 about it because I think that that falls into  
3 really the long-term disability process. It  
4 is not about compensation. And really, I  
5 think what we have to acknowledge is this  
6 initial lack of my being able to continue as  
7 an employee of DoD is really about my ability  
8 to earn an income and then transition to my  
9 next life. What my future quality of life is,  
10 what my future happiness is, I don't think is  
11 part of this discussion. And I would have  
12 trouble supporting that. I understand where  
13 you are coming from but I think that there is  
14 a way to get to that in the VBA system.

15 CO-CHAIR NATHAN: What I hear you  
16 saying is that is an intangible that is going  
17 to be difficult to figure out some sort of pro  
18 rata compensation for.

19 DR. STONE: That is a way better  
20 way of saying it, yes.

21 CAPT SANDERS: But I think you  
22 have to recognize that that is a factor. I



1 have to follow with Dave's comments that we  
2 have to consider that and it needs to be in  
3 the mix.

4 I guess I would also ask is it  
5 clear that when we say compensation for lost  
6 pay, it is lost future pay, post-service, or  
7 is that a lost pay of continued service?

8 CO-CHAIR NATHAN: I think once you  
9 are in the DES system, you are headed out the  
10 door. And so, we are compensating you for  
11 what you may or may not be able to do in the  
12 future. You are going to get, depending on  
13 how ill or injured you are, you are going to  
14 get a medical retirement. But this, to me, if  
15 you are in the DES system, we have determined  
16 that you no longer can remain on active duty.  
17 And so, we are going to try to figure out if  
18 you have either acquired something or we have  
19 done something to you that is going to hamper  
20 your ability to be financially productive in  
21 some other venue.

22 And it was well stated there are

1 two ways to do that. One is to say I was an  
2 MA in the service and I can't be a policeman.  
3 And the other is, I have diabetes and that is  
4 going to affect me generally. But I look at  
5 it as lost future pay. So, I think it is fine  
6 if you want to put future in there.

7 CO-CHAIR CROCKETT-JONES: I think  
8 that we could allay the fears that want us to  
9 include diminished quality of life by  
10 including potentially in the findings that the  
11 VA system needs to focus on the health and  
12 quality of life and have benefits that focus  
13 on that, rather than on rating as they do now,  
14 the ability to perform the job. That that  
15 weighting should be done by the military and  
16 compensation should be made and the VA system  
17 is where health and quality of life needs to  
18 be consideration.

19 CO-CHAIR NATHAN: So, you would  
20 make that a finding?

21 CO-CHAIR CROCKETT-JONES: I think  
22 that should go into the findings, exactly.

1 Because we are not telling -- this  
2 recommendation is for what the DoD to do.

3 CO-CHAIR NATHAN: Okay, so we have  
4 Ms. Crockett-Jones has said we will leave it  
5 as compensation for lost future pay or lost  
6 employment ability. And then we will further  
7 add to the findings that the VA system needs  
8 to focus on health and quality of life in  
9 their disability evaluations. Any concern  
10 with that?

11 MR. REHBEIN: No. In fact, that  
12 satisfies my original concern. I just don't  
13 want quality of life to not be considered here  
14 anywhere. And including that in the findings  
15 as a VA, an area of VA responsibility, yes.

16 DR. PHILLIPS: Perhaps a word that  
17 we should be using for this particular  
18 recommendation is objective, objective  
19 findings versus subjective, which would be  
20 more toward the VA.

21 MS. MALEBRANCHE: A question, I  
22 guess. Sorry. I apologize I have urgent

1 stuff.

2                   Quality of life, when we talk  
3 about quality of life, and we have had these  
4 discussions before, I guess defining that,  
5 when you say VA for that quality of life, that  
6 can be pretty broad. And I think we need to  
7 have some sort of parameters or discussion on  
8 what quality of life that could be --

9                   CO-CHAIR CROCKETT-JONES: I think  
10 we are only saying, so I don't think we need  
11 to actually define it because we are not  
12 making this recommendation to VA. This is a  
13 recommendation to DoD to clean up IDES,  
14 actually, to get rid of it and start a new  
15 system.

16                   The concern is that if we say move  
17 to a career compensation, which actually now  
18 that I think of it, might be a word we want to  
19 put in that line because really what is  
20 happening is for some folks it is a loss of  
21 future really but some folks have a very  
22 technical and specific career in the military

1 that they lose the ability to do. So, career  
2 might need to be in there.

3 But what we are saying is that  
4 this is a compensation about employment and  
5 pay. And that is what the system needs to do  
6 in the DoD. Those issues related to  
7 longevity, long-term health, quality of life  
8 are really what the VA benefit system is  
9 designed better to address. So, that is why  
10 the VA has rehabilitation services, OIF/OEF  
11 programs, adaptive sports, whatever. Do you  
12 see what I am saying?

13 So, we are just saying that these  
14 need to be separated. And I don't think we  
15 need to make a recommendation, clarify what we  
16 are recommending the VA do because we are  
17 talking to DoD here.

18 DR. STONE: So one of the things,  
19 Karen, I think we are coming to is a rejection  
20 of integration. This is about career  
21 compensation and transition to next  
22 employment. And we reject the concept of

1 integration and that somehow this needs to be  
2 integrated.

3 Now, from a timing standpoint,  
4 yes, we want service members and employees to  
5 be not left in a lurch in the middle between.  
6 But that is strictly a bureaucratic process  
7 which needs to be worked through. But this,  
8 in its simplification is about compensation  
9 and transition to next employment. And then  
10 all of the other pieces are more rightfully  
11 held with the veterans benefit system.

12 MS. MALEBRANCHE: Okay. I  
13 understand. It makes sense the way you both  
14 explained it and I would tend to agree on  
15 that. I think I am just maybe overly  
16 sensitive to all the different definitions and  
17 what we are supposed to be doing now.

18 CO-CHAIR NATHAN: So, I read it as  
19 the moral majority here is happy with  
20 compensation for lost future or lost  
21 employment ability as a bullet.

22 Moving to incentivization of work

1 and illness, you have seen some of the  
2 verbiage that has been added there talking  
3 about the GI bill. Too much? Too little?  
4 Any dis-ease with the bullet as it stands?

5 DR. STONE: Sir, would you  
6 consider in this reference to a single payout  
7 system, that one of the principles of  
8 incentivizing wellness is a single payout  
9 system?

10 CO-CHAIR NATHAN: The here is your  
11 money, spend it in Vegas or put it in a CD,  
12 whatever you want to do, it is up to you now,  
13 you are not getting any more down the road  
14 unless you come back to the VA with a  
15 significant change in your health status based  
16 on, which happens all the time, people come  
17 back 20 years' later after service and have an  
18 aggravation in their original disease process  
19 which wasn't apparent at the time and they can  
20 apply for a new compensation.

21 CO-CHAIR CROCKETT-JONES: I'm  
22 going to throw a monkey in that wrench. I

1 don't think we should necessarily encourage a  
2 single payout. We, right now, we see  
3 transitioning members who get the TSGLI in a  
4 single payout and there is even problems with  
5 that amount of money.

6           So, I am concerned. I think that  
7 it is great for the 35-year-old. It is not  
8 necessarily a single payout for the 20-year-  
9 old who has traumatic, very serious traumatic  
10 injuries and is going through a very long  
11 process of transition to a new normal to get  
12 a single payout.

13           DR. STONE: So a single payout  
14 does not mean necessarily cash. A single  
15 payout says that I am not disincentivized to  
16 recover. So that the government commits to  
17 the payment in advance. And, let's say, I'm  
18 in the first two years of my first enlistment  
19 and I am injured in basic training. It may be  
20 a system is developed that says we will cover  
21 you for two to three years. That three years  
22 of compensation is then placed into an



1 annuity. It can be paid out for some period  
2 time but it protects people from a lump sum  
3 being handed to someone who may not be able to  
4 be prepared to handle that and it protects the  
5 individual in the future.

6 Now, I am always hesitant to say  
7 that there is some sort of bureaucratic system  
8 that knows better than the individual.  
9 However, I think that that option does exist  
10 and could be rectified appropriately. By the  
11 same token, there is actuarial data that says  
12 that if I reach eight, nine, ten years' of  
13 service, what the prediction is that I am  
14 going to go on to a 20 year career. If  
15 someone is receiving ten years' of  
16 compensation, the basic premise to this is  
17 that the government should not be incentivized  
18 to declare me better when I am not yet better,  
19 that the payout should be done. It can be  
20 placed in an annuity. It can be placed in  
21 some other manner that protects the individual  
22 for the future but yet my recovery then is

1 independent. I may have eight years of income  
2 coming from Department of Defense as part of  
3 an annuity that I structured over my lifetime  
4 but I am still incentivized to return to work  
5 to complete my education. And the American  
6 system is then incentivized by discussion with  
7 the IRS to employ me in the future as an  
8 advantageous employer.

9 CO-CHAIR NATHAN: So let me call  
10 for the question on that because we don't want  
11 to devolve into telling anybody who creates  
12 the new system or a better system how to suck  
13 the egg. But we have, basically, on the  
14 floor, is adding or leaving off the term  
15 consideration for a single payout system,  
16 which, in its rudimentary rough form simply  
17 means I give you some sort of compensation at  
18 one time and then I am done with you.

19 Any comments for or against that?

20 MR. REHBEIN: I think somewhere  
21 there has to be a definition about what Rich  
22 just talked about to the single payout system

1 is not just a lump sum because I think that is  
2 going to be the assumption that is made by at  
3 least 90 percent of the readership.

4 DR. PHILLIPS: Yes, I agree. I  
5 like the single payout concept. Perhaps we  
6 call it a capped amount or something like  
7 that. It is more semantics. But I think the  
8 concept of not having someone to continue  
9 their disability because of the need for  
10 continued support, as opposed to yes, you are  
11 done. Here is something for you but don't  
12 expect this to -- don't be incentivized to  
13 continue your illness because you expect to be  
14 compensated.

15 CO-CHAIR NATHAN: So, Rich, how  
16 would you phrase with ten words or less a  
17 single payout system that is better defined as  
18 not necessarily a lump sum?

19 DR. STONE: That the options in  
20 payout can fund long-term income processes.  
21 I can't get the words together at this point,  
22 necessarily.

1 MS. MALEBRANCHE: You know this  
2 sounds so similar to like some of the  
3 European, the UK and the like with the single  
4 payout. But the thing that is there that is  
5 different is, I think, their social medicine  
6 that if we had a single payout and then they  
7 had the ability to get the care and continuity  
8 in VA, which they should, the disability, I  
9 don't know how you would tier that or say that  
10 or how much. But the fact that they have care  
11 beyond a single payout because I think the  
12 worry to the individuals is that you are going  
13 to pay me off and then that is it and I am  
14 done and I am all on my own.

15 And I think so if you know that  
16 you are not all on your own, you still now  
17 have care because of your disability in a  
18 system, then I think that -- but I don't know  
19 how to phrase that.

20 DR. STONE: Yes, I need the wisdom  
21 of the crowd here to help me through this.  
22 Now, I know where I want to get here. I just

1 don't know how to do it in ten words or less.

2 DR. PHILLIPS: I mean what would  
3 we say for the subjective injury or illness?  
4 This is your compensation. And of course,  
5 then you move on to the VA.

6 MS. DAILEY: So how does that  
7 phraseology up on the screen right now look to  
8 you? Is that helpful?

9 So, compensation for lost future  
10 pay or lost employment ability, via a single  
11 payout that is not affected by subsequent  
12 recovery. Is that helpful?

13 CO-CHAIR CROCKETT-JONES: Instead  
14 of single payout, a set payout. Because I  
15 think it is the word single, a set payout that  
16 indicates there is a set amount and it can be  
17 an annuity. It can be an over time  
18 compensation. But that it is a set amount or  
19 a set time frame.

20 I think that that is better than  
21 saying single.

22 MR. DRACH: Well, we currently,

1 unless it has changed, I haven't heard it  
2 discussed the last four years but we already  
3 have a single pay system, a single -- on  
4 severance pay. So, somebody that goes through  
5 the process and they don't meet the 30 percent  
6 for disability retirement but they have 10 or  
7 20, they get severance pay, which is not  
8 totally different from what we are saying here  
9 but that is a lump sum. There is no options  
10 on that.

11 So, are we talking something  
12 different here or conceptually the same type  
13 of thing? Should we reference severance pay  
14 as an example? I don't know.

15 DR. STONE: I like that. I like  
16 the idea that this is severance pay, the  
17 structure of the payout to be discussed and  
18 too, based on the fact that we just don't want  
19 a large sum of cash that may be wasted.

20 CO-CHAIR CROCKETT-JONES: Yes, it  
21 may be a modified severance that considers  
22 transition issues.

1                   CO-CHAIR NATHAN: I think once you  
2 start using the term severance pay, though, or  
3 other things, you are starting to get into the  
4 tactical implementation of how you would do  
5 this. I think you still want to hold on to  
6 just some concept, the concept of set payment,  
7 consolidated payment. Otherwise, we are going  
8 to get too far down the rabbit hole.

9                   DR. STONE: What if we used the  
10 word structured?

11                   DR. PHILLIPS: Yes, exactly.  
12 Instead of set use structured.

13                   CO-CHAIR NATHAN: That's fine.

14                   DR. STONE: Which allows broad  
15 latitude, then, of how it is compensated.

16                   CO-CHAIR NATHAN: So, as it reads  
17 now, concerns? Compensation for lost future  
18 pay or lost employment ability possibly via a  
19 structured payment, lump sum or annuity, that  
20 cannot be changed by subsequent recovery.

21                   DR. PHILLIPS: I have a little  
22 trouble with the word possibly. I mean do we

1 need that?

2 MS. DAILEY: No, take possibly  
3 out.

4 MR. REHBEIN: Probably just remove  
5 the comma, too.

6 CO-CHAIR NATHAN: Any other  
7 concerns? Going once. Going twice. Sold.

8 DR. PHILLIPS: Wait. Do we even  
9 need lump sum or annuity? I mean that sort of  
10 restricts them. Just a structured payment and  
11 it could be worked out.

12 CO-CHAIR NATHAN: Well, I think  
13 the lump sum or annuity conveys a little more.  
14 It puts a finer point on it to help people  
15 understand what structured payment means.

16 DR. PHILLIPS: Maybe such as a  
17 lump sum or annuity.

18 CO-CHAIR NATHAN: Well, because  
19 structured payment is what you have now. In  
20 the current disability system, you get a  
21 structured payment but it is not necessarily  
22 a lump sum or annuity.



1                   So, I think lump sum defines it,  
2                   totally defines it.

3                   Okay?

4                   CO-CHAIR CROCKETT-JONES: Okay.

5                   CO-CHAIR NATHAN: All right.

6                   Let's move to --

7                   LT COL KEANE: Sir, I have one  
8                   quick question. Do we have enough information  
9                   in the findings to cover that bullet? Because  
10                  it is getting a little --

11                  MS. DAILEY: We're going to go  
12                  back and include more information about the  
13                  many -- well, include more information about  
14                  police and firefighters compensation programs  
15                  and the high-risk programs. We will bring in  
16                  a paragraph about high-risk programs that  
17                  might be able to support that.

18                  LT COL WONG: Just a quick  
19                  question. Just I am concerned that we are  
20                  going down a path where we used to be before  
21                  it was IDES because now we are mincing between  
22                  Title 10 and Title 38 here. In one aspect we

1 are saying we need to separate the two,  
2 although we have brought them together. We  
3 need to have the DoD focus on, and the DoD  
4 will say we used to and now we have brought  
5 this VA piece in. We are trying to simplify  
6 it by making it faster, et cetera. I think on  
7 this bullet, unless we define it more in the  
8 findings, they are going to say well, we  
9 already do that with the Title 10 with either  
10 set pay or medical retirement, they are going  
11 to get that and it is not going to change your  
12 base after their recovery, if that is what  
13 their percentage rating is at.

14 And when we say respective of  
15 recovery, does that mean when they are in the  
16 IDES, they recover, they are still able to get  
17 that because they were -- I think then that  
18 needs to be more defined in the findings  
19 because as the bullet stands alone, it is not  
20 --

21 CO-CHAIR NATHAN: Well, no, these  
22 are concepts that we are trying to get across,

1 not necessarily the tactical implementation of  
2 how a new system or the current system would  
3 work. These are concepts.

4 The concept is standardized across  
5 DoD. In other words, there should be no  
6 different in either IDES or DES for a Marine  
7 as there is for a Soldier. And currently  
8 there is a difference.

9 Compensation for lost future pay  
10 or lost employment ability would be a  
11 structured payment, lump sum or annuity. That  
12 has never been done before. That is a  
13 different way to award people monies or  
14 compensation based on their injury or  
15 illnesses.

16 DR. STONE: So Ted, I think to me  
17 simplified means that it is really  
18 predictable. And it doesn't vary, you know if  
19 somebody very early on in the process can sort  
20 of see what is going to happen to them. Okay,  
21 I am in the first couple years of my service.  
22 Here is how much I am going to get. Here is

1 the percentage of my income I am going to get.  
2 And here is the window I have got to sort of  
3 structure my life for the future. So,  
4 simplification is predictability and no  
5 variance.

6 CO-CHAIR CROCKETT-JONES: And  
7 transparency.

8 MS. DAILEY: Okay, I do need to  
9 kind of corral the argument a little bit here.  
10 The last thing we were talking about was the  
11 compensation for lost or future. Are we still  
12 there or are we moved on to simplicity?

13 Do we have some agreement on  
14 compensation for future pay? Focus here.

15 DR. STONE: Well, I think we are  
16 focused, Denise. I think we are responding to  
17 Ted's concern and I am not sure we have done  
18 that. Have we done that?

19 LT COL WONG: Yes, sir.

20 CO-CHAIR CROCKETT-JONES: Yes, so  
21 I think Rich came up with some language for  
22 simplicity that we can move to that and put

1 that in because we have really struggled with  
2 that.

3 MS. DAILEY: Are we okay with  
4 compensation? Is everyone okay with the  
5 compensation bullet?

6 CO-CHAIR NATHAN: Okay, let's move  
7 to simplicity.

8 MR. REHBEIN: Sir, before you go  
9 directly to simplicity, I want to drop down to  
10 patient and family-centered because I think  
11 those words are well understood out there.  
12 And I think if a system was developed that was  
13 truly patient and family-centered, it would  
14 be, by definition, simple, simplified,  
15 understandable. And so now, I am, frankly,  
16 wondering if we even want to struggle with  
17 defining simplicity or if we want to hang our  
18 hat on maybe not patient- and family-centered  
19 but service member- and family-centered.

20 CO-CHAIR NATHAN: Right. The  
21 conversation centered for patient- and family-  
22 centered was, I can't remember who said it in

1 the past but it was basically the system is  
2 tilted towards the system in trying to figure  
3 out how to be expedient for the system and not  
4 necessarily for the member or their family.  
5 They get caught in the gears. It takes  
6 forever. They don't know who to call. They  
7 don't know who to talk to. It varies from  
8 person to person. Two people with the same  
9 issue can get different compensations.

10 And so it was a concept of putting  
11 patient -- which again is a warm, fuzzy,  
12 squishy sort of term. It would be no  
13 different than if we wrote the system should  
14 be fair. Let's just, one of our bullets for  
15 the system should be fair. Okay, got it.  
16 What does that mean?

17 So, patient- and family-centered  
18 was just more of a warm and fuzzy, I think.

19 CO-CHAIR CROCKETT-JONES: I think  
20 that when we say simplicity, I think Rich got  
21 it right, it is about predictability and  
22 transparency. I think when we talk about

1 patient- and family-centered, I think we are  
2 talking about reducing confrontationality and  
3 increasing patient -- well service member and  
4 family understanding of the process. So, I  
5 think we should keep them separate because I  
6 think there is two components that we see  
7 missing in current IDES, predictability and  
8 transparency. I think that is what we mean by  
9 simplicity.

10 And when we say patient- and  
11 family-centered, I think we are talking about  
12 and I know it sounds like a warm fuzzy but I  
13 think it is about that us and them  
14 confrontation that people experience that  
15 makes them game the system.

16 CO-CHAIR NATHAN: I've got no  
17 problem with patient. How do you argue  
18 against something being patient- and family-  
19 centered? So I have zero problem with leaving  
20 it there. I am just saying that it is  
21 somewhat nebulous but I think it conveys that  
22 this committee, this task force believes that

1 the DES system should always take into account  
2 first, should be centered around what the  
3 patient and the family need, both in the way  
4 they approach the processing of it and in the  
5 way the final outcomes are. So, that is what  
6 patient- and family-centered means to me.

7 It is unfortunate that we have to  
8 say it but I think we do have to say it.  
9 Because by saying it, what you are saying is  
10 please don't make this system-centered. Don't  
11 make it DoD-centered. Don't make it VA-  
12 centered. Don't make it taxpayer-centered.  
13 Don't make it congressionally-centered. Make  
14 it patient- and family-centered.

15 MR. REHBEIN: And my argument is I  
16 think the words patient- and family-centered  
17 are much less nebulous than simplicity.  
18 Because I think if you walk up to most people  
19 and ask them what they think patient-centered  
20 means, they have a grasp. They have an  
21 understanding.

22 If you walk up to most people and



1 tell them that you want this to be simplified,  
2 that doesn't take them anywhere. But I think  
3 if a new system is truly patient- and family-  
4 centered, it is transparent to the patient and  
5 family. It is understandable to the patient  
6 and family. It is predictable to the patient  
7 and family. And, therefore, it is simpler.

8 CO-CHAIR CROCKETT-JONES: Well,  
9 maybe we'll combine them.

10 CO-CHAIR NATHAN: Okay, so let's  
11 call for that question.

12 MR. DRACH: Excuse me. I have one  
13 more comment, if I may.

14 Let us not delude ourselves into  
15 thinking that this change is going to  
16 mitigate, let alone eliminate confrontation.  
17 It is going to exacerbate confrontation.

18 CAPT SANDERS: Could I ask if we  
19 think about what we said on page 12 of the  
20 findings, the first sentence and the last  
21 sentence, I thought at least partially defines  
22 what we were saying in simplicity. In that

1 sentence, it talks about move away from a  
2 system of compensation for illness or injury,  
3 illness and a loss of career to a simple  
4 system. And in the last sentence, it defines  
5 our five hallmarks, ability over disability,  
6 return to work, patient- and family-centered,  
7 and good care, and standardization across  
8 service Components. Is that what we were  
9 saying? Or is that beyond what simplicity is  
10 meant to be?

11 MS. MALEBRANCHE: I think those  
12 are right on target. I think it is very nice.  
13 And they don't use the negative piece like  
14 non-confrontational but you are saying what it  
15 is. Actually, I guess our team wrote those.  
16 That is a really nice job.

17 CAPT SANDERS: Maybe a combination  
18 of those two sentences and paring it down a  
19 little bit to make it more on point, get you  
20 what you need from simplicity.

21 CO-CHAIR NATHAN: So, what would  
22 you say?

1                   CAPT SANDERS: I would start with

2                   --

3                   MS. DAILEY: Okay, I need to  
4 clear. Where are you talking about?

5                   CAPT SANDERS: I am on page 12,  
6 paragraph one, the first sentence, six words  
7 or seven words in. Move away through that  
8 sentence, it goes down to the word system.  
9 And then I would jump down to the word on in  
10 the next to the last line of the last sentence  
11 and follow that through to the end.

12                  MS. DAILEY: Okay and this is  
13 being applied to simplicity or family? Or  
14 have we combined it?

15                  CAPT SANDERS: No, just to  
16 simplicity. I was not attempting to combine  
17 it. I think they stand alone separately in a  
18 much better way than they would if they were  
19 combined.

20                  MS. DAILEY: Okay, so you only  
21 kind of decide first, combine or leave  
22 separate. And then we can put a definition to

1 either the combined or the separate.

2 CO-CHAIR CROCKETT-JONES: I think  
3 when I look at that sentence, it does combine  
4 them. We don't need to reiterate.

5 MS. DAILEY: Okay.

6 MR. REHBEIN: If I understand  
7 Captain Sanders right, then the simplicity  
8 bullet would include the words patient- and  
9 family-centered. And so I agree. I don't  
10 think we need to repeat them as a separate  
11 bullet.

12 MS. DAILEY: Okay, so Suzanne, it  
13 would be: Simplicity, a system that  
14 incentivizes optimal functioning and capacity  
15 through patient-centered integrated care.

16 And then it goes down to tell me  
17 again, Captain Sanders, where it goes down to.

18 CAPT SANDERS: I went down to the  
19 five hallmarks.

20 MS. DAILEY: Okay, on five  
21 hallmarks, colon.

22 Ability over disability, return to

1 work --

2 DR. STONE: So, at some point, I  
3 think we have to come back to Ron's statement  
4 that these changes will enhance confrontation.  
5 So, at the appropriate point, if we could come  
6 back to that.

7 MS. DAILEY: Patient- and family-  
8 centered, integrative care, and  
9 standardization.

10 CO-CHAIR CROCKETT-JONES: I am  
11 just going to throw something in here and I am  
12 sorry. That is too repetitive. It repeats  
13 our five hallmarks that we are working on.

14 CAPT SANDERS: That is why I said  
15 that it had to be pared down from that.

16 CO-CHAIR CROCKETT-JONES: Okay.

17 CAPT SANDERS: But it is heading  
18 in the direction of where I thought we were  
19 trying to get to with simplicity.

20 LT COL WONG: And before you  
21 delete the rest of that, could you just take  
22 the predictable and transparent and just move

1 it up to standardization, initially, as a sort  
2 of placeholder so that we don't lose that? I  
3 think it is a good place for it.

4 CO-CHAIR CROCKETT-JONES: I think  
5 that this is --

6 LT COL WONG: And Captain Sanders,  
7 I thought you wanted to start -- I didn't  
8 think -- for the first part, I thought you  
9 wanted to start right after, you know, start  
10 with the word system after the eighth or ninth  
11 word and stop at system, not start at system.

12 CAPT SANDERS: Actually said move  
13 away from because that was the point we had  
14 been emphasizing here.

15 LT COL WONG: I thought was what  
16 you wanted. They took the second part of the  
17 sentence instead of the first part that you  
18 wanted, I think. To begin with, move away.  
19 Then for simplicity. Is that correct?

20 CAPT SANDERS: Correct, and end at  
21 the word system.

22 LT COL WONG: Right. And they

1 started at the word system.

2 MS. DAILEY: It got it. Move away  
3 from a system --

4 CAPT SANDERS: There you go.

5 MS. DAILEY: -- of compensation  
6 for injury, illness, and a lost career to a  
7 system.

8 CAPT SANDERS: Right. And at that  
9 point, it went on to the five hallmarks, which  
10 I thought needed to emphasize what we were  
11 saying but was a little bit verbose, had too  
12 much verbiage. And I said paring that down to  
13 something less wordy. I don't know what that  
14 would be, right off the top of my head.

15 CO-CHAIR CROCKETT-JONES: Okay,  
16 how about this as an alternate? We can strike  
17 through those.

18 Let's say move away from a system  
19 of compensation for injury, illness and lost  
20 career. But we have already said that we are  
21 compensating for a lost career, so it would be  
22 for that. Moving away from a system of

1 compensation for injury or illness to a system  
2 that is predictable and transparent.

3 Or should we just leave it at  
4 language that the hallmark should be  
5 simplicity, predictability, transparency? We  
6 have two choices, a very pared down or a more  
7 full sentence. How do folks feel about the  
8 two, those two basic options?

9 CO-CHAIR NATHAN: Yes, I just I am  
10 having trouble with simplicity right now. You  
11 are going to move away from a system of  
12 compensation for injury or illness, which is  
13 what a disability evaluation system does to  
14 compensate you for injury or illness. But  
15 wanted to compensate you in a way that  
16 motivates or incentivizes optimal functioning  
17 and capacity through patient-centered  
18 integrated care.

19 CO-CHAIR NATHAN: I would rather, I  
20 mean I am just having a hard time with moving  
21 away from a system of compensation for injury  
22 or illness because that is exactly that it is



1 designed to do, is to compensate you. But it  
2 would be a system, maybe take away move away  
3 from a system of compensation for injury  
4 illness that is predictable and transparent  
5 and incentivizes.

6 CO-CHAIR CROCKETT-JONES: Okay but  
7 we are saying, instead of compensating for the  
8 injury or the illness, the DoD should be in  
9 the business of compensating for the pay and  
10 lost career and that the VA should be in the  
11 business of adjudicating the injury and  
12 illness and for providing benefits for the  
13 health.

14 So, we can't recommend both to  
15 maintain a system that compensates for injury  
16 or illness and get rid of that system and move  
17 to a system that compensates for employment  
18 and career loss.

19 CO-CHAIR NATHAN: Well, you have  
20 sort of got that in the compensation bullet  
21 down below.

22 CO-CHAIR CROCKETT-JONES: Well

1       yes, but we are saying we should be  
2       compensating for pay and lost employment, not  
3       for injury and illness through a rating  
4       system.

5                       CO-CHAIR NATHAN:  No, I  
6       understand.

7                       CO-CHAIR CROCKETT-JONES:  So, we  
8       can't also say -- we can't say get rid of this  
9       IDES and keep IDES.  I mean I feel like that  
10      is what we are saying if we include a system  
11      of compensation for injury or illness, we are  
12      saying both things.  And I think we want to be  
13      clear.

14                      DR. PHILLIPS:  The word modified,  
15      perhaps, after simplicity.

16                      MR. REHBEIN:  I beginning to  
17      believe that the word simplicity is a swamp  
18      that we will never go out of.

19                      CO-CHAIR CROCKETT-JONES:  I think  
20      that Rich's language of predictability and  
21      transparency could be substituted for  
22      simplicity and get rid of simplicity

1 altogether.

2 DR. STONE: Yes.

3 CO-CHAIR NATHAN: Any problems  
4 with that? So, we would eighty-six the  
5 simplicity bullet and we would replace it with  
6 predictability and transparency.

7 CAPT SANDERS: I would also ask  
8 then that we go back and have that first block  
9 of the findings on page 12 that needs to be  
10 rewritten to conform the predictability and  
11 transparency as a statement versus simplicity.

12 CO-CHAIR NATHAN: Okay. So, this  
13 is where we are now. We have one, two, three,  
14 four, five bullets. We have standardization.  
15 We have the next bullet of predictable and  
16 transparent or predictability and  
17 transparency. We have a third bullet  
18 compensation for lost future pay. We have a  
19 fourth bullet, incentivization of work and  
20 wellness.

21 CO-CHAIR CROCKETT-JONES: As a  
22 point of order, can we make that incentivizing

1 and have it be a real word?

2 CO-CHAIR NATHAN: Well, if you are  
3 actually going to start using real words now,  
4 we are in a whole different vein. Okay, if  
5 you insist on using real words.

6 DR. PHILLIPS: I agree with  
7 replacing the simplicity with predictable and  
8 transparent but do we want to leave out the  
9 language that was there behind the simplicity?  
10 Would we want to put that back in, moving from  
11 a system of et cetera, et cetera?

12 CO-CHAIR CROCKETT-JONES: I don't  
13 think we need to repeat that language. I  
14 don't know how anybody else feels. But I  
15 think that language is better found in the  
16 findings. But I think that Captain Sanders is  
17 right, the findings language needs to match.

18 MS. DAILEY: Okay, this finding  
19 language will now say a new paradigm for  
20 rehabilitation of recovering warriors would be  
21 a simple system that incentivizes optimal  
22 functioning and capacity to patient-centered,

1 integrated care. That is what it would sound  
2 like.

3 CO-CHAIR CROCKETT-JONES: Well,  
4 that is exactly what it already says.

5 MS. DAILEY: No, that is not  
6 exactly what it already says.

7 CO-CHAIR CROCKETT-JONES: I see  
8 what you are saying. But it also, instead of  
9 simple system, it could be a predictable and  
10 transparent system, since we are getting rid  
11 of the word simplicity. Is that what you were  
12 saying, Captain Sanders, or do you want it to  
13 --

14 MS. DAILEY: Let's not deal with  
15 the findings. I apologize. I will  
16 consistencize them. You are two hours behind  
17 schedule in the first one. We need to be  
18 focused on the wording of the recommendation.  
19 I will align it with the findings, if you will  
20 give me a recommendation.

21 CO-CHAIR NATHAN: So, to continue,  
22 we have standardization, predictability,

1 transparency, the compensation bullet,  
2 incentivization of work and wellness, and then  
3 the final bullet, patient- and family-  
4 centered, including reduction of  
5 confrontations, focused first and foremost  
6 what the patient and family need, rather than  
7 what the system needs.

8 Is everybody okay with that?  
9 Myers-Briggs kicking in now, those of you who  
10 are thinkers and feelers and judges.

11 CAPT SANDERS: I guess I like the  
12 action word predictable and transparent versus  
13 predictability and transparency.

14 CO-CHAIR NATHAN: Okay, those are  
15 both real words. So, we can consider those.  
16 Predictable and transparent. It is the  
17 passive tense.

18 LT COL WONG: Do we want to order  
19 these, if we are fine, if we are set where  
20 they are at?

21 CO-CHAIR CROCKETT-JONES: Let's  
22 get them on there before we worry about the

1 order.

2 CO-CHAIR NATHAN: Is everybody  
3 okay with predictable and transparent?

4 CO-CHAIR CROCKETT-JONES: Well, it  
5 says -- well, if we are using after a colon,  
6 it is just English, but hallmarks of a  
7 redesigned approach should include predictable  
8 and transparent, we need a noun, I think.

9 CO-CHAIR NATHAN: I thought that  
10 was its own bullet, predictable and  
11 transparent.

12 MS. MALEBRANCHE: Well, it is but  
13 --

14 CO-CHAIR CROCKETT-JONES: Well, it  
15 is but it tied to that colon. They should be  
16 nouns. Hallmarks of the approach should  
17 include --

18 CO-CHAIR NATHAN: No, it's not  
19 part of the first bullet, Karen.

20 CO-CHAIR CROCKETT-JONES: No, it's  
21 not.

22 MS. MALEBRANCHE: It's part of the

1 hallmarks of the redesigned approach.

2 CO-CHAIR CROCKETT-JONES:

3 Hallmarks should be nouns. And so,  
4 predictable and transparent has to have a  
5 noun. There you go. Predictable and  
6 transparent processes.

7 MS. MALEBRANCHE: Processes,  
8 that's good.

9 CO-CHAIR NATHAN: Okay.

10 All right, any other comments?

11 Going once.

12 MS. DAILEY: Hold on just one  
13 moment here. Did you want to include the  
14 evidence-based bullet that you had talked  
15 about earlier, Ms. Crockett-Jones?

16 CO-CHAIR CROCKETT-JONES: I think  
17 that that is the -- we haven't looked at the  
18 last two bullets and I think evidence-based is  
19 really the last bullet.

20 DR. STONE: So, Denise, I think  
21 that ends up in the findings portion because  
22 predictability requires that it is based on



1 some evidence or it becomes, going back to  
2 Ron's point, just in case anyone forgot, it  
3 becomes more confrontational if it is not  
4 based on fact.

5 MS. DAILEY: All right. So, recap  
6 for me one more time where we are at.

7 CO-CHAIR CROCKETT-JONES: We need  
8 to all come to an agreement on the bullet that  
9 says incentivization of work and wellness,  
10 including linkage to the GI Bill.

11 I would say, once again,  
12 incentivizing because incentivization is not  
13 a word.

14 And I am not sure I am comfortable  
15 with including linkage to the GI Bill. It  
16 changes. It has different forms. I am a  
17 little worried about that.

18 DR. STONE: Yes, I think that part  
19 of this was a response to, I think, some  
20 really good points from Ron of how do we  
21 include other things and how do we create a  
22 system that fosters success in the future.

1 Part of that is retraining me for my next job  
2 and to make sure that I am an attractive  
3 employee. But clearly, when I begin to do  
4 that, I now reach into other areas. But  
5 including a principle that during the time I  
6 am going through this, I am being retrained  
7 for another job.

8 CO-CHAIR NATHAN: But I think that  
9 is a concept, Rich. Again, I think that is  
10 beyond the scope of this task force --

11 DR. STONE: And I think you are  
12 right. I think you are right.

13 CO-CHAIR NATHAN: -- to start  
14 talking about how you are going to execute  
15 incentivizing work and wellness.

16 DR. STONE: And my point is, I  
17 think you are right but I think we need to be  
18 responsive by saying the principles should  
19 include. I am not just sitting still. Pretty  
20 much we have talked lots about how I recover  
21 in the healthcare system. How do I retrain?  
22 I think there should be a principle placed in

1 that we assume this will be ongoing at that  
2 time.

3 CO-CHAIR CROCKETT-JONES: Okay, so  
4 how is this? Incentivizing work, wellness,  
5 and retraining opportunities.

6 CO-CHAIR NATHAN: That's fine. I  
7 think that is motherhood and apple pie. And  
8 I think that is the scope of this.

9 You know, I look at our function  
10 as to tell people how Congress and DoD and VA,  
11 what the tenets of your disability system  
12 should be. And then if you agree with us, and  
13 Congress says you know what, these guys are  
14 right. We need to incentivize work and  
15 wellness. Then, they charter or task a  
16 disability working group to figure out how to  
17 do that. And things that would be on the  
18 table would be the GI Bill. There would be  
19 other recovery programs. But we really don't  
20 have the expertise or the time or the effort  
21 to tell them to really map an execution  
22 tactical plan on how to incentivize work and

1 wellness. We just need to make sure that that  
2 is done as part of a disability evaluation  
3 system.

4 TSGT EUDY: That statement should  
5 have education and retraining. The previous  
6 statement of just GI Bill would then state  
7 just education versus vocational  
8 rehabilitation. We need to make sure that --

9 CO-CHAIR NATHAN: Again, I think  
10 that is broad enough that nobody would argue  
11 with that.

12 LT COL WONG: And I think within  
13 this group we all understand but for work  
14 should we also have work transition?

15 CO-CHAIR CROCKETT-JONES: I don't  
16 know because we want people to consider MOS  
17 changes and that might mitigate that. So, I  
18 don't know.

19 LT COL WONG: Or returning to  
20 work?

21 CO-CHAIR NATHAN: Well, I think  
22 incentivizing of work means -- what does that

1 mean to everybody? I mean to most people it  
2 means going to work. Going to work, whether  
3 you are transitioning to work, whether you are  
4 -- it means going to work. Incentivizing of  
5 work.

6 Going once. Going twice on that  
7 bullet. We are going to eighty-six the add  
8 linkage to GI Bill.

9 I think we talked about this. Any  
10 visceral issues with patient- and family-  
11 centered?

12 MS. MALEBRANCHE: Patient- and  
13 family-centered --

14 CO-CHAIR NATHAN: Process?

15 MS. MALEBRANCHE: -- process or --

16 CO-CHAIR NATHAN: System?

17 MS. MALEBRANCHE: -- focus.

18 CO-CHAIR NATHAN: Focus?

19 CAPT SANDERS: Focus.

20 MS. MALEBRANCHE: And then are we  
21 going to re-order these?

22 MS. DAILEY: Okay, do you want the

1 rest of the language in there?

2 CO-CHAIR NATHAN: I think, again,  
3 it is not specific. So, it is okay. IN that  
4 sense, it is not telling how you are going to  
5 build the patient- and family-centered focus.  
6 It just defines it a little better. You could  
7 leave it. I don't think it hurts. I don't  
8 think it helps that much.

9 MS. MALEBRANCHE: The reduction of  
10 confrontation or some of the negative --

11 CO-CHAIR CROCKETT-JONES: Yes, we  
12 can take out reduction of confrontation.

13 MR. REHBEIN: How do you measure  
14 confrontation? How do you know if you have  
15 reduced it?

16 CO-CHAIR NATHAN: It's like right  
17 now.

18 MR. REHBEIN: To use the Admiral's  
19 words is violent agreement confrontation?

20 CO-CHAIR NATHAN: It is sort of  
21 like when we are past this recommendation, it  
22 will be horrible relief.

1                   The patient- and family-centered  
2 focus on what the patient and family need,  
3 rather than what the system needs. Is that  
4 okay?

5                   MS. MALEBRANCHE: That's okay.

6                   CO-CHAIR NATHAN: All right. And  
7 then the last thing we have is evidence-based  
8 or not?

9                   MS. MALEBRANCHE: I think we said  
10 that was included in --

11                  CO-CHAIR CROCKETT-JONES: It can  
12 either be included in predictable and  
13 transparent processes or it can be included in  
14 the findings. Where do you all think it  
15 belongs?

16                  CO-CHAIR NATHAN: I'm good with  
17 the findings.

18                  CO-CHAIR CROCKETT-JONES: Then put  
19 it in the findings.

20                  CO-CHAIR NATHAN: Okay. All  
21 right. So, you all can see it. That is where  
22 we are right now.

1 MS. DAILEY: All right. So, we  
2 included a lot of the language up on top. Do  
3 you want any of it?

4 CO-CHAIR CROCKETT-JONES: I,  
5 personally, would rather have the simple  
6 sentence. I want them to hear us loud and  
7 clear.

8 MS. DAILEY: Okay, so we will take  
9 it all out. And then we go to a DoD should  
10 design a new -- DoD should design --

11 DR. STONE: So, I am not  
12 comfortable with it all coming out because I  
13 think it frames the discussion that follows.

14 LT COL KEANE: I do think that the  
15 words that follow D(1) need to be  
16 strengthened. Ms. Crockett-Jones' original  
17 discussion an hour and a half ago about burn  
18 it down, while we can't say that, I think that  
19 is too vanilla.

20 One big point that Wounded Warrior  
21 Regiment would say and others is that the  
22 process takes too long. We haven't really



1 addressed that. And I don't know if we need  
2 to make a bullet of streamlining.

3 But I think to reword, DoD should  
4 design a new approach to replace the current  
5 IDES. The current IDES is inadequate,  
6 cumbersome, and takes much too long to get  
7 through, words to that effect. I'm sure Dr.  
8 Stone could wordsmith it much better than I  
9 can.

10 CO-CHAIR CROCKETT-JONES: I think  
11 that my problem with the language following  
12 the first sentence is that it is all  
13 reiterated in the five bullets. I think it  
14 serves the same purpose as the five bullets  
15 and that it gets too fine a grain to make  
16 clear that -- I think it does too much in  
17 telling them how to, as Admiral Nathan said,  
18 suck the egg.

19 I think that that language could  
20 be included in the findings but that I think  
21 that Colonel Keane is right, that first  
22 sentence is too vanilla. And I think the rest

1 of the language is too fine a grain.

2 So, I would really love us to see  
3 if we are going to rework this first portion  
4 of this recommendation, let's make it simple  
5 and clear and bold.

6 DR. STONE: So, I would defer to  
7 the committee. If you feel the individual  
8 bullet points below combine enough of the  
9 preamble that the reader can understand where  
10 we want this system structured for the future,  
11 then I am comfortable with where the committee  
12 wants to go.

13 DR. LEDERER: I like the idea of  
14 the simplicity. I think if you wanted to add  
15 one thing beyond the part up there, that very  
16 last sentence, just to say that emphasis  
17 should be placed on the return to work as soon  
18 as possible after injury, including separation  
19 and transition, I kind of like that sentence  
20 because the whole purpose of IDES is not to  
21 gain benefits but it is to get people back to  
22 normal functioning. And I think all the

1 things down below there, if you know that is  
2 the concept of what this is about, I kind of  
3 like that. I think that is kind of concise  
4 and gets there.

5 CO-CHAIR NATHAN: That works for  
6 me. I am with Suzanne, where I think that  
7 yes, the simpler, the better. I think that we  
8 have talked about putting some of that  
9 preamble into the findings. So, if it were up  
10 to me, I would retain that last statement that  
11 Karen talked about. I would reconfigure the  
12 rest of it into the findings and I would  
13 strengthen the initial bullet from DoD should,  
14 we can't say burn it down. DoD should design  
15 a new approach to replace the current  
16 disability evaluation system. You know, if  
17 you wanted to be stronger you could say the  
18 current DES system is not viable, nor  
19 effective and must be replaced with a new  
20 system. You know, whatever you want to do.

21 CO-CHAIR CROCKETT-JONES: And  
22 Suzanne, if we eliminate and move that to the

1 findings, we can eliminate the word  
2 additional. So, it would just be emphasis.

3 CO-CHAIR NATHAN: Any discussion  
4 on the first eight words?

5 DR. PHILLIPS: I would like to see  
6 some term that reflects doesn't incentivize  
7 disability, leave it in there. In other  
8 words, DoD design a new approach to replace  
9 the current DES, an approach that doesn't  
10 incentivize disability or I hate to have --

11 CO-CHAIR NATHAN: Isn't that said  
12 by emphasis should be placed on return to  
13 work?

14 MS. MALEBRANCHE: I think it is  
15 said by that but --

16 DR. PHILLIPS: Well, you can argue  
17 that.

18 MS. MALEBRANCHE: But a positive.  
19 I think we want to make this in a positive  
20 way.

21 DR. PHILLIPS: I agree with  
22 removing everything else.

1 MS. MALEBRANCHE: We could call it  
2 the ability evaluation.

3 CO-CHAIR CROCKETT-JONES: I think  
4 that if we want to see something a little  
5 less, then we should say that the current DES  
6 is not functional or is not adequate and DoD  
7 should design a new approach. We can reword  
8 it to make more clear, that we really think  
9 IDES is broken.

10 DR. PHILLIPS: And can we just go  
11 back to saying DoD should replace the current  
12 DES? I know we said we shouldn't burn it down  
13 but this is what we want.

14 CO-CHAIR CROCKETT-JONES: I mean,  
15 can we say that the current IDES is broken?  
16 So, the current IDES is not adequate or what  
17 is the right language to say what we really  
18 mean if we can't say burn it down or it is  
19 broken and DoD should design a new approach to  
20 replace it?

21 DR. STONE: So, if we say it is  
22 not adequate, then there is something you

1 could add to it to make it adequate. It is a  
2 fundamentally flawed system in which we, as a  
3 committee reject.

4 CO-CHAIR CROCKETT-JONES: There we  
5 go. It is fundamentally flawed. Thank you.

6 CO-CHAIR NATHAN: Is everybody  
7 okay with the current IDES is fundamentally  
8 flawed and DoD should design a new approach to  
9 replace it?

10 MS. DAILEY: Possibly a period  
11 after approach.

12 CO-CHAIR NATHAN: Do you want to  
13 say should design a new approach or do you  
14 want to just simply say DoD should replace it  
15 with one that --

16 CO-CHAIR CROCKETT-JONES: Just  
17 replace it. And then we say emphasis should  
18 be placed on the return to work.

19 LT COL KEANE: I don't know if  
20 this is the place for it but I want to just  
21 echo what I mentioned earlier, how lengthy the  
22 current process is. I don't know if it is

1 appropriate to put here or in the findings.

2 MS. MALEBRANCHE: I think that is  
3 and fundamentally flawed and I think  
4 fundamentally flawed also covers that it is  
5 focused on disability. I mean, you can  
6 interpret a lot but fundamentally flawed,  
7 those are some pretty basic things, work and  
8 pay.

9 CO-CHAIR NATHAN: So what we have  
10 now is the current IDES is fundamentally  
11 flawed and DoD should replace it, followed by  
12 emphasis should be placed on return to work as  
13 soon as possible after injury, including  
14 separation and transition to civilian  
15 employment when injuries clearly indicate the  
16 service member cannot be retained in the  
17 military. And then the other bullets, which  
18 we approved.

19 Going once. Going twice. Anybody  
20 want to make a motion?

21 MS. DAILEY: Can we take just five  
22 minutes to clean it up for you and put it up

1 there in a manner that don't have a lot of red  
2 lines and gaps and stuff and you can read it  
3 cogently.

4 CO-CHAIR CROCKETT-JONES: How  
5 about this? Five minute bio break.  
6 Seriously, only five minutes. And then we  
7 will come back and read the new one.

8 DR. PHILLIPS: I just want to  
9 mention that redesign probably doesn't really  
10 correlate with burning it down. Can you go  
11 back, Suzanne? The hallmarks of the redesign  
12 approach should be we are not telling them to  
13 redesign it any longer. I just would take the  
14 redesign part out.

15 CO-CHAIR CROCKETT-JONES: How  
16 about just replace that with new?

17 DR. PHILLIPS: Just take the word  
18 redesign out.

19 CO-CHAIR CROCKETT-JONES: Five  
20 minutes.

21 (Whereupon, the above-entitled  
22 matter went off the record at 9:54



1 a.m. and resumed at 10:01 a.m.)

2 CO-CHAIR NATHAN: So, we have  
3 before us the cleaned up version of where we  
4 all arrived. I was just reminded that I have  
5 General Mustion's proxy. So, I am twice as  
6 agonizing on the points that I bring up.

7 Anybody want to make a motion on  
8 what we have before us?

9 MS. MALEBRANCHE: Okay, only a  
10 little tiny picky thing. Do we want to  
11 prioritize the bullets underneath or is that  
12 order comfortable? Do we want to just leave  
13 them as they are?

14 DR. PHILLIPS: I so move.

15 CO-CHAIR NATHAN: We have a motion  
16 to adopt this recommendation as D1. Do I have  
17 a second?

18 MS. MALEBRANCHE: Second.

19 CO-CHAIR NATHAN: Okay, all those  
20 in favor of adopting this motion as D1 as  
21 written, please signify by raising your hands.

22 Before -- point of order. I think

1 that is what I was supposed to say, it was so  
2 many hours ago.

3 CO-CHAIR NATHAN: The Chair  
4 recognizes the gentleman from the state of  
5 confusion.

6 DR. STONE: As a friendly  
7 amendment, therefore, I would suggest that the  
8 DES letters be removed from bullet number one.  
9 It is a new process. It is not DES.

10 CO-CHAIR NATHAN: Anyone have any  
11 concerns with that?

12 Okay, we have a motion before us  
13 to now adopt it as it is currently written,  
14 the wording for D1. We have a second. All  
15 those in favor, signify by raising your hands.

16 (A show of hands.)

17 CO-CHAIR NATHAN: All those  
18 opposed. Being none opposed, the vote is to  
19 adopt this as the language for D1.

20 Okay, we will now discuss another  
21 IDES recommendation. This recommendation --  
22 I think I saw a Twilight Zone episode like

1 this once.

2 This recommendation states until a  
3 new approach is found, the Department of  
4 Defense needs to continue to improve or  
5 address the following issues in the IDES  
6 process: transparency, timeliness, ensuring  
7 only those service members likely to leave the  
8 military enter the process, fully informing  
9 family members at the outset and at  
10 significant decision points throughout the  
11 process, including mandatory family member or  
12 significant other accompaniment to the initial  
13 IDES brief, ensuring productive work  
14 opportunities for the service member in all  
15 levels of government, as well as in civilian  
16 companies; allowing the service member access  
17 to and enrollment in education and training  
18 programs through college and certification  
19 education programs; emphasizing recovery and  
20 rehabilitation; allowing eligibility for  
21 elective treatments with consideration to  
22 recovery time and time remaining in IDES;

1 improving legal services for geographically  
2 dislocating Recovering Warriors, with special  
3 considerations for early contact,  
4 confidentiality, and involvement of family  
5 members; providing all Reserve Component  
6 enrollees with the same access as Active  
7 Component enrollees to compensation and  
8 pension exams at military treatment facilities  
9 in-person briefings and counseling at  
10 significant points during the process, and TAP  
11 participation prior to discharge; initiating  
12 a default commander's letter from the losing  
13 line commander before the service member  
14 transitions to the Warrior Transition Unit;  
15 and ensuring scalability of the disability  
16 evaluation system.

17 I invite anyone to move to adopt  
18 this recommendation for discussion.

19 DR. PHILLIPS: I have a question.

20 CO-CHAIR CROCKETT-JONES: If it is  
21 about this thing, we have to move to discuss  
22 it first.

1 DR. PHILLIPS: I move to discuss.

2 CAPT SANDERS: Second.

3 DR. PHILLIPS: All right, so I  
4 have a question.

5 CO-CHAIR NATHAN: Discuss away.

6 DR. PHILLIPS: And this is just a  
7 question. By including Recommendation D2 in  
8 our whole process, do you think that will slow  
9 down the D1 effort, since we are giving them  
10 an option?

11 CO-CHAIR NATHAN: Well, I think  
12 there is some redundancy here between D1. I  
13 mean, as Yogi Berra would say, this is deja vu  
14 all over again. In many of the pieces of  
15 this, this goes further in its delineation of  
16 specifics. I read this one as look, your  
17 current IDES system is pretty hosed up. It is  
18 not informative. It is confusing. It has  
19 people lingering. The problem, this is just  
20 me speaking, this is just my personal view,  
21 the problem with this recommendation is that  
22 in the first one, this is your point which I

1 think is very well made, the first one sort of  
2 said throw the thing out and come up with a  
3 new system, based on transparency,  
4 simplification, incentive to work, yadda,  
5 yadda, yadda.

6 This one basically says take the  
7 current IDES process and fine tune it so that  
8 it doesn't have all of the issues to improve  
9 the current IDES process that until a new  
10 approach is found, until a new approach is  
11 found, and we have kind of recommended in D1  
12 a new approach, until a new approach is found,  
13 the Department needs to continue to improve or  
14 address the following issues in the IDES  
15 process. It is cumbersome. It is not  
16 informant. It is not transparent. It needs  
17 improving access for legal services. It needs  
18 to be more expeditious, people are lingering.  
19 It needs to mandate that people go through TAP  
20 prior to discharge. So, it really throws a  
21 lot of tactical recommendations in to the  
22 current IDES process as it exists because we,

1 as a task force in our visits and hearing  
2 about the IDES, these have been many of the  
3 laments, based on the findings that you read  
4 on D2, these are many of the laments that  
5 people find with the current IDES process.

6 DR. PHILLIPS: So, I agree. I was  
7 just wondering based on past history, DoD may  
8 turn around and say well, we don't agree with  
9 D1 but we will do D2. That is what I was  
10 concerned about.

11 DR. STONE: The opening statement  
12 of D1 was fundamentally flawed, not  
13 inadequate. And the reason for that is D2  
14 approaches it is inadequate but here is the  
15 things you could make it to do be more  
16 adequate. That is confusing to the reader and  
17 I would speak against D2 in its entirety. I  
18 think D2 should be turned down in its  
19 entirety.

20 DR. PHILLIPS: Yes, that is what I  
21 was driving at.

22 LT COL KEANE: I would suggest

1 that the bulk of D2 become findings for D2.

2 MR. DRACH: Well, one of the  
3 problems with D1 is DoD cannot unilaterally  
4 implement. It has to go through Congress.  
5 There is a whole bunch of hoops that have to  
6 be jumped through. So, even if DoD embraces  
7 it September third, it doesn't mean it is  
8 going to move very fast. You have got to get  
9 Congress to do it.

10 So, I think D2 is good. Can I  
11 make a couple of comments on D2? On  
12 timeliness, we had a little bit of discussion  
13 I think at the last meeting. Are we talking  
14 about and should we qualify this, are we  
15 talking about overall timeliness or timeliness  
16 to get into the IDES system or timeliness once  
17 you are in the IDES system or all of the  
18 above?

19 MS. DAILEY: It is overall.

20 CO-CHAIR NATHAN: I think it is  
21 all of the above. I think it is, as I read  
22 this, it is once you have partitioned yourself



1 out of full duty and you are on limited duty.  
2 And you are on limited duty with the hopes  
3 that you can return to full duty. But if you  
4 can't, at some point you are going to be  
5 kicked over to the IDES system. So, there is  
6 two complaints. One is that people linger too  
7 long before a decision is made as to whether  
8 they are going to be returned to duty or  
9 discharged through the disability evaluation  
10 system. And then the other is that once the  
11 decision is made to put them through the  
12 integrated system, it takes too long. And  
13 that is a hodgepodge of complaint because half  
14 the people you talk to in the IDES system  
15 don't think it is long enough. And half of  
16 the people you talk to in the IDES system  
17 thinks it is too long.

18 And so, it depends on what your  
19 personal motivations are, how quickly you want  
20 to recover.

21 But let me go back to a more  
22 fundamental -- so, I appreciate, Ron, the

1 question. I think it is a good one for this.  
2 But let me go back to a more fundamental issue  
3 because we have a statement by General Stone  
4 that we should get rid of this, in light of  
5 D1. So, I need a motion from you, Rich, to  
6 say I recommend we dispense -- I recommend  
7 that we remove this as a recommendation. That  
8 may or may not get approved. But if that is  
9 what you are recommending, I need a motion  
10 that we dismiss this as a recommendation.

11 CO-CHAIR CROCKETT-JONES: Let's  
12 have more discussion before we make that  
13 motion.

14 MS. DAILEY: You don't really need  
15 to make that motion. You just need to vote it  
16 down and maybe do another one that might be  
17 more scaled down. But you would vote it down.

18 DR. PHILLIPS: I would agree with  
19 voting it down but I would like to have some  
20 of that included in the findings for D1.

21 CO-CHAIR CROCKETT-JONES: I think  
22 that instead of completely voting it down or

1 we could and then substitute something, but I  
2 think it is perfectly legitimate to say, and  
3 I would use much stronger language, until a  
4 new approach is found is so passive, it makes  
5 me crazy. I would say that while a new system  
6 is being developed or until the new system is  
7 in place, the most egregious flaws of the  
8 current system should be mitigated and then I  
9 would say that the things that are not covered  
10 in our bullets of the hallmarks of a new  
11 system are what should be included in what we  
12 consider the most egregious flaws that need to  
13 be addressed separate from the new system.

14 For instance, the legal services,  
15 the reserve component issues, just those  
16 things that are not covered by the hallmarks,  
17 when we look at that list, which would  
18 eliminate transparency, timeliness, informing  
19 family members, ensuring productive work  
20 opportunities. We should just, I think it is  
21 okay to say there are some flaws that are so  
22 bad that they shouldn't stand while you make

1 a new system that addresses the big issue.  
2 And I think it is okay to say that and it  
3 doesn't take away from saying you need a new  
4 system. And if you want to make it clear in  
5 your language, then you use the emphasis in  
6 the language of the recommendation.

7 DR. PHILLIPS: I can't agree with  
8 that. I think I don't want to leave them any  
9 wiggle room to say well, we will dispense on  
10 fixing it. You know, the system is flawed.  
11 I think we could just simply say included in  
12 D1 that the new system should be based on D2  
13 recommendations. Perhaps you feel  
14 differently. I just feel that if we leave  
15 them wiggle room --

16 CO-CHAIR CROCKETT-JONES: I think  
17 my only concern is when I look at, for  
18 instance, the DoD and VA decided to have an  
19 integrated electronic health record. And they  
20 are going to have a new system. And the  
21 reality is that that has so much time fits and  
22 starts that and, at any point in this process

1 since that was determined to be a mission,  
2 they could say we are working on that and it  
3 has taken a decade.

4 MS. MALEBRANCHE: Well actually,  
5 our DES office at VA knowing that I was coming  
6 here for this and having looked at this, they  
7 did mention that they have been focused on  
8 eliminating the current excess case inventory  
9 in the process and they are on track by the  
10 end of August 2014. DoD and VA are on track  
11 to achieve their timeliness goals for the core  
12 IDES stages, I'm not sure what core IDES but  
13 I know they have divided them, by October  
14 2014. And they are also planning to commence  
15 a review of the entire process, DES process  
16 for opportunities to improve.

17 So, I just wanted to let you know.  
18 Because I asked them what is your stance. And  
19 they said well, it is really kind of neutral  
20 from what our summary was. But there are some  
21 things in the works.

22 Now, our report is going to go

1 before the October time frame, so it doesn't  
2 hurt to say. And I think you are right, what  
3 is timeliness transparency. But also  
4 understand, we don't want to be, necessarily  
5 redundant in our things. But until something  
6 else is happening, make sure you are looking  
7 at the current process and you are not just  
8 letting that slide. I don't know exact  
9 wording for that but I did want to let you  
10 know what our team said.

11 CO-CHAIR NATHAN: That seems to be  
12 the two sides of the coin that I am hearing.  
13 One is, hey, we have said that you need to  
14 come up with a new system. And these are  
15 findings that should be incorporated in that  
16 new system. The second side of the coin is  
17 hey, we have told them to come up with a new  
18 system but if they don't, we still need to  
19 have a definitive in your face recommendation  
20 on what you need to do to optimize and improve  
21 the current system. The current system is  
22 IDES. That is living and breathing right now.

1 And this enumerates bullets that we have  
2 learned through our visits and through our  
3 briefings that flaws the current system.

4 So, if you believe -- I am  
5 thinking out loud here. If you believe that  
6 you still need that as a discrete  
7 recommendation, then this should stay a  
8 recommendation and we need to discuss if all  
9 these bullets are appropriate or not.  
10 Otherwise, you go with what sort of Rich Stone  
11 was talking about, which is, look, we have  
12 already said the current system is flawed.  
13 Get rid of it. We have made that  
14 recommendation in D1. There is not much point  
15 in talking about the current system, other  
16 than putting in findings what we think the new  
17 system should look like.

18 CO-CHAIR CROCKETT-JONES: I just  
19 want to point out that this would not belong  
20 in the findings on a new system because it is  
21 changes to the old system. So, I think I  
22 could live with getting rid of this but the

1 reality is, this should not be findings for D1  
2 because it is about the old system, instead of  
3 about the new one.

4 So, if we get rid of this, I think  
5 we lose it. Or unless there is some other  
6 recommendation under which it would be  
7 sensible finding. But I don't think that this  
8 makes sense as findings on a new system.

9 DR. STONE: So, my point in this,  
10 and you could roll this verbiage into, we  
11 reached a conclusion of a fundamentally flawed  
12 system because it has existed since the 1940s  
13 in various states of evolution and failed to  
14 be improved. Its current shortcomings include  
15 the following.

16 MS. MALEBRANCHE: Well, that's  
17 nice, if you roll it into that.

18 DR. STONE: And then --

19 MS. MALEBRANCHE: Yes, because I  
20 think if they don't adopt the first one, don't  
21 do a new system, we still have this system and  
22 there still are problems with this system that



1 we may not address. So, I hear what you are  
2 saying. And that is going to take a while to  
3 get a new system.

4 DR. STONE: And everything that we  
5 say in these bullets are well-known to both  
6 the DoD and the VA teams. These are not new  
7 findings.

8 CO-CHAIR NATHAN: So, summarizing  
9 where we are now, our choices are going to be,  
10 I think, either voting this down as an  
11 independent recommendation and if we do so,  
12 one of the thoughts being given that we modify  
13 the verbiage for this so that it becomes  
14 findings that support the way we were going to  
15 build a new one. So, you would take out  
16 verbiage on this on the findings that talk  
17 about the current IDES system. You would put  
18 in verbiage on these bullets that in the  
19 findings that talk about how the new system  
20 must have these issues addressed.

21 CO-CHAIR CROCKETT-JONES: Well, I  
22 think that actually Rich got it right. I

1 think that we can say in the findings if the  
2 language is changed to say these were the  
3 flaws that led us to conclude it is  
4 fundamentally flawed. That is actually a  
5 legitimate way to include it in the findings.  
6 We don't want them to think that we are saying  
7 the new system should do this because we  
8 don't. We don't want the new system to do  
9 this. This would be a fix for the old system.  
10 So, these would just be perpetuating the  
11 flaws.

12 So, if we can correct that  
13 language, we can vote on maybe this.

14 MS. DAILEY: We would take the  
15 bullets that you have here and we would put  
16 them over in the findings of D1 and we would  
17 say that the following current system flaws  
18 have led us to the recommendation to  
19 fundamentally change and create a new system.  
20 So, we would take these bullets, we would take  
21 some of the findings that support them but not  
22 all of them. These are the two longest. Your

1 Recommendation 1 is going to be very long.  
2 So, we are going cut out some of the findings.  
3 But mostly, you want the bullets over in D1  
4 and you want them highlighted as the issues in  
5 the current system that need to be changed.

6 DR. PHILLIPS: I don't mean to be  
7 picky but I agree with that. I would just say  
8 examples of these findings, rather than have  
9 it all codified as these are the only things  
10 that are wrong with the system. Well, that is  
11 not what the recommendations -- well --

12 MR. REHBEIN: Yes, I think we have  
13 to be very careful because we have used the  
14 words fundamentally flawed in that first  
15 recommendation. These bullets are not  
16 addressing fundamental flaws. They are  
17 addressing specific issues. Fundamental  
18 flaws, to me, says that we are looking for a  
19 total redesign and a new concept. And so  
20 these problems addressed in findings for the  
21 first recommendation would not support a  
22 complete redesign.

1 CO-CHAIR CROCKETT-JONES: No, I  
2 think that the language that --

3 MR. REHBEIN: I'm not arguing that  
4 we should do that. I just think we need to be  
5 very careful about how we go about that.

6 CO-CHAIR CROCKETT-JONES: I think  
7 that you are right. I think that is why  
8 saying the current system has been reworked  
9 for however many years and never become a  
10 functional process. It has never been the  
11 right process. It has never gotten -- no  
12 amount of reworking has made this the right  
13 process.

14 I think that we need to say it and  
15 we can then say that these are included. We  
16 can just say that these are examples of the  
17 current problems that service members  
18 experience in this process and I don't think  
19 it deflects from our saying that it is  
20 fundamentally flawed, if we used that  
21 language. And I don't know if you could  
22 repeat it. You didn't write it down, did you?

1                   But basically saying this system  
2                   has been in place for this many years and no  
3                   amount of reworking has --

4                   MS. DAILEY:   Okay, and we are  
5                   talking about language in the findings for D1.

6                   CO-CHAIR CROCKETT-JONES:   Yes, to  
7                   make it possible to eliminate this.

8                   MS. DAILEY:   Okay, we got that.  
9                   We will do that.

10                  MR. REHBEIN:   So, my only concern,  
11                  yes that system has been in place for 40  
12                  years, which means it has built up a vast  
13                  amount of bureaucratic inertia.   And while I  
14                  am somewhat of a gambler, I don't know if I am  
15                  willing to risk everything on what seems to me  
16                  to be a fairly longshot roll of the dice.

17                  CO-CHAIR NATHAN:   Mr. Rehbein,  
18                  what I hear you saying is that in the event  
19                  that D1 is not even considered by Congress,  
20                  DoD and/or VA, how do we emphasize the fact  
21                  that the existing system needs dramatic  
22                  improvement utilizing these?

1                   General Stone added color to it by  
2                   saying the current system has been around for  
3                   41 years or since the 40s and is, in essence,  
4                   a disaster. All that being true, what I hear  
5                   you saying is that doesn't make the case to  
6                   people. And they go, you know what? The war  
7                   is over. We are grinding down. We have  
8                   already spent a gazillion dollars on the  
9                   current system. It is not time to throw out  
10                  the whole system, which we believe they need  
11                  to do. And I think we voted our conscious on  
12                  D1, I really do. I think that is the right  
13                  thing. You don't necessarily vote for what  
14                  you hope you will get. You vote for what you  
15                  believe you need.

16                   But, if that doesn't happen, you  
17                   are saying how do we make sure that we stick  
18                   this in their eye if the current system  
19                   doesn't change to improve it. That is what I  
20                   hear you saying.

21                   So, do I hear you saying that you  
22                   would retain this as an actual recommendation

1 by using it as how to put the -- by putting it  
2 in as findings for D1 to add some more English  
3 to the ball on D1?

4 MR. REHBEIN: I am having trouble  
5 reconciling not doing it as a recommendation  
6 because we are taking force away from D1. But  
7 at the same time, wouldn't we do that same  
8 thing by putting them as a findings to D1? I  
9 think maybe we could pair this recommendation  
10 down a lot and only deal with maybe three or  
11 four of the most significant issues that we  
12 see affecting the people that are in the  
13 system right now?

14 CO-CHAIR NATHAN: Well, I think  
15 all these were pretty germane to what people  
16 complain about in the IDES system. To me, it  
17 comes down to if you believe that the people  
18 who are reading D1 will read the findings and  
19 put emphasis and gravitas on the findings,  
20 this sentiment gets carried as part of D1,  
21 even though the system may not change. They  
22 may not throw out the whole system. If you

1 believe they will stop after reading D1 and  
2 just say no, we are not going to read the  
3 findings, it is too hard to do, and you have  
4 lost your inertia on the current system.

5 DR. PHILLIPS: And Dave, I don't  
6 know if this will help but the Admiral and  
7 others mentioned that everybody knows what is  
8 wrong with this system. I mean, so perhaps we  
9 don't need to delineate that. And perhaps, as  
10 Dr. Stone mentioned earlier, maybe we just  
11 throw out D2 and leave D1 as it stands and not  
12 be schizophrenic about it and just emphasize  
13 what we feel.

14 MR. REHBEIN: But if everybody  
15 knows what is wrong with the system and is  
16 doing nothing to fix it, why would they then  
17 devote effort to a total redesign?

18 It appears to me that if everybody  
19 knows what is wrong with the system and  
20 nothing is being done to fix it, then  
21 everybody is satisfied with the system as is.

22 DR. PHILLIPS: But maybe someone



1 like us has to say finally, the system is bad.  
2 You know it is bad. And here is our  
3 recommendation. And that is our  
4 recommendation.

5 CO-CHAIR CROCKETT-JONES: Yes, I  
6 think that what we are hoping for is that our  
7 voice will be a tipping point. And that is  
8 what our first recommendation is about, is  
9 lending weight.

10 And I think that my experience is  
11 everyone reads the findings. In fact, they  
12 read the findings in great detail and get very  
13 worked up over things in the findings  
14 sometimes.

15 So, I am not concerned that by  
16 putting it in the findings that we will lose  
17 it completely. I think that the findings are  
18 germane to most of the folks who wind up being  
19 the worker bees.

20 MR. REHBEIN: Yes, I could see  
21 where the findings could say immediate steps  
22 could be taken to address these issues but

1 they would not fix the system.

2 CO-CHAIR CROCKETT-JONES: That is  
3 almost perfect language.

4 DR. STONE: So bureaucracies  
5 perpetuate themselves forever. And I rarely  
6 worry about whether people will respond to  
7 what we are recommending, although every one  
8 of the bullet points in D2 has a face and a  
9 voice of a family that has dealt with these  
10 problems. And I think we need to be sensitive  
11 to that. But part of being sensitive to it is  
12 to help senior leaders as they read whatever  
13 part they are willing to read understand  
14 absolutely clearly that this system and this  
15 bureaucracy, after 70 years, must be replaced.

16 CO-CHAIR CROCKETT-JONES: So, are  
17 we comfortable with taking a vote?

18 CSM DEJONG: I am going to go  
19 forward with a motion to strike D2 as written,  
20 with --

21 CO-CHAIR CROCKETT-JONES: We just  
22 have to vote it down.

1                   CSM DEJONG: I'm willing to trust  
2 the collective judgment of the Task Force.

3                   LT COL WONG: Before we go to the  
4 vote, and if we are going to move with the  
5 findings, one thing I just wanted to get clear  
6 that I wasn't on, was bullet number three. It  
7 says ensuring only the service members likely  
8 to leave the military enter the process.  
9 Should that have been all service members  
10 likely to leave the military enter the  
11 process? It sounds like we are trying to  
12 prevent people from getting into the process.

13                   CO-CHAIR CROCKETT-JONES: Our  
14 concern was that folks were getting into the  
15 process --

16                   CSM DEJONG: Bogging the system  
17 down?

18                   CO-CHAIR CROCKETT-JONES: Yes,  
19 bogging the system down and also being in  
20 limbo and then returning to work. And it was  
21 very hard for them to maintain momentum in  
22 their careers within their MOS if they had a

1 long time in a DES process that was going to  
2 return them to work anyway.

3 CSM DEJONG: Okay.

4 CO-CHAIR CROCKETT-JONES: Are we  
5 ready to take a vote? Okay, on the matter of  
6 D2, do we have to move to vote actually?

7 CO-CHAIR NATHAN: We need a motion  
8 to either vote for it or vote against it.  
9 Either one.

10 CSM DEJONG: I make a motion to  
11 vote against D2.

12 CO-CHAIR CROCKETT-JONES: You just  
13 have to make a motion to vote. Now we need a  
14 second.

15 MS. MALEBRANCHE: I'll second.

16 CO-CHAIR CROCKETT-JONES: Okay.

17 MR. DRACH: The motion would be to  
18 delete D2?

19 CO-CHAIR CROCKETT-JONES: The  
20 motion is just a vote. You can vote against  
21 -- if we get all nays, then D2 will not be one  
22 of their recommendations.

1 CO-CHAIR NATHAN: The motion is to  
2 adopt D2 as a recommendation. If you vote yea  
3 or raise your hand for yea, it will be adopted  
4 if you want it to be adopted. If you vote  
5 nay, it will not be adopted.

6 CO-CHAIR CROCKETT-JONES: We have  
7 the motion to vote. Okay, all those in favor,  
8 raise your hand. All those yeas.

9 MS. DAILEY: And I will need you  
10 to leave your hand up. And I need my staff to  
11 get a full vote here.

12 CO-CHAIR CROCKETT-JONES: All  
13 those in favor of this recommendation, raise  
14 your hand.

15 (Show of hands.)

16 MS. DAILEY: Hands up. Hands up.  
17 If you are voting for this, get your hands up,  
18 please.

19 CO-CHAIR CROCKETT-JONES: All  
20 those opposed?

21 (Show of hands.)

22 CO-CHAIR CROCKETT-JONES: Are we

1 ready?

2 Any abstaining?

3 (Show of hands.)

4 CO-CHAIR CROCKETT-JONES: All  
5 right, we can move on to D3.

6 MS. DAILEY: Okay, for clarity for  
7 my staff, so what we will do is we will take  
8 the bullets and some of the relevant findings  
9 in D2 and we will incorporate it into framing  
10 the case for redesign of the system in  
11 recommendation number one.

12 CO-CHAIR CROCKETT-JONES: Yes,  
13 thank you.

14 Are we ready to move on to D3?  
15 Does the staff need any writing time? Okay.

16 The next recommendation to be  
17 discussed addresses the needs of Recovering  
18 Warrior family members and caregivers. The  
19 recommendation states, publish a Department of  
20 Defense instruction policy for addressing for  
21 addressing the needs of Recovering Warrior  
22 family members and caregivers and identifying

1 baseline services to be delivered by each  
2 service and component.

3 I invite anyone to move to adopt  
4 this recommendation for discussion.

5 DR. PHILLIPS: So moved.

6 MR. DRACH: Second.

7 CO-CHAIR CROCKETT-JONES: All  
8 right. Anyone want to open this discussion?

9 CAPT SANDERS: Does this leave  
10 open the question or the point that was made  
11 earlier of standardization? And do we need to  
12 somehow reflect in this that DoDI is to make  
13 sure that all of the Services and Components  
14 make it a standard process of Services?

15 CO-CHAIR NATHAN: You could but,  
16 by definition, isn't that what a DoDI does?

17 CAPT SANDERS: I hope so, sir.  
18 But I am not so sure it says that.

19 CO-CHAIR NATHAN: I mean I am fine  
20 with amplifying it, if you want to. But by  
21 definition, a DoDI is telling the Army, the  
22 Navy, the Air Force and the Marine Corps this

1 is how you are going to do it.

2 CO-CHAIR CROCKETT-JONES: I think  
3 that if we also eliminated the word each  
4 instead of all Services and Components, it  
5 would sound more like standardization.

6 CAPT SANDERS: I think that helps.  
7 My concern is when you get into the standard  
8 implementing reg within this service, they  
9 start varying things.

10 CO-CHAIR NATHAN: So, I'm fine  
11 with the word standard. Captain Sanders, are  
12 you still --

13 CAPT SANDERS: I like the addition  
14 of all. That helps me.

15 CO-CHAIR NATHAN: Okay. Any more  
16 discussion on this? The genesis of this was,  
17 of course, that in our experiences there was  
18 differences among Services in how they take  
19 care of, inform, provide to the family members  
20 and the caregivers services.

21 MS. MALEBRANCHE: Just a comment  
22 in support of this. I concur with this



1 recommendation. And one of the things I  
2 thought was good about this is in the  
3 discussion effort, they also talked about  
4 SCAADL and the VA Caregiver Program. And they  
5 have two different programs designed for two  
6 different things and I think that hasn't  
7 always been clear. So, this is a nice, I  
8 think, delineation of those things because  
9 they are legislatively different and they do  
10 different things. So, we have concurred with  
11 that from the VA.

12 CO-CHAIR NATHAN: Any more  
13 discussion on this?

14 LT COL WONG: One thing I thought  
15 was missing out of the findings I don't know  
16 if we should include or not, it talks about  
17 the Army SFAC and maybe how we also run the  
18 Exceptional Family Program to mimic some of  
19 the caregiver and family support. We are  
20 getting more into the weeds or the tactical  
21 error of telling them how to supp VA. I'm  
22 just not sure if that should be included or

1 not.

2 CO-CHAIR CROCKETT-JONES: I think  
3 in our previous reports we have emphasized the  
4 successful nature of the SFACs and that they  
5 are best practice. I think we have done that  
6 in more than one way. I think that the reason  
7 we need this, considering everything we  
8 recommended previously about families is that  
9 not only the standardization but because one  
10 of the reasons that programs for wounded, ill,  
11 and injured have given us, told us creates the  
12 issue for them providing services or proper  
13 resourcing for family members and caregivers  
14 is that they don't have instruction on what  
15 they really need to do, that they need  
16 guidance.

17 So, I think that as far as some of  
18 the finer points go, I think we have had a lot  
19 of them in our previous reports. This is  
20 saying, instead, that the burden needs to bump  
21 up to the highest level to give people  
22 instruction and guidance.

1 Does anyone want to move to vote?

2 CAPT SANDERS: I so move.

3 LT COL KEANE: Second.

4 CO-CHAIR CROCKETT-JONES: All in  
5 favor of adopting this recommendation, raise  
6 your hand.

7 (Show of hands.)

8 CO-CHAIR CROCKETT-JONES: We are  
9 unanimous. So, I'm not forced by Robert's  
10 Rules to do anything -- good. We can take a  
11 break or we can move on to the next  
12 recommendation.

13 CO-CHAIR NATHAN: Unless anybody  
14 needs to, I think we have another one which,  
15 famous last words, should go pretty quickly.  
16 And then we can see at that time. Okay with  
17 moving ahead?

18 So, our next recommendation  
19 discussion addresses a manpower requirement.  
20 This recommendation states establish a  
21 uniformed representative from each service at  
22 the Office of Warrior Care Policy.

1 I invite members to move to adopt  
2 this recommendation for discussion.

3 MR. REHBEIN: So moved.

4 TSGT EUDY: I second.

5 CO-CHAIR NATHAN: Okay, so it is  
6 open to the floor here for discussion.

7 DR. STONE: One of my concerns  
8 about this one is whether we really go far  
9 enough in this recommendation. The Office of  
10 Warrior Care Policy has been populated by  
11 extraordinarily well-motivated people with  
12 very nice skill sets and backgrounds but has  
13 never quite reached the potential that we  
14 thought, over the last four years, that it  
15 should. And simply by adding uniformed  
16 personnel to the office, you strengthen it.  
17 I acknowledge that. But I really wonder if we  
18 could carry this recommendation another step.  
19 And that is, to formalize the permanence of  
20 this office to really place it properly within  
21 the Department of Defense to ensure that the  
22 ranking of its personnel are appropriate to

1 the level of the mission and then to integrate  
2 it with the uniformed Services as the four  
3 principles.

4 And based on our earlier  
5 discussion that went on for so long, I am not  
6 terribly interested in telling them exactly  
7 how to do it but those are sort of the four  
8 principles that I would place in strengthening  
9 the Office of Warrior Care Policy.

10 MS. DAILEY: Can I get you to go  
11 over that again, sir? Let's get them down.

12 DR. STONE: Was nobody writing  
13 while I was speaking?

14 MS. DAILEY: Sorry, sir.

15 DR. STONE: Suzanne, did you?

16 DR. LEDERER: I actually have been  
17 instructed to cut back on my capturing  
18 everything, so unfortunately, I didn't but I  
19 will now.

20 DR. STONE: Okay. So the sort of  
21 four principles are is this a permanent office  
22 and where is it placed within the Department

1 of Defense. Number two, the leader of that  
2 office and the leadership personnel, are they  
3 appropriately ranked and structured within the  
4 DoD system? Number three was the linkage to  
5 the Services which this captures. And there  
6 is a fourth one, I think.

7 CO-CHAIR CROCKETT-JONES: The  
8 permanence and location.

9 DR. STONE: Okay, good. That was  
10 it.

11 MS. DAILEY: Okay. We have made  
12 this recommendation and we captured it in the  
13 findings. We recommended it be placed in law  
14 and DoD said we don't need to do that. And  
15 you made the recommendation also at the same  
16 time that it be at the Assistant Secretary  
17 level and they said it is already at that  
18 level. And we captured that in the findings.  
19 It is all, the previous recommendations on  
20 this office has been -- is in the findings.

21 CO-CHAIR NATHAN: If you look at  
22 the findings it says in annual reports over

1 the past three years, the Task Force has  
2 repeatedly challenged the WCP to do more. And  
3 then in 2012 we recommended that they take  
4 steps to institutionalize the WCP by enacting  
5 legislation to permanently establish the  
6 office under the SECDEF for P&R at a level no  
7 less than the Deputy Assistant Secretary. DoD  
8 non-concurred. In light of DoD's decision  
9 against solidifying WCP's permanence as  
10 recommended, we urge DoD to strengthen the  
11 viability of the office in a different way by  
12 facilitating its relationships with the  
13 Services. And ergo, that is where they -- and  
14 then when they came to brief us in February or  
15 actually when we went to see them in February,  
16 they told us, as in the findings, that they  
17 have had occasionally uniformed  
18 representatives but that they haven't been  
19 codified or assigned in permanence. And so we  
20 are recommending they assign them in  
21 permanence.

22 That is sort of the genesis behind

1 this recommendation.

2 DR. STONE: And am I not correct,  
3 sir, that this office is now split under the  
4 Assistant Secretary of Defense for Health?  
5 Isn't that where this office is working today?

6 MS. DAILEY: Correct. That is a  
7 correct statement.

8 DR. STONE: Which is then one  
9 level of removal from P&R, which we find  
10 inappropriate, or at least I do.

11 MS. MALEBRANCHE: One point of  
12 discussion here I just want to bring to the  
13 surface. VA has that IC3, the Interagency  
14 Care Coordination Office. That is at the  
15 level of the Secretary. It started out at VHA  
16 and got pushed up. And in that office, and we  
17 have been briefed on that before as a group,  
18 there is a three-group center at the Policy  
19 and Planning, Community of Practice and  
20 Technology. It is now Technology and Tools.  
21 There is a VA person and a DoD person. That  
22 DoD person does not necessarily come from



1 Warrior Care Policy, which is where you would  
2 think that you would have sort of a parallel,  
3 not that we have to be exactly parallel  
4 agencies and understanding we are not. But in  
5 the past, sometimes, we have had P&R where we  
6 need health and vice-versa. But maybe those  
7 co-leads of those people, they are from  
8 different Services, could be part of this  
9 group or the people in here.

10           Somehow or other, I think there  
11 has to be some connectivity there, we don't  
12 necessarily always have. And IC3 falls under  
13 the JEC, which is also both.

14           So, I am not sure of the right  
15 answer for this but I know that oftentimes in  
16 our side, we are looking for our co-person on  
17 the DoD side and we have go through all the  
18 Services. It would seem that this Warrior  
19 Care Policy Office should be the one stop we  
20 go to, like who is the co-lead for all of DoD  
21 on community and practice. And maybe there is  
22 two or three and there has been. Usually it

1 has been a general officer, it was Colonel  
2 West or General West and then now I think it  
3 is from the Air Force, a person from the Air  
4 Force.

5 So anyway, it has changed over  
6 time. But just some discussion and some  
7 thought as we do this one for the Warrior  
8 Policy Office, we would like to have that  
9 parallel structure to go to and not have to go  
10 to P&R, to Health, and to other places, which  
11 kind of dilutes some of the, I think the  
12 things that we are trying to get solidified.

13 CO-CHAIR CROCKETT-JONES: So, here  
14 is my question. Can we reiterate a prior  
15 recommendation and say that especially in  
16 light of interagency working groups, we call  
17 again for a move of Warrior Care Policy Office  
18 up to P&R and --

19 MS. DAILEY: Hold on. Your last  
20 recommendation 2012 with General Green made a  
21 conscious decision to not tell DoD where to  
22 place this office. It was, at the time, a

1 very political and a very hot topic. You are,  
2 basically, you can but you need to be aware  
3 that you are reversing that decision.

4 CO-CHAIR NATHAN: I don't know  
5 that we are reversing the decision. I think  
6 we are revisiting it under a new time and  
7 reference point in the continuum of Recovering  
8 Warrior care.

9 CO-CHAIR CROCKETT-JONES: I think  
10 that we can say we have additional -- well, we  
11 sort of have additional evidence because the  
12 IC3 Working Group and interagency work has  
13 shown that it is still an issue, that the  
14 placement isn't necessarily appropriate.

15 DR. STONE: And are an evolving  
16 concern, based on two additional years of  
17 experience in which the Department has now  
18 slid Warrior Care Policy under the ASD of  
19 Health, which we find inappropriate.

20 MS. MALEBRANCHE: And we have the  
21 DHA now, too. I'm not sure but there have  
22 been some changes throughout. So, I am not

1 exactly sure, again, how you phrase it.

2 DR. STONE: Clearly, this office  
3 is a policy office, is well beyond health in  
4 disability, in the evolution of these systems  
5 we have been discussing all morning and really  
6 would more rightfully be a direct report to  
7 P&R at the DoD level.

8 MS. DAILEY: Okay, I'm game to do  
9 this. You know that, ladies and gentlemen.  
10 The problem is is that Health Affairs, this is  
11 a whole new recommendation. The  
12 recommendation here is dealing with putting  
13 military in this office. To move this under  
14 Health Affairs is an opportunity that they are  
15 not going to get to respond to, if you want to  
16 build a new recommendation here. But again,  
17 I am game. Let's be aware that you will not  
18 -- your process of allowing them to respond,  
19 allowing them to give us feedback is going to  
20 be truncated. They are not going to get that  
21 opportunity.

22 MS. MALEBRANCHE: Well, Denise,

1 since Health Affairs still comes under P&R and  
2 it has an impact there, they wouldn't have the  
3 opportunity because I think, ideally, the  
4 whole piece of P&R was to have both policy and  
5 the health component or the operational piece.  
6 Could we not structure our recommendation that  
7 we need that health component, the policy. I  
8 guess I am not exactly sure how this works.

9 MS. DAILEY: Okay, so let's do  
10 something with this recommendation. And then  
11 lets include it in a different recommendation  
12 along the lines of what you are thinking.

13 CO-CHAIR NATHAN: Well, let's not  
14 necessarily vote it -- I think what you mean,  
15 Denise, is let's vote to see a majority feel  
16 that it should go away. And then if it does,  
17 we can have discussion about restructuring it.  
18 I think Denise's point is a good one in our  
19 lead up to this. In all of our sessions, our  
20 workgroup sessions, we never really during  
21 this year landed on realigning the WCP again.  
22 Right? I mean when we visited the WCP, all of

1 our center of gravity was should they have  
2 service representation as an organic part of  
3 it. So, Ms. Dailey makes a very good point,  
4 which is right now you are sort of, we are  
5 sort of calling an audible at our voting  
6 meeting and saying hey, when it comes to WCP,  
7 maybe we should have done this year. We  
8 didn't. It belongs in P&R now because we just  
9 had an aha moment, which we didn't have  
10 earlier. We are allowed to do that. We are  
11 allowed to do that but we are sort of calling  
12 an audible here without the footwork and the  
13 discussion that went into it during the  
14 working group meetings and when we were  
15 meeting with WCP.

16 CO-CHAIR CROCKETT-JONES: Well,  
17 during our other working meetings, we did  
18 discuss our frustration with Warrior Care  
19 Policy Office and its placement, though we  
20 decided that we had attempted once before and  
21 we walked away from it. We did have a little  
22 bit of discussion of this previously. And the

1 only point that we could all agree on was that  
2 they needed more, a stronger link to the  
3 Services.

4 We have talked about this before  
5 and really, it is a matter of voting and  
6 deciding is this where we want to stop or do  
7 we want to move away from this and find a  
8 different recommendation. But we have, at  
9 least, discussed this before.

10 CO-CHAIR NATHAN: Oh, I think not  
11 only did we discuss it before, it was a  
12 recommendation before.

13 CO-CHAIR CROCKETT-JONES: Yes, but  
14 I mean even in this year.

15 CO-CHAIR NATHAN: Right. No, I  
16 think it has come up in the past but I agree.  
17 And I mean at this point, we either -- we have  
18 a recommendation in front of us. So,  
19 entertain more discussion on it but where this  
20 is heading is we are either going to vote to  
21 adopt this recommendation as stated or we are  
22 going to vote against adopting this

1 recommendation with a motion to restructure it  
2 with adding realignment of the WCP in  
3 Personnel and Readiness.

4 And I guess I would ask, just for  
5 completeness sake, maybe Rich or whoever, the  
6 advantages you see of moving it into P&R. I  
7 mean it moves to a higher level, of course.  
8 What are the tactical advantages, do you  
9 think?

10 DR. STONE: So our concern has  
11 been really for the entire time and during  
12 nature of the structure. And there are two  
13 things. Number one, have you created the  
14 structure itself to allow you to develop  
15 policy? And number two, do you then put  
16 dollars against it and were to come to dollar  
17 funding during on an enduring basis later?

18 So, the advantage I see here is  
19 sort of our last chance to say you must create  
20 a structure that has the appropriate voice to  
21 create policy at the right level. I do not  
22 believe that where it is currently sitting, is



1 able to have the appropriate voice. That is,  
2 in no way, the leadership of ASD health  
3 affairs, who has been a great proponent of  
4 this office. But I think on an enduring  
5 basis, we must ensure that we providing  
6 guidance to those that are reading this report  
7 of where we think this should go.

8 LT COL WONG: In reading it here,  
9 when we look at Recommendations 4, 5, and 6,  
10 I mean they all talk about the enduring  
11 requirement and capability. And I believe  
12 that these recommendations stand alone  
13 themselves as solid recommendations. Because  
14 if we lump them into one, it dilutes it and  
15 doesn't get to the specific nature of what  
16 each one of these groups bring to the table as  
17 they are brought forth as recommendations. I  
18 would hate to dilute or combine any of them  
19 because I think they should stand alone and  
20 show the emphasis on our recommendation.

21 CO-CHAIR CROCKETT-JONES: I would  
22 like to say that one of my concerns about the

1 placement, when we were thinking about the  
2 uniformed representative being at WCP, one of  
3 the concerns that I had seen personally was  
4 that it was unclear to me whether Warrior Care  
5 Policy Office actually had the authority to  
6 disseminate policy. And so I think that there  
7 is a concern about leadership, appropriately  
8 ranked leadership and connections to the  
9 service.

10 So, I understand all of the  
11 discussion that has gone on so far and I think  
12 the members just have to consider where they  
13 stand on D4, as it is worded or whether there  
14 needs to be more, a different recommendation  
15 that we can work on later. I mean work on  
16 later today.

17 CO-CHAIR NATHAN: We need a  
18 motion.

19 MS. DAILEY: And I just want  
20 clarify for the record your concern about this  
21 office generating policy. They have got five  
22 policies, five DoDIs out. They have got the

1 RCP. They have got the IDES. They have got  
2 the E2I, Warrior -- what's that warrior  
3 program -- Operation Warfighter. So, they  
4 write policy. They do that right now.

5 CO-CHAIR NATHAN: So, I think we  
6 need a motion. If somebody is so inclined, we  
7 need a motion to adopt this as written and  
8 first establish whether or not there is going  
9 to be a majority rule to adopt it as written  
10 and then move on to the next recommendation or  
11 to vote against the documents as written. And  
12 if we vote against the document, if the  
13 majority votes against the document as  
14 written, then there will be discussion. And  
15 if somebody makes a motion to restructure it  
16 a different way, then we would entertain that,  
17 have discussion and then vote on that.

18 So, the first thing we have before  
19 us is a Recommendation D4 as written,  
20 establish a uniformed representative from each  
21 service at the WCP. Do I have a motion to  
22 call a vote for that?

1 CSM DEJONG: So moved.

2 CO-CHAIR NATHAN: A second?

3 MR. REHBEIN: I'll second.

4 CO-CHAIR NATHAN: Okay, so there  
5 has been a motion with a second to vote on  
6 this. If you vote yea, you are voting to  
7 establish the -- to adopt it as written. If  
8 you vote no, then this goes away as a  
9 recommendation and there may be further  
10 discussion on restructuring it or rewriting  
11 it.

12 All those in favor of adopting it  
13 as written, please signify by raising your  
14 hand.

15 (A show of hands.)

16 MS. DAILEY: Raise your hands,  
17 please. This is going to be close. I need an  
18 absolute count. Hands up in the air.

19 And so what is my count here?

20 CO-CHAIR CROCKETT-JONES: Eight.

21 CO-CHAIR NATHAN: All those  
22 opposed to adopting it as written, please

1 raise your hands.

2 MS. DAILEY: Ma'am, did you raise  
3 your hand?

4 CO-CHAIR CROCKETT-JONES: No, I'm  
5 sorry. I'm sorry.

6 CO-CHAIR NATHAN: Uh-oh. She is  
7 from Chicago.

8 (Laughter.)

9 (A show of hands.)

10 MS. DAILEY: Good.

11 CO-CHAIR NATHAN: So what do we  
12 have in the count? Eight to five. Okay, so  
13 the motion carries that we will establish a  
14 uniformed -- the recommendation carries that  
15 we will establish a uniformed representative  
16 from each service at the WCP.

17 MR. REHBEIN: Question, sir.  
18 Then, does that, the way it was phrased going  
19 into this vote, does that preclude discussion  
20 of another recommendation on structure?

21 CO-CHAIR NATHAN: Not that I am  
22 aware of.



1 second to that motion?

2 DR. PHILLIPS: Second.

3 CO-CHAIR NATHAN: Any further  
4 discussion on that motion?

5 MR. REHBEIN: Not necessarily  
6 discussion but question. Because one of the  
7 concerns that came to me through the findings  
8 was the rapid turnover of leadership in this  
9 office. And I didn't know, many of you folks  
10 are much closer than I am to events here. Are  
11 the continual structure moves leading to that  
12 rapid change? We are averaging about one year  
13 and that is not really long enough to be  
14 effective.

15 So, that is just a concern of  
16 mine, when you have that kind of rapid  
17 leadership. We talked about this office not  
18 being as effective as we would like. That, I  
19 think, is a real contributing factor.

20 LT COL KEANE: By having four  
21 service members there, that may help with that  
22 continuity. You would assume that they would

1 be there two to three years.

2 MS. DAILEY: Yes, and we're  
3 talking about the Assistant Secretary  
4 position. It has had a lot of turnover. The  
5 Deputy Assistant Secretary position has had a  
6 lot of turnover. I can't answer your question  
7 on that, Mr. Rehbein.

8 MR. REHBEIN: I'm just speculating  
9 there. I don't think any organization is  
10 healthy when the top leadership is changing  
11 that quickly.

12 DR. STONE: And these positions  
13 are at the DASD level. And I think that is a  
14 question for debate for the Department of  
15 whether that is the appropriate level you know  
16 where to effectively work in the interagency  
17 area. And I think Karen's comments were right  
18 on target. Is this position appropriately  
19 placed and graded in order to work in the  
20 interagency environment to drive policy  
21 decisions and to get the appropriate attention  
22 of the senior leadership in order to change



1 policy when necessary?

2 CO-CHAIR CROCKETT-JONES: I think  
3 that this addresses my concern better than six  
4 years, five policies is not -- that might be  
5 due to turnover. That might be due to  
6 placement. I think all of those are addressed  
7 by alignment and I do want to separate it. I  
8 am happy to see a separate assertion, a  
9 recommendation from the uniformed  
10 representative.

11 Is there any further discussion?  
12 Does anyone --

13 CO-CHAIR NATHAN: Well, I mean  
14 before we just pick on Health Affairs, don't  
15 forget P&R has kind of been a revolving door,  
16 too.

17 So, if you think you are --  
18 because currently you have got the Acting  
19 Under Secretary of Defense for Personnel and  
20 Readiness.

21 MS. DAILEY: No, sir, she was just  
22 appointed on the second of July. She was

1 officially appointed 2 July.

2 CO-CHAIR NATHAN: Okay.

3 MS. DAILEY: After a year and a  
4 half, agreed, but on the record.

5 CO-CHAIR NATHAN: But  
6 nevertheless, I mean you had Cliff Stanley for  
7 a while and then this. So, all I am saying is  
8 that is the lay of the landscape these days is  
9 there has been a fair amount of flux in the  
10 DoD leadership with Acting Assistant Deputy  
11 Secretaries of Defense and now Bob Work is  
12 confirmed, but all the way down.

13 Ironically, the person who has  
14 been -- ironically, the people who have been  
15 serving the longest in our chain has been  
16 Health Affairs and the principle Deputy for  
17 Health Affairs, Dr. Woodson and Dr. Guice.  
18 They have been there for years. But  
19 admittedly, their position, their DASD on  
20 Wounded Warrior Care has come and gone.

21 So anyway, I just offer that to  
22 say that you are not necessarily jumping out.

1 If you are doing it for continuity, there is  
2 no real guarantee. And with an election year  
3 coming up, who is to say it is not going to --  
4 all the cards are going to change again.

5 So, I really think, this is how I  
6 am thinking about it before I vote is I think  
7 about voting to change it. Where will it get  
8 the most traction? Where will it get the most  
9 attention? Where do the Services have the  
10 most input to it?

11 I have much more leverage as a  
12 service representative, as a Service Surgeon  
13 General with the Office of Health Affairs and  
14 I can pick up and call them directly more so  
15 than I can USD(P&R). So for me, and I am able  
16 to sort of walk over and really jump on desks  
17 in Health Affairs Office to the DASD there,  
18 then I am at USD(P&R). I like the gravitas of  
19 having it at a higher level but I am not sure  
20 that pragmatically that gives me more leverage  
21 with getting things moved.

22 CO-CHAIR CROCKETT-JONES: Well, I

1 am going to maybe make somebody unhappy but I  
2 am a little concerned that the Services pull  
3 Warrior Care Policy all over the map. And  
4 that is what delays some of their ability to  
5 write policy that standardizes. And so, I  
6 think moving it higher gives them more  
7 authority to standardize and reduces some of  
8 that service-specific pull and tug.

9 MS. MALEBRANCHE: Just another  
10 comment, again, from a VA perspective with  
11 IC3, the reason it is there and not under the  
12 Under Secretary for Health was because half of  
13 the issues for VA was the benefits portion.  
14 And so in order to have that be able to fall  
15 under both, it came directly under the  
16 Secretary because, as you recall we talked  
17 about before, was this disability evaluation  
18 system, which was a great deal of issues for  
19 the warriors. Not to say that that is the  
20 same way it works in DoD.

21 And I don't know. In working with  
22 Health Affairs, frankly, for a disability they

1 have been real helpful but it has been under  
2 a P&R level. But just some thoughts of what  
3 we were thinking at the time because there was  
4 a tendency to want to put that all under  
5 health because health was working it, frankly.  
6 It is a smaller, tighter group. They seem to  
7 do real well with that.

8 CO-CHAIR NATHAN: And Suzanne, I  
9 think your point is well-taken. What you are  
10 saying is hey, the very fact that the Services  
11 have leverage is creating this sort of Heinz  
12 57 issue because the Services are sort of  
13 doing their own thing and there is nobody  
14 there sort of a Tito to bring the Balkans  
15 together and do one thing.

16 I think in theory that is very  
17 true and makes good sense. My observation has  
18 been that it is not given the attention. It  
19 just doesn't get the attention at the higher  
20 levels. They have other things they are  
21 working on and we have trouble. The Services  
22 have trouble energizing the higher levels when

1 it comes to this.

2 So, in theory, I think your point  
3 is spot on. In practice, I am not so sure we  
4 get our day in court the higher this goes up  
5 into the food chain.

6 MS. MALEBRANCHE: You know, as you  
7 are saying, I am thinking when we voted on the  
8 earlier one it said to have a service rep at  
9 the WCP, that is when that is under Health  
10 Affairs, not necessarily under P&R.

11 Now, when we go to the Services to  
12 ask for representatives, sometimes we get  
13 Health people and sometimes we get P&R people.  
14 So, when we say voting a service rep,  
15 obviously, the service is going to choose who  
16 they send but you don't know who you are going  
17 to get. Are you going to get a health person  
18 or are you going to get a personnel person?  
19 A significant difference when you are putting  
20 on your issues.

21 CO-CHAIR NATHAN: Any further,  
22 discussion?

1                   CAPT SANDERS: Just a point of  
2 order. If we are to address the additional  
3 point, additional directive, do we do that at  
4 the end, do we go through all 13 before the  
5 add on?

6                   CO-CHAIR NATHAN: No, we can do it  
7 now, I think.

8                   MS. DAILEY: We can do it now.

9                   CO-CHAIR NATHAN: We have a motion  
10 made by General Stone to create a D4.1,  
11 written as follows. So, I am asking for the  
12 discussion. If there is none, we are going to  
13 call for the motion.

14                  DR. STONE: Well, I guess my  
15 further question would be to follow up.

16                  The last point, because that was  
17 my concern as to the type of personnel that  
18 would be added to the WCP and whether or not  
19 they actually got an individual as a uniformed  
20 member that helps further the mission.

21                  CO-CHAIR CROCKETT-JONES: That was  
22 actually the last recommendation. That is not

1 -- the service --

2 CAPT SANDERS: No, this is to  
3 Karen's point.

4 CO-CHAIR NATHAN: So, D4 was to  
5 provide a service rep to the WCP. We  
6 recommended that and approved that. Now, what  
7 I hear you saying do we need more nuances to  
8 what type of dog or cat the service sends to  
9 the WCP. Should we add amplification?

10 CAPT SANDERS: Along with Dr.  
11 Stone's point.

12 CO-CHAIR NATHAN: Right. What I  
13 hear you saying is you would modify or augment  
14 Dr. Stone's motion to include specifying the  
15 type or where in the service the individual  
16 comes from.

17 CAPT SANDERS: I don't know if we  
18 are the right people to specify where the  
19 person comes from but I think there needs to  
20 be some attention to that at some level. And  
21 I think we should specify --

22 CO-CHAIR NATHAN: So, that



1 probably goes back to D4, rather than D4.1.

2 CAPT SANDERS: Well, D4 is done,  
3 as I understood. That is why I asked the  
4 question.

5 CO-CHAIR NATHAN: Well, Denise and  
6 her staff could tweak the findings in D4 to  
7 talk about where the individual should come  
8 from.

9 MS. DAILEY: Yes, I mean we could  
10 talk to Warrior Care Policy, basically, and  
11 ask them what they think to be the best. I  
12 mean, that is the only way I would be able to  
13 do the findings, would basically go straight  
14 back to Warrior Care Policy.

15 CO-CHAIR NATHAN: Right.

16 CAPT SANDERS: Okay, the jump back  
17 is to put it into --

18 MS. DAILEY: The findings.

19 CAPT SANDERS: -- the findings in  
20 D4.

21 MS. DAILEY: Yes.

22 CAPT SANDERS: Then, my point is

1 addressed. And I don't know if that addressed  
2 to yours, Karen, or not.

3 MS. MALEBRANCHE: Well, if you put  
4 in the findings, when you go to the Services,  
5 you ask for someone with Health or Personnel  
6 experience. If they are under Health Affairs,  
7 then you are going to probably need the  
8 opposite. If they are under P&R, you are  
9 probably going to need somebody with some  
10 health background. So, I just want to get  
11 that balance because or I guess you could say  
12 you need one from either one, depending on the  
13 issue. But the thing is when you say for a  
14 service rep, if you are asking for a permanent  
15 person over there, then we are kind of getting  
16 into their how to do your staffing. And I am  
17 not sure that we want to do that.

18 CO-CHAIR NATHAN: Right. I don't  
19 know that we want to suck the egg on that or  
20 tell them how to do it. But, I think your  
21 point is a good one.

22 What was the genesis in the first

1 place? The genesis of this was that we felt  
2 the WCP was making decisions somewhat in a  
3 vacuum of the Services.

4 MS. DAILEY: I would really like  
5 Tech Sergeant Eudy to step into this  
6 discussion. He built this recommendation and  
7 he needs to talk to us.

8 CO-CHAIR NATHAN: Oh, man. Tag,  
9 you're it!

10 CAPT SANDERS: Sorry.

11 TSGT EUDY: The best interests of  
12 everyone, including the Services, we looked at  
13 the overall population from all briefings from  
14 the Services talking about the increases in  
15 the ill and injured population, even as the  
16 main portion of conflict goes away.

17 For the long-term purposes of  
18 continuity, those individuals that were  
19 represented from the Services in the creation  
20 of policy that is given back to them, instead  
21 of just phone calls through all issues  
22 pertaining forth, regarding Recovering

1 Warriors post-conflict, those individuals can  
2 come directly from the Services. We have the  
3 personnel that have the tactical and  
4 operational experience within the Recovering  
5 Warrior Units of the Services themselves to  
6 provide this and to continue this process on.

7           Because each service told us that  
8 they are going to draw down whether they are  
9 officers, enlisted men, their cadre and their  
10 leadership within their representative  
11 organizations as their numbers decreased. But  
12 we know that certain numbers are going to  
13 increase when it comes to disability  
14 evaluation systems.

15           The emphasis of that  
16 recommendation is to provide that. So, the  
17 Services on findings themselves is reinventing  
18 the wheel. It is, in essence, the Reserve --  
19 it is the Guard and Reserve force. It is  
20 going to stand up and make sure everything is  
21 continued to move on as these organizations  
22 change over the next several years over the

1 period of a decade as we move on to the next  
2 conflict.

3 CSM DEJONG: I understand what you  
4 are saying but we also need to establish --  
5 this can't be a cadre member that comes up  
6 there. We need somebody with the rank  
7 structure to allow for policy but that also  
8 has a working knowledge of what has happened  
9 to reach back and take forward into policy  
10 what we have established. Is that what you  
11 are saying?

12 TSGT EUDY: That is exactly what I  
13 am saying, someone that has had the longevity  
14 within their respective service organizations,  
15 with that rank and experience in order to help  
16 facilitate those actions. We don't want to  
17 pull someone from outside of those  
18 organizations, unless they have had direct  
19 experience involved in Recovering Warrior  
20 Care.

21 MS. DAILEY: That is good to have  
22 on the record. We will include something in

1 the findings for DEE for that. And then  
2 again, I will talk to the Service about the  
3 findings for D4 and I will talk to the Warrior  
4 Care Policy Office on what they would need.  
5 Okay, Captain Sanders? Are we okay with that?  
6 I can put that in D4 with some input from  
7 Warrior Care Policy. Okay?

8 CAPT SANDERS: Thank you.

9 MS. DAILEY: Thank you. Okay, off  
10 the table. It is resolved.

11 CO-CHAIR NATHAN: Okay, so now  
12 what we have before us is 4.1. And we have  
13 had a motion to adopt as a recommendation,  
14 realigning the WCP and re-grade the WCP  
15 leadership position to better work at the  
16 interagency environment and drive policy  
17 within the DoD. Do we have any further  
18 discussion on that?

19 MR. REHBEIN: Sir, I would like to  
20 suggest a wording change.

21 CO-CHAIR NATHAN: Okay.

22 MR. REHBEIN: In place of to

1 better work, I would substitute to increase  
2 effectiveness.

3 DR. STONE: So, let's strike the  
4 word drive. You can replace with create,  
5 implement, effectuate. Well, it is a choice  
6 of three.

7 CO-CHAIR NATHAN: Any further  
8 discussion?

9 MS. DAILEY: And last comment from  
10 me. I have to tell you guys, I have got  
11 nothing but your discussion here to  
12 substantiate this. This is going to be a  
13 short set of findings here. I don't even have  
14 Warrior Care Policy behind it. When they  
15 talked to us in February, they said they were  
16 fine with their current alignment.

17 MR. REHBEIN: I think many of the  
18 findings out of D4 could be moved here.

19 MS. DAILEY: Okay, that is good.  
20 We will rearrange the findings in D4 to plug  
21 into this.

22 MS. MALEBRANCHE: I think the

1 other thing, Denise, that you brought up we  
2 probably ought to address, too, is that if we  
3 last year, did we do something contrary  
4 before? Because I mean okay, so if we did, I  
5 think we have to address that because that is  
6 kind of like the elephant like last year you  
7 said don't. This year, you say do this.

8 MS. DAILEY: Yes, your first  
9 recommendation in 2012 was silent in where it  
10 was a conscious decision on your part to not  
11 tell P&R where to put this office. And  
12 consequently, this year you are going to be  
13 directive in nature and tell them where to put  
14 it.

15 So, yes, we will address that. It  
16 is the same dilemma we have with DHA's  
17 recommendation, wherein the past you  
18 recommended aligning them under the Services.  
19 But you have got new perspectives now and you  
20 will have a different perspective to present.

21 MS. MALEBRANCHE: Okay, that is  
22 what I was just thinking, in light of all of



1 the changes that have occurred this year, so  
2 we are not just coming out --

3 MS. DAILEY: That is how it would  
4 come out. You know, that is how I would  
5 justify it. You have to demonstrate, you have  
6 to show some conviction is it what you want or  
7 not. You know your other findings are just as  
8 good as your current perspective.

9 MS. MALEBRANCHE: One of the  
10 things just to add to that, the current MOA,  
11 which has gotten through all the stages except  
12 up to the final signature for the IC3, which  
13 is going to be Mrs. Wright and -- actually, it  
14 is going to be Mr. Snyder now, I'm sorry, the  
15 Deputy Secretary because they didn't want to  
16 have them sign initially because of his title.  
17 And he was kind of interim or Acting  
18 Secretary. We wanted to keep it at the level  
19 of Ms. Wright and the deputy.

20 I think that sort of things helps  
21 in the justification because when you are  
22 talking about the interagency MOA, that is

1 coming under that level and it is under P&R.  
2 So, I guess that is what I am saying in a  
3 roundabout way.

4 CO-CHAIR CROCKETT-JONES: To  
5 include that in the findings add support?

6 MS. MALEBRANCHE: Yes, that is  
7 what I am thinking. That is supportive. In  
8 the interagency MOA right now, the signature  
9 level is at the P&R and at our Deputy  
10 Secretary. So, that is what the IC3 has been  
11 working and that would be what WCP is working.  
12 So, it keeps it again at the same sort of  
13 level and supports this interagency  
14 environment, which is a change to what we had  
15 last year. We didn't have it last year.

16 CO-CHAIR NATHAN: So, Karen, you  
17 confused me a little bit. So, are you saying  
18 that in your opinion elevating the WCP to  
19 under P&R adds more congruency to the way it  
20 all works?

21 MS. MALEBRANCHE: Yes, the way it  
22 is working today. Right. Right, that is what

1 I am saying.

2 CO-CHAIR NATHAN: Okay.

3 MS. MALEBRANCHE: So, it does add  
4 that, which, again, understanding how  
5 different things in every individual piece but  
6 that is what it is at today. So, we are now  
7 being consistent with how we are practicing.

8 CO-CHAIR NATHAN: Okay.

9 LT COL KEANE: I would like to  
10 make a comment. I think it is significant  
11 that we don't have input from WCP on this.

12 MS. DAILEY: We have input back in  
13 February that they are okay with the alignment  
14 where they are at now. They do not, Warrior  
15 Care Policy does not have -- did not give us  
16 comments on this recommendation.

17 LT COL KEANE: Right. That is  
18 what I meant to stress. This is new.

19 And I also want to echo my  
20 comments in May. I think the last  
21 recommendation is better. I think we have  
22 kind of discussed this. We have discussed

1 this in the past.

2 CO-CHAIR CROCKETT-JONES: It's  
3 true. We also eliminated one.

4 I just want to emphasize that this  
5 is an area where we made recommendations but  
6 we really, the same concerns that brought us  
7 to the earlier recommendation still exist. We  
8 are still -- you know the status quo was  
9 maintained and our recommendations weren't  
10 taken. But there are concerns about policy  
11 dissemination and the effectiveness of the  
12 office and its permanence were not resolved.  
13 So, it is legitimate for us to try and remake  
14 a recommendation more specific and to continue  
15 to try and find a way to make a recommendation  
16 that addresses our concerns, even if we it is  
17 a rework of our prior one, if our concerns  
18 about Warrior Care Policy Office's permanence  
19 and its authority and its effectiveness in the  
20 interagency environment, if those concerns had  
21 already been resolved, if we were seeing this  
22 as an issue, it would never have come up

1 again.

2 So, I am not too concerned. I  
3 think that this is not a stretch from what we  
4 have been sort of sensing all along.

5 CO-CHAIR NATHAN: Suzanne, if I  
6 could just add to what you are saying because  
7 I am very conflicted on this. So, I think  
8 Major General Mustion is probably going to  
9 vote for it and I am going to vote against it.

10 (Laughter.)

11 CO-CHAIR NATHAN: But I think what  
12 it comes down to me, is this comes down does  
13 the WCP have a voice in goodness and making a  
14 change that moves policy and moves execution  
15 forward and better. And now I have to ask  
16 myself, is that going to be resolved?  
17 Because, I agree with what you are saying. So  
18 far, we have not seen from the WCP what we  
19 were hoping to see.

20 The question I have to ask myself  
21 is moving it to USD(P&R) going to fix that or  
22 improve that? Or should I give a chance for

1 the Services to put their reps on there, who  
2 now come back to the Services and the Services  
3 have a more direct input, output from the WCP.  
4 And the Services, therefore, can utilize their  
5 service secretaries and their assistant  
6 secretaries to then move up through USD(P&R)  
7 and Deputy Secretary of Defense.

8           So, I agree completely with you  
9 that we need to improve traction of the WCP  
10 and that it needs to have a bigger voice. I  
11 am not convinced that moving it to USD(P&R) is  
12 going to fix that. I am more inclined to  
13 think that the first step to take in the right  
14 direction was adding service members.

15           And the reason I say that is to  
16 get back to what you were saying, Colonel,  
17 which is what the WCP did tell us is we need  
18 service representation. What they didn't tell  
19 us is we need to be moved up to USD(P&R). So,  
20 that is where I am conflicted.

21           DR. STONE: So, sir, I would like  
22 to help you get your vote in line with General

1 Mustion's. I think that adding service  
2 members is going to help, making sure that the  
3 office, which is responsible for policy, has  
4 policy that is responsive to the operational  
5 needs of the Services. It does not, in any  
6 way, help that office interact in the  
7 interagency milieu, which is really where the  
8 power comes. And, therefore, it must move.  
9 I think this really does come down to a  
10 discussion of where it exists within the  
11 Department and it must move in order to  
12 interact in effective manner in the  
13 interagency environment.

14 And as we begin that discussion  
15 and as you change your vote, sir, to General  
16 Mustion's and align firmly, I think this about  
17 that policy, not so much the service members  
18 involved.

19 CO-CHAIR CROCKETT-JONES: I also  
20 want to point out that they have service  
21 members in the past. And while I think it has  
22 been helpful to them, I don't think it was

1 enough or we would have seen that already  
2 included and we would have seen more traction  
3 at those times.

4 CO-CHAIR NATHAN: So, entertain  
5 for discussion. Some of the key points that  
6 have been made are that if you are going to  
7 affect policy, then you need to put this at  
8 the policy level of P&R. Some of the points  
9 that are made is that they have had service  
10 representation, although, it has been  
11 representational, it has been spotty. They  
12 have had it in the past and we are still  
13 lacking in their ability to make significant  
14 and dramatic change that we believe gets  
15 traction. Some of the points that have been  
16 made is that the WCP themselves did not come  
17 to us with this request. They came to us with  
18 the request for permanent service  
19 representation. And some of the points that  
20 have been made is that we all agree that WCP  
21 needs more bite, needs more traction, needs  
22 more of a voice in the system but this may or



1 may not be -- may or may not deliver that.

2 So, those are some of the points for and  
3 against it.

4 If is there anybody else who has  
5 other points to make, we are happy to hear.  
6 Otherwise, we have a motion to adopt -- oh,  
7 and then the other point was less is more,  
8 meaning should we avoid adding too many  
9 recommendations. So, all very good points  
10 both for and against it. And the Chair thanks  
11 the gentleman from Michigan?

12 DR. STONE: I'm not quite sure  
13 anymore.

14 CO-CHAIR NATHAN: Not anymore?  
15 Has the family moved?

16 DR. STONE: Another week.

17 CO-CHAIR NATHAN: Another week,  
18 okay. So, the gentleman formerly from  
19 Michigan for his very cogent data and then all  
20 the others who added and subtracted from that.

21 So, with no further discussion,  
22 all those in favor of adopting as a

1 recommendation D4.1, which is to realign the  
2 WCP and re-grade the DASD WCP leadership  
3 position to increase effectiveness in the  
4 interagency environment and to better create  
5 policy within the DoD. Note, it doesn't say  
6 where to realign it. Do you wish to have that  
7 in there, Rich?

8 DR. STONE: No, I think you can  
9 leave it as is.

10 CO-CHAIR NATHAN: Okay. All those  
11 in favor of that as written, please signify by  
12 raising your hand.

13 (A show of hands.)

14 CO-CHAIR NATHAN: I convinced  
15 Mustion in my arguments. Have we got a count?  
16 Come on, Eudy, get it up high, buddy. All  
17 right, there you go. This is your thing.

18 MS. DAILEY: If your hand is up,  
19 please leave it up, one more time. Okay,  
20 thank you.

21 CO-CHAIR NATHAN: All those  
22 opposed.

1 (A show of hands.)

2 CO-CHAIR NATHAN: The Naval  
3 Maritime Forces.

4 MS. DAILEY: Did you vote, sir?

5 CO-CHAIR NATHAN: Mustion abstains  
6 because he wants to be supportive of his  
7 battle buddy, Stone. But on the other hand,  
8 he morally understands that I had the winning  
9 argument.

10 Okay, so the recommendation  
11 carries and we now have D4.1.

12 MS. DAILEY: And ladies and  
13 gentlemen, that takes us to lunch. Very good  
14 job getting through the agenda and being on  
15 time. So, good job. Thank you very much.

16 CO-CHAIR CROCKETT-JONES: And  
17 reconvene at 12:20.

18 MS. DAILEY: Is that what my  
19 agenda says?

20 CO-CHAIR CROCKETT-JONES: That is  
21 what your agenda says.

22 MS. DAILEY: Okay, then 12:20 it

1 is, ladies and gentlemen.

2 (Whereupon, the above-entitled matt went  
3 off the record at 11:32 a.m. and resumed at  
4 12:30 p.m.)

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1 Malebranche.

2 CO-CHAIR NATHAN: So, anybody have  
3 questions or concerns? I see this as  
4 basically the Task Force going on record to  
5 get a commitment from DoD to institutionalize  
6 and/or preserve the work that has been done  
7 over the next -- over the last ten years.

8 You know the challenge we have is  
9 that I tell people all the time, given that  
10 war has presumably ended and I recognize that  
11 it hasn't ended for people who are sacrificing  
12 right now and are in the middle east still but  
13 you know we are not sure what to do with all  
14 our trauma personnel now, all our critical  
15 care folks, trying to get them back to work  
16 but we are going to be short of the recovering  
17 warrior support personnel, mainly in the  
18 emotional health business and in the chronic  
19 pain business. We are going to be short for  
20 the next 20 years. So, how do we maintain  
21 this? Because we have created the largest  
22 reservoir of recovering warriors in the

1 history of the country over the last 12 years  
2 and more will be coming off the rolls in the  
3 next three to four years if we continue to  
4 have sequestration and/or reduction in force.

5 So, the question is I see this as  
6 going on record basically saying you can't  
7 pull up your tent, at this time, for  
8 recovering warriors, simply because,  
9 presumably, kinetic conflict has lessened  
10 tremendously.

11 LT COL WONG: I would like to move  
12 vote. I think this is fairly clearly written  
13 and we spent a lot of time prior to this  
14 meeting, so I would like to move to vote.

15 CO-CHAIR NATHAN: Okay. If there  
16 is no further -- okay, a second?

17 TSGT EUDY: Second.

18 CO-CHAIR NATHAN: So, there is a  
19 motion to adopt -- to vote on the adoption of  
20 D5, which is secure enduring resources for  
21 maintaining the capability infrastructure and  
22 institutional knowledge for supporting

1 recovering warriors that have been developed  
2 over the last ten years.

3 All those in favor of adopting  
4 this as a recommendation, signify by raising  
5 your hands.

6 (A show of hands.)

7 CO-CHAIR NATHAN: Note all present  
8 vote yea. Any opposed? None opposed.

9 LT COL WONG: Before the vote  
10 passed we had to have four non-DoD and four  
11 DoD and we have enough for that quorum.

12 CO-CHAIR NATHAN: Good  
13 observation. Thanks.

14 All righty, then, D6. This will  
15 cover the recommendations specific to  
16 interagency and cross-agency policy. The  
17 recommendation states to develop interagency  
18 and cross-agency Department of Defense and  
19 Veteran Affairs policy that binds and commits  
20 both agencies to implement and  
21 institutionalize programs that span  
22 departments. The Department of Defense and



1 the Veterans Affairs Joint Executive Council,  
2 otherwise known as the JEC, should establish  
3 the capability for the creation of interagency  
4 policy.

5 Do we have a motion to adopt this  
6 for discussion?

7 MR. REHBEIN: So moved.

8 MR. DRACH: Second.

9 CO-CHAIR NATHAN: Okay, thank you.

10 MS. DAILEY: Okay, ladies and  
11 gentlemen, if you will see in front of you  
12 there is a rewriting of this recommendation.  
13 Has that been passed out? Okay. So, when we  
14 first wrote this, we had to rewrite it because  
15 the JEC can't do what is up there. The JEC is  
16 not empowered. So, that language needs to  
17 come out. The JEC language needs to come out.

18 And if you read the findings, the  
19 findings only really support a recommendation  
20 that really goes to Congress or it goes to the  
21 President, in which only higher authorities  
22 than the Executive Branch can require the

1 Executive Branch to produce interagency  
2 policies.

3 CO-CHAIR NATHAN: Right. I think  
4 the JEC could probably recommend and come up  
5 with ideas for interagency cooperation and  
6 policies but they certainly can't require it.

7 MS. MALEBRANCHE: That, I think,  
8 was the intent in our discussion. Because we  
9 want to make sure both agencies are writing  
10 the same legislation and that it is endorsed  
11 by the leadership on both sides and they write  
12 it the same because we each have our own folks  
13 that write the legislation and propose it.  
14 So, if they could propose the same legislation  
15 at the same time to get to this, it was to  
16 always have congress be the ones that do this.  
17 But we just wanted to make sure we had the  
18 JEC's support, I guess.

19 MS. DAILEY: So, the new  
20 recommendation is in red up there. The new  
21 recommendation is in red and it allows and  
22 aligns this recommendation with the

1 appropriate agency to make it.

2 MR. REHBEIN: Is develop the  
3 correct word there? Can Congress develop  
4 policy? Or should it say something like  
5 authorize? It just seems odd that Congress  
6 would be developing policy.

7 MS. DAILEY: The word would be  
8 legislation.

9 LT COL WONG: So, create  
10 legislation or legislate?

11 CO-CHAIR CROCKETT-JONES: Yes, it  
12 would really be that Congress should legislate  
13 a method for interagency DoD/VA cross-agency  
14 policy writing. I mean we want them to create  
15 a structure or an authority.

16 MS. DAILEY: They have to  
17 legislate.

18 CO-CHAIR CROCKETT-JONES: They  
19 have to legislation. Well, in legislation, we  
20 want them to require that this be done, a  
21 policy that can bind more than one agency.

22 LT COL WONG: Now that we have had

1           that discussion, have we fallen back to, many  
2           times, well, Lieutenant Colonel Keane is not  
3           here, less is more sometimes? And I'm not  
4           sure if this is outside the lane because this  
5           is not a recommendation to DoD but more of a  
6           recommendation to Congress.

7                           CO-CHAIR CROCKETT-JONES: We have  
8           made recommendations for legislation in the  
9           past and we are specifically, Congress told us  
10          that interagency programming was within our  
11          purview. So, I think that we are good as far  
12          as the lingo. And in fact I think that what  
13          we found is, they told us to look at this in  
14          interagency programming and what we found is  
15          they have something to do to make that  
16          effective. That all of these, that they have  
17          been using what winds up being a stop gap  
18          method of memorandums of understanding and  
19          agreement that are not, they are not  
20          permanent. They can go away with a change of  
21          leadership and at very short notice. And it  
22          is kind of concerning how short a notice

1 memorandums of agreement can go away.

2 So, I think we are safe in our  
3 lane. And I think, in fact, this is really  
4 specifically like an overtime idea that has  
5 become really apparent to us.

6 CO-CHAIR NATHAN: Colonel Sergeant  
7 Major, did you want to say something?

8 CSM DEJONG: I'm just rereading it  
9 before I --

10 With the amount of discussion that  
11 we had last meeting about this, and I think  
12 that as a group we came to an understanding  
13 that this is the only way we are going to move  
14 both organizations forward in the same  
15 direction at the same time.

16 So, at this time, I am going to go  
17 ahead and make a motion to vote as written.

18 MS. MALEBRANCHE: I have a  
19 question. When they say create legislation to  
20 develop a structure, are we asking to develop  
21 a structure or --

22 CO-CHAIR CROCKETT-JONES: I think

1 we are because we don't want to them to have  
2 to legislate every time there is an  
3 interagency policy.

4 MS. MALEBRANCHE: Got you. It is  
5 a process. I see what you are saying. Okay.

6 CO-CHAIR CROCKETT-JONES: They  
7 need to legislate the format or the authority  
8 for that to be done.

9 CO-CHAIR NATHAN: So the JEC has  
10 the Under Secretary of the VA, right, --

11 MS. MALEBRANCHE: Has the --

12 CO-CHAIR NATHAN: -- with  
13 USD(P&R).

14 MS. MALEBRANCHE: -- Deputy  
15 Secretary --

16 CO-CHAIR NATHAN: Deputy  
17 Secretary.

18 MS. MALEBRANCHE: -- of the VA  
19 with the USD(P&R) are the two chairs.

20 CO-CHAIR NATHAN: USD(P&R) are the  
21 two co-chairs of the JEC.

22 MS. MALEBRANCHE: Right. So, that

1 is a mechanism.

2 CO-CHAIR CROCKETT-JONES: Congress  
3 can give the JEC the authority to write it by  
4 legislation but they don't have the authority  
5 without it.

6 MS. MALEBRANCHE: Right.

7 MS. DAILEY: No, no. Only a  
8 higher agency can create the requirement for  
9 interagency policy.

10 MS. MALEBRANCHE: So they could  
11 create -- Congress can create the requirement?  
12 No, they do the legislation but the JEC could  
13 be the body. That could be part of the  
14 structure of the mechanism to put forth policy  
15 to make sure that they are both in sync.

16 CO-CHAIR NATHAN: Right. In other  
17 words who? We understand the intent of this.  
18 The intent of this is -- we will worry about  
19 the rules in a minute. But the intent of this  
20 is to make sure that both agencies create  
21 policy in parallel and in concert and not  
22 disparately where it overlaps with recovering

1 warriors.

2 So, and Ms. Dailey's point is well  
3 taken that the only people who can do that are  
4 people who are higher common higher, who have  
5 the highest common denominator of both  
6 Services or, I'm sorry, both agencies. So,  
7 that would have to be the executive level or  
8 congressional level.

9 But the question is who would be  
10 the people from the Services from the agencies  
11 who get together to broker that policy, to  
12 broker common policies. And I believe it  
13 would be the JEC.

14 MS. MALEBRANCHE: That is what I  
15 am thinking, too. So, the JEC is involved in  
16 there. They didn't create the policy but they  
17 have to like broker the deal, kind of.

18 CO-CHAIR NATHAN: They have to  
19 broker the deal or somebody has to bring to  
20 the JEC from a service from the agency. The  
21 VA or the DoD comes to the JEC and says hey  
22 listen, here is something that we think should



1           be a coordinated policy at the two agencies.  
2           And the JEC then kicks it around, says yes, I  
3           think that is the existing body that would do  
4           this, kicks it around, says let's do more  
5           research or sounds good or no. And when they  
6           come to conclusion and say yes, they then have  
7           to submit that. The JEC has to submit that to  
8           who?

9                           MS. MALEBRANCHE: The offices in  
10           our different committees.

11                          CO-CHAIR NATHAN: I guess of the  
12           legislation.

13                          MS. MALEBRANCHE: SASC, SFAC,  
14           HFAC, and HASC. That actually is really a  
15           good piece, too, because the JEC is  
16           legislated. So, I mean they are the  
17           legislative body already. So, if they --

18                          CO-CHAIR CROCKETT-JONES: Right.  
19           They are legislated to make recommendations  
20           already. What we want is a method, an agency,  
21           or a legislation that allows them to have an  
22           authority that takes the recommendations and

1 makes them policy.

2 MS. MALEBRANCHE: Well, I have to  
3 tell you, too, I think it also gives added, I  
4 don't know what the word is, to one of our  
5 previous recommendations that the JEC be co-  
6 chaired by the two deputies. I think that  
7 that is a significant issue. And we didn't  
8 get that but if we could get through a policy,  
9 there might be renewed interest. Just a  
10 thought.

11 CO-CHAIR NATHAN: So, Suzanne,  
12 what is the deliverable from this? In other  
13 words, what actually appears if DoD and the VA  
14 buy off on this, Congress buys off on this?  
15 What actually --

16 CO-CHAIR CROCKETT-JONES:  
17 Basically, the current system is that anytime  
18 they seem to overlap, that there are  
19 memorandums of agreement, or memorandums of  
20 understanding. They can be local. They can  
21 be regional but they are always not permanent  
22 and non-binding, if one of the agencies, say

1 the head of one of the agencies changes, they  
2 can say 30 days' from now this is over. And  
3 policy changes. And if the head of the agency  
4 changed every six months for a while because  
5 of issues, then every six months that  
6 memorandum could go away and the memorandum  
7 that replaced it could go away. And some of  
8 these issues, as they go forward, need the  
9 level of permanence and predictability of a  
10 policy that doesn't go away with every  
11 leadership change.

12 And so, and there is only going to  
13 be more interagency operations in programming.  
14 Agencies are moving together more and more to  
15 share resources and Department of Labor gets  
16 pulled in, all these. And we are saying that  
17 when we look at with just the last  
18 recommendation was to say we want longevity.  
19 And we don't want to have the wheel reinvented  
20 every time. This is part of that as well.

21 CO-CHAIR NATHAN: No, I  
22 understand. I understand the concept and the

1 sentiment. I just don't understand what would  
2 be different at the end of the day. What is  
3 the product that would happen if Congress buys  
4 off on this? A law?

5 CO-CHAIR CROCKETT-JONES: Well,  
6 Congress can only legislate. So, it would  
7 seem that there would be a named office at the  
8 executive level for signing off on policy. I  
9 mean I am confused by what the limitations  
10 are.

11 MS. DAILEY: So, the visual is  
12 that Congress tells the DoD and the VA to make  
13 interagency policy covering these areas that  
14 we have outlined in the findings. So, they  
15 legislate. DoD and VA will develop  
16 interagency policy. It is not the MOU. It is  
17 not the MOA but they direct them to create  
18 interagency policy.

19 MS. MALEBRANCHE: And part of the  
20 -- when we talked about this, this was in  
21 relation to the IC3 and a lot of the things we  
22 talked about the MOA that is currently going.

1 But then there was also, remember, the added  
2 benefit. Because had we policy before with  
3 the DES system, we wouldn't have created an  
4 MOU at every site where we had every DES  
5 system going in place and every time a  
6 commander and/or a VISN Director or a facility  
7 person left, they may say my priorities have  
8 changed. I no longer want this MOA. I want  
9 something else. So, that was the second  
10 example.

11 I think the third one was like in  
12 separation health assessments, where we need  
13 to be able to do those things together in  
14 concert. So, we have a lot of things that  
15 could lend itself well to joint policy. And  
16 through the JEC --

17 MS. DAILEY: Interagency policy?

18 MS. MALEBRANCHE: Interagency  
19 policy. But where you have the JEC, which is  
20 an interagency group, you also have the  
21 General Counsel, the legislative folks that  
22 sit on that on the highest levels of the

1 Services that that was, I think that is the  
2 place to have that discussion. They might say  
3 no, we don't want a policy on this. We don't  
4 need it. But it also is a place that hey,  
5 this is a long-lasting sort of thing for the  
6 DES.

7 CO-CHAIR NATHAN: So, I'm just  
8 looking for a little more clarity. In other  
9 words, I understand the intent completely and  
10 I think it is a good intent. Hey, VA, hey,  
11 DoD, you will go beyond just your local all  
12 politics or local MOAs, MOUs. You will craft  
13 interagency policy together that is binding  
14 across the agencies. We, Congress, dictate  
15 that. I guess.

16 So, I asked Suzanne. And she said  
17 it might be in the form of an office or a  
18 person who oversees that.

19 CO-CHAIR CROCKETT-JONES: I only  
20 say that because I didn't --

21 CO-CHAIR NATHAN: As an example.  
22 So, now I am asking Denise, how would you see

1           it?  If this is adopted --

2                       MS. DAILEY:  I see it being done  
3           in the JEC.  And I see it being a combination  
4           of a VA regulation, whatever word they use,  
5           and a DoDI or a DoDD.  These two documents  
6           would come together.  It would come together  
7           in a unique interagency policy document that  
8           has maybe a different name.  It is not a DoDI  
9           and it is not whatever you call your  
10          administrative regulations.

11                    CO-CHAIR NATHAN:  So, if this  
12          recommendation is adopted by Congress and  
13          everybody signs up for it, what you see then  
14          as the deliverable is -- admonition is  
15          probably the wrong word but a direction from  
16          Congress to the JEC saying you will create  
17          joint policy, where appropriate.  Okay.

18                    CO-CHAIR CROCKETT-JONES:  Okay, so  
19          this is what I did.  Congress can say that the  
20          JEC is going to do that.  Congress can  
21          legislate that the JEC will consider and craft  
22          interagency policy.  It is what -- okay.  So,

1           they don't need to be -- there doesn't need to  
2           be that higher level every time a policy is  
3           written. That can be directed as a function  
4           of the JEC by legislation in Congress.

5                       MS. MALEBRANCHE: That's what I  
6           hear you saying. So, it can be the ability to  
7           do that as conferred or given to the JEC or  
8           policy because it is not --

9                       CO-CHAIR CROCKETT-JONES: I didn't  
10          understand that.

11                      MS. MALEBRANCHE: It is the  
12          legislation for the policy that has to come  
13          from Congress and the JEC can determine what  
14          can be done in policy. Is that what I am  
15          hearing?

16                      MS. DAILEY: Yes.

17                      MS. MALEBRANCHE: Okay.

18                      MS. DAILEY: Yes.

19                      MS. MALEBRANCHE: Okay, and then  
20          from policy, I think the way it goes, actually  
21          DoDI and for the VA its directives flow from  
22          that. So, then that could in synch because



1           they have the same policy they are referring  
2           to.

3                       CO-CHAIR NATHAN:   Okay, any  
4           further questions, concerns, discussion?

5                       Hearing none, we will call for --  
6           do I have a motion to adopt D6 as a  
7           recommendation?

8                       MS. MALEBRANCHE:   I move we adopt  
9           D6.

10                      CO-CHAIR NATHAN:   Okay, so we have  
11           a movement.   Second?

12                      MR. DRACH:   Second.

13                      CO-CHAIR NATHAN:   Okay.   So, the  
14           motion before us is to vote on the adoption of  
15           D6.

16                      MS. DAILEY:   Can we read it out  
17           loud, please?

18                      CO-CHAIR NATHAN:   We will do it.  
19           Great minds think alike.   I was just about to  
20           do that.   You don't happen to know the lottery  
21           numbers for tomorrow, do you?

22                      CO-CHAIR CROCKETT-JONES:

1 Highlight the final wording.

2 CO-CHAIR NATHAN: Congress should  
3 create legislation directing DoD and VA to  
4 develop interagency/cross-agency DoD-VA policy  
5 that binds and commits both agencies to  
6 implement and institutionalize programs that  
7 span departments.

8 As I read it, I know what the  
9 intent of that span departments means but  
10 should it be that spans both departments or  
11 that spans both agencies or that is common to  
12 both agencies or that -- because programs that  
13 span both departments -- I know the intent.  
14 Maybe I am trying to make it too articulate.

15 MR. REHBEIN: No, I think the  
16 words that are common to both departments  
17 would express it better, yes.

18 MS. DAILEY: And we may want to  
19 put wounded, ill, and injured before programs.

20 CO-CHAIR NATHAN: Okay.

21 MS. MALEBRANCHE: Congress should  
22 create legislation conferring -- I don't know

1 if it is conferring upon the JEC the authority  
2 to develop. Our lawyer is here. I am going  
3 to ask. I am going to call a friend.

4 Captain Sanders, what would be the  
5 appropriate language for Congress should  
6 create legislation conferring to the JEC, upon  
7 the JEC the authority to develop  
8 interagency/cross-agency DoD-VA policy, what  
9 is the appropriate language for that?

10 MR. REHBEIN: Is the JEC a  
11 permanent body?

12 MS. DAILEY: The JEC is a  
13 legislative body.

14 MS. MALEBRANCHE: The JEC is a  
15 legislative body.

16 CAPT SANDERS: They already have  
17 authority to do it. They just need this  
18 specific authority?

19 MS. MALEBRANCHE: I don't know  
20 they have the authority to create legislation.  
21 What this is doing is saying you can come to  
22 us with a proposed legislation proposing this.

1 I guess I am just not sure.

2 CAPT SANDERS: So, are you asking  
3 the JEC to provide Congress with legislation?

4 MS. MALEBRANCHE: Yes.

5 CO-CHAIR CROCKETT-JONES: No, no,  
6 no. We are saying that Congress should give  
7 the JEC the authority to create interagency  
8 policy.

9 CAPT SANDERS: Policy not  
10 legislation.

11 CO-CHAIR CROCKETT-JONES: Not  
12 memorandums of understanding, not parallel  
13 MOUs but a policy that binds the agencies to  
14 permanent policy and programs.

15 CAPT SANDERS: Then I guess I  
16 would just simplify it and just say Congress  
17 should confer to the JEC authority to develop  
18 interagency DoD-VA policies in the area you  
19 want.

20 CO-CHAIR CROCKETT-JONES: We want  
21 them to choose. We want the JEC to be able to  
22 say this needs to be a matter of interagency

1 policy.

2 Okay, so Congress should confer to  
3 the JEC --

4 CAPT SANDERS: Authority. I would  
5 simplify it.

6 MS. DAILEY: Ladies and gentlemen,  
7 it is two parts. Congress must establish the  
8 requirement for interagency policy to be  
9 written. Then, in the recommendation, we are  
10 asking them to establish the requirement for  
11 interagency policy. And then, we say the JEC  
12 should be writing that interagency policy.

13 CAPT SANDERS: So for part 1, do  
14 we need to specify that?

15 MS. DAILEY: Yes.

16 CAPT SANDERS: And we should do  
17 that separately, then, right, if it is two  
18 parts, as opposed to mushing it into one  
19 statement.

20 MS. DAILEY: We have mushed  
21 before. So, it is however you want to do it  
22 but it has got to be two. Congress has to

1           establish the requirement for the interagency  
2           policy.

3                        CAPT SANDERS: Well, I think that  
4           really says it, if you are going to break it  
5           up into two parts or at least make it  
6           distinctly --

7                        CO-CHAIR CROCKETT-JONES: Yes,  
8           Denise's language was just right then. I get  
9           it. I get what you are saying, Denise.

10                      CAPT SANDERS: To make it distinct  
11           as two parts.

12                      CO-CHAIR CROCKETT-JONES: Say it  
13           again, Denise.

14                      MS. DAILEY: Congress needs to  
15           establish the requirement for interagency  
16           policy between DoD and VA on wounded, ill, and  
17           injured programs. Additionally, direct the  
18           JEC to write this policy.

19                      CAPT SANDERS: Thank you, counsel.

20                      (Laughter.)

21                      CO-CHAIR NATHAN: Very good.

22                      DR. PHILLIPS: Do we need to

1 specify that this policy should be in concert  
2 or harmonized? I mean what if the JEC just  
3 says we recommend one policy for the VA and  
4 one policy for the DoD? Or am I just being  
5 too picky?

6 CO-CHAIR CROCKETT-JONES: No, I  
7 think this is --

8 CO-CHAIR NATHAN: Well, it says  
9 interagency policy.

10 CO-CHAIR CROCKETT-JONES:  
11 Interagency policy is assumed.

12 CO-CHAIR NATHAN: It means the  
13 two, two issues.

14 So, that is the latest and  
15 greatest that you see there at the bottom.  
16 Any questions, concerns, more discussion?  
17 Anybody want to add the right to bear arms or  
18 anything like that?

19 So, we have changed the wording.  
20 I will need a motion to adopt as written for  
21 Recommendation D6.

22 CAPT SANDERS: So moved.

1 DR. PHILLIPS: Second.

2 CO-CHAIR NATHAN: So, the motion  
3 before us is to vote on the adoption of D6,  
4 revised as following: Congress should  
5 establish the requirement for interagency  
6 policy between DoD and VA on wounded, ill, and  
7 injured programs. Additionally, Congress  
8 should direct the JEC, the Joint Executive  
9 Council, to write this policy.

10 All those in favor of adopting  
11 this language as D6, signify by raising your  
12 hands.

13 (Show of hands.)

14 CO-CHAIR NATHAN: All those  
15 opposed?

16 (Show of hands.)

17 CO-CHAIR NATHAN: One opposition.  
18 Okay, so the motion carries.

19 CO-CHAIR CROCKETT-JONES: That was  
20 tenuous.

21 LT COL KEANE: I'm sorry, I need  
22 to clarify a point. I thought the Admiral was



1 asking if we accept this the way it is  
2 written. I was expecting him to then say are  
3 we going to vote on it. So, I misunderstood.  
4 I also would like to say no. I am sorry about  
5 the misunderstanding.

6 CO-CHAIR NATHAN: Okay, just so we  
7 are clear, why don't we do this again, just to  
8 be correct?

9 MS. DAILEY: I would like to hear  
10 the nos. I'm not sure I got a good no  
11 understanding. So maybe we might even want to  
12 reopen discussion.

13 CO-CHAIR NATHAN: Yes, we will.  
14 We will.

15 MS. DAILEY: Okay.

16 CO-CHAIR NATHAN: I think there is  
17 enough confusion that we will reopen.

18 So, is there any more discussion?  
19 Because the next vote we are going to take is  
20 not in the wording of this. The next vote we  
21 are going to take is should this be adopted as  
22 Recommendation D6. So, before that, is there

1 any discussion on this recommendation as  
2 currently written?

3 LT COL KEANE: As I mentioned  
4 before, this is our last shot. I believe this  
5 is going to fall on deaf ears. I think by  
6 adding this one and others takes away from the  
7 ones that I feel are important. I think we  
8 need to hammer, I was thinking a one-two-three  
9 punch but I am up to one-two-three-four-five  
10 possibly six punch. This doesn't meet my  
11 level.

12 This, I think, would be a great  
13 one for last year or the year before because  
14 we could follow-up on it. This is going to  
15 fall on deaf ears, I believe.

16 CO-CHAIR NATHAN: So, if I  
17 understand you correctly, Colonel, you are  
18 saying that this doesn't add that much to the  
19 mix. You don't think it will really change  
20 things substantially. And as such, dilutes  
21 the attention from some of the other  
22 recommendations that you believe are more

1 critical and actionable.

2 LT COL KEANE: Exactly, sir.

3 CO-CHAIR NATHAN: Any other  
4 comments on discussion or concern?

5 MS. DAILEY: If you voted no, you  
6 need to put your voice up on the record.

7 CO-CHAIR NATHAN: You don't have  
8 to put your voice up on the record.

9 LT COL WONG: I mean I am just  
10 reiterating what Lieutenant Colonel Keane  
11 mentioned. And again, I feel the same. I  
12 think although this is within our lane, I  
13 still think it is a little bit outside of our  
14 lane. I think it dilutes from the other two  
15 recommendations as we have talked about during  
16 processes. And the JEC is already operational  
17 and I understand they are writing MOAs and  
18 MOUs. But as they move further into their  
19 comfort zone, they will already start doing  
20 this type of stuff. And I think we are  
21 getting more into the sausage making, telling  
22 people how to do their job.

1                   And again, less is sometimes more.

2                   And I don't know if this rises to the level of  
3                   official recommendations on this Task Force.

4                   CO-CHAIR NATHAN: So, my two cents  
5                   would be, and you guys are fairly persuasive  
6                   because you made me reconsider what I was  
7                   thinking, but my two cents would be that the  
8                   genesis of this would have been that this task  
9                   force believed, based on its visits and/or its  
10                  briefs over the working sessions, that a lack  
11                  of interagency policy was hampering the  
12                  ability to provide the best support for  
13                  recovering warriors, for wounded, ill, and  
14                  injured warriors. That would be the genesis  
15                  of this.

16                  In other words, because there is  
17                  not interagency joint policy, there is either  
18                  inefficiency or lack of optimal action that is  
19                  common to the VA and DoD to support  
20                  recovering, wounded, ill, and injured  
21                  warriors.

22                  Your premise being, Colonel, that

1           A) there is already a JEC going on and they  
2           are coordinating things there as needed. And  
3           that this really is telling Congress how to do  
4           their job or what they need. I agree with  
5           that aspect of it. It is telling Congress  
6           here is what you need to do. So, we are  
7           telling them. Is it outside of our lane?  
8           Only if we believe that -- is it out of our  
9           lane? Not if we believe that this  
10          recommendation or lack of it has material  
11          effect on the effective support and care of  
12          wounded warriors, ill, injured, and their  
13          families.

14                           CO-CHAIR CROCKETT-JONES: I think  
15          that both the JEC and the Interagency Program  
16          Office were given to us as specific lanes of  
17          our interest. So, I think that it would be  
18          really hard to say that this is out of our  
19          lane.

20                           These are part of our -- it falls  
21          under more than one of the topics that we were  
22          given specifically. So, I think -- I

1 understand it might still be objectionable but  
2 there is nothing out of our lane about this.

3 And I also would say right now the  
4 JEC doesn't have this authority. And when we  
5 have talked to them about interagency policies  
6 before, they have said that they don't have  
7 this authority.

8 So, I get that this might be  
9 something that a person feels we shouldn't  
10 tackle or that it is not going to be received  
11 well. But I think that we can rest assured  
12 that we are comfortably within our lane.

13 MR. DRACH: I'm also not sure that  
14 the legislation to do this doesn't already  
15 exist. The JEC is codified -- shoot, I just  
16 lost it -- is codified at Section 320 of Title  
17 38. And I just lost it. There are a couple  
18 of things in there that allows them to do in  
19 terms of policies and procedures and  
20 recommendations.

21 MS. DAILEY: Okay.

22 MR. DRACH: So, I'm not sure.

1 MS. DAILEY: Yes, we tried to be  
2 very clear in the research on this. And we  
3 were very clear that the JEC does not have  
4 this authority at this time. Now, if you want  
5 to argue with me, which is fine, I need to go  
6 back and do more research. But I am pretty  
7 sure, based on our research that --

8 MS. MALEBRANCHE: They don't.

9 MS. DAILEY: Okay.

10 MS. MALEBRANCHE: We briefed, as  
11 the IC3, because I am a co-chair on the IC3,  
12 we briefed. And at the time, Dr. Guice and  
13 Mr. Riojas, our Chief of Staff, said I hope  
14 you are going to pursue this policy issue  
15 because it is an MLA. And right now I can  
16 tell you that one of the Services is not  
17 working on this model of this coordinated care  
18 because they want an MOU in place and DoDI  
19 and/or whatever follows that MOU in the VA for  
20 the directive piece to start on this lead  
21 coordinator piece. They will not start  
22 without the DoDI. And they said the DoDI has

1 to come from either an MOA or a policy. The  
2 MOA has been taking an inordinate amount of  
3 time.

4 So, we were asked to pursue. And  
5 so each of the agencies, in their own way, I  
6 don't know how DoD is, but VA is pursuing the  
7 issue of the policy, trying to get so we have  
8 the counterpart to work with.

9 CO-CHAIR NATHAN: Okay, so to  
10 summarize what I have heard, the JEC does not  
11 have the authority to create interagency  
12 policy. The JEC has the ability to reconcile  
13 and bring together various ideas on where  
14 joint or interagency policy might be  
15 beneficial and then send that up for a DoDI  
16 for directive from the agency. They would  
17 have to send it up to their respective  
18 agencies. They would have to do it at the  
19 cabinet level, I am guessing, or suggest it as  
20 a law, legislative and then Congress  
21 legislate.

22 The intent on this, I think, I



1 personally am less worried about the letter of  
2 it and more about the spirit of it. I like  
3 the spirit of it, which is Congress put  
4 pressure on the VA and the DoD to find joint  
5 policy that deals with commonalities for  
6 wounded warriors.

7 Other questions, issues, concerns?

8 LT COL WONG: I do think there is  
9 a point that we capture as part of the record.  
10 And I think a better place for it is when we  
11 did the summary of past actions and past  
12 reports where we are with the JEC and maybe  
13 relate what strength they don't have and  
14 identify that on a past recommendation in our  
15 summary of the report.

16 MS. DAILEY: We don't have any  
17 past recommendations on the JEC.

18 CO-CHAIR NATHAN: Right. But are  
19 you talking about in the findings maybe? Are  
20 you talking about in the findings what the JEC  
21 is and what it isn't?

22 LT COL WONG: I don't know if we

1 can include it in findings if it is not a  
2 recommendation, how the format is.

3 CO-CHAIR NATHAN: Oh, you are  
4 saying if it is not a recommendation. Right,  
5 you are correct, you wouldn't.

6 Okay. The dead horse is not  
7 going to get any deader. Right? Although, I  
8 never cease to be amazed.

9 Congress should establish the  
10 requirements for interagency policy between  
11 DoD and VA on wounded, ill, and injured  
12 programs. Additionally, Congress should  
13 direct the JEC to write this policy.

14 If there is one, I need a motion  
15 to take this wording to a recommendation.

16 MR. DRACH: So moved.

17 CO-CHAIR NATHAN: Second?

18 MR. REHBEIN: I'll second.

19 CO-CHAIR NATHAN: Okay. So, if  
20 you vote, a vote in the affirmative, or voting  
21 aye or raising your hand for this, means you  
22 are voting to make this, and not just this

1           wording, but you are voting to make this  
2           wording a recommendation for the record.

3                       All those in favor of making that  
4           wording that I just read a recommendation D6  
5           for the record, please raise your hands.

6                       (A show of hands.)

7                       CO-CHAIR NATHAN: Got it? All  
8           those opposed, please raise your hands.

9                       (A show of hands.)

10                      CO-CHAIR NATHAN: Okay. Thank  
11          you. All right, the recommendation carries  
12          and D6 will be approved as a recommendation.

13                      CO-CHAIR CROCKETT-JONES: Do we  
14          need a break or are we going to move on to D7?

15                      Okay, Task Force Consolidated  
16          Voting Session Center of Excellence Alignment.  
17          The next recommendation for discussion  
18          addresses the alignment of the centers of  
19          excellence. The recommendation states align  
20          the centers of excellence under the Defense  
21          Health Agency to enable joint effort and  
22          direct links to governance processes within

1 the military health system structure and to  
2 allow for translation of scientific findings  
3 to clinical settings. The Defense Health  
4 Agency Chief Medical Officer should work in  
5 concert with the Medical Director of the  
6 National Institute of Health.

7 In invite anyone to move this  
8 recommendation for discussion.

9 MR. REHBEIN: So moved.

10 MR. DRACH: Second.

11 CO-CHAIR NATHAN: What was the  
12 genesis of the NIH in this?

13 DR. PHILLIPS: I think basically,  
14 if I remember correctly, there was a lot going  
15 on in centers of excellence but there was no  
16 translation toward the civilian sector or  
17 bidirectional translation. And so I think, I  
18 am not sure who generated the words, I don't  
19 know if I did or if someone else did but to  
20 connect it up to the Department of Health and  
21 Human Services, I mean to get the two  
22 departments together.

1 I'm not sure if the word concert  
2 works. I don't know what that means. If I  
3 had my druthers, I would say that they should  
4 meet periodically or develop a common  
5 committee or something like that, rather than  
6 just leave it hanging there.

7 LT COL WONG: Again, I think a lot  
8 of the information in the findings that we  
9 have included on this are important to  
10 capture. And I think the centers of  
11 excellence have done some great things in  
12 their best practices. I believe that is  
13 probably the best place for it. And then we  
14 can in summary add a statement like the  
15 recommendation is under best practices I think  
16 would improve it for the future. But I don't  
17 think this bubbles up to the level of a  
18 recommendation. It dilutes the strength over  
19 the other recommendations.

20 MR. DRACH: In my original  
21 comment, I raised the question as to and I  
22 have no objection to the recommendation as per

1           se, but whether or not we should include the  
2           Under Secretary for Health at VA after NIH.  
3           I think if we are going to include NIH, I  
4           don't know how we can exclude VA.

5                       CO-CHAIR CROCKETT-JONES:  I  
6           believe the centers of excellence already have  
7           the interagency staffing from both DoD and VA.  
8           The centers of excellence, at least some of  
9           them, have VA co-directors.

10                      CO-CHAIR NATHAN:  Yes, so for  
11           instance, the Visual Center of Excellence has  
12           a DoD chairman or director and a VA deputy  
13           director and so do some of the others.

14                      So, I think they are trying to  
15           cross-link the two agencies by putting the  
16           mixed governance in each CoE.

17                      Now, when it says align CoEs under  
18           DHA, that means viz the executive agencies  
19           that they belong to now, for instance, Army  
20           has the DCoE.

21                      MS. DAILEY:  Correct, sir.

22                      CO-CHAIR NATHAN:  Okay.

1 CO-CHAIR CROCKETT-JONES: And I  
2 think that when we started realizing that the  
3 executive agency for any particular center of  
4 excellence was the one who was getting the  
5 product and it was no moving up to other  
6 services very well, for instance the Fox  
7 Shield issue, that we started to think that  
8 although the executive agency finally gave  
9 them authority and a guaranteed sort of  
10 funding and an understanding of their  
11 structure, it started limiting their  
12 dissemination of the product.

13 TSGT EUDY: And that was last  
14 year's first recommendation, the translation  
15 of outcomes. But one of the things  
16 highlighted within the past year was the  
17 Oversight Board and the lack of oversight from  
18 the Oversight Board. And I think that is the  
19 generation of this recommendation come from to  
20 greater enable them into the future and have  
21 some oversight.

22 MS. MALEBRANCHE: Actually, yes.

1 MR. REHBEIN: That and I believe  
2 that there is some administrative practices.  
3 I sent in some words about establishing some  
4 linkages between the various CoEs. And this  
5 is a much better idea to bring them under DHA.  
6 But they are beyond just a better idea than I  
7 had.

8 Beyond just the translation of  
9 results into practice, I think there are some  
10 administrative practices that they can learn  
11 from each other in order for the centers to  
12 become more effective.

13 MS. MALEBRANCHE: I'm not exactly  
14 sure of the answer to this but you are right  
15 about the Oversight Board. And by the way,  
16 they haven't met since last September. And I  
17 think since they came here, they have since  
18 met.

19 And then I agree with Mr. Drach as  
20 far as the Under Secretary for Health because  
21 the extremity and the amputation DCoE is the  
22 only legislated joint CoE for VA and DoD. So,



1 I think we had to acknowledge that and the  
2 putting things into practice.

3 I don't know about the  
4 administrative efficiencies under DHA because  
5 it is so new. But understanding that we had  
6 always thought that there should be some  
7 linkages, for example, if there were the  
8 registry issues because there are some co-  
9 morbidities amongst these different issues but  
10 I don't know. I mean I don't know about the  
11 DHA is new and out there but it is kind of  
12 hard to tell.

13 I guess I don't know. The  
14 Services probably have more to venture under  
15 that. For VA, we have the one joint and we  
16 work with wherever they are placed we are  
17 going to work with them. So, I guess I just  
18 don't know what the best place is.

19 CO-CHAIR NATHAN: So, here is my  
20 fairly parochial take on this. Number one, I  
21 am a zealot about trying to get more  
22 translational research and action from the

1 CoEs. As you know, I have been, depending on  
2 how you look at it, either a fan or a screamer  
3 for a long time that the CoEs come up with  
4 good stuff but somehow it does not get  
5 propagated either at all or it doesn't get  
6 propagated quickly throughout the entire  
7 spectrum of the DoD VA, such as the Fox Eye  
8 Shield.

9 So, that is where we really wanted  
10 to have the Oversight Board to have the common  
11 operating picture of these CoEs to be able to  
12 gather this stuff up and move it out.

13 I'm not a fan of the DHA oversight  
14 for it. And again, this is full disclosure.  
15 I represent the Services. The Services  
16 currently service the executive agents for  
17 each CoE. The Army has one, Navy has a  
18 couple, Air Force has a couple.

19 I believe that is the best  
20 relationship right now because the Services  
21 have the bench and the execution arms to hire  
22 to a staff, to fund, to make sure the lights

1 are on and the trains are running on time.

2 The DHA is not so equipped to do  
3 that. We learned this the hard way when we  
4 had the DCoE, which was a DHA, which was a  
5 TMA, Health Affairs Agency, running the NICoE  
6 center of excellence and the NICoE floundered,  
7 not because the people in the DCoE weren't  
8 wonderful in their expertise of policy and of  
9 knowledge and research but they weren't  
10 executioners. They didn't know how to hire  
11 and put a staff together and deal with some of  
12 the nuances of human resources and all those  
13 things. I don't believe the DHA has that as  
14 a core competency either. And so, which and  
15 you haven't thought of this, but if you wanted  
16 to you could combat my argument with well the  
17 DHA only owns the biggest flagship military  
18 hospital in history, which is Walter Reed-  
19 Bethesda. So you are saying they can own  
20 Walter Reed-Bethesda but they can't own the  
21 Visual Center of Excellence. Correct.

22 (Laughter.)

1 CO-CHAIR NATHAN: And one must  
2 make the presumption they should own Walter  
3 Reed-Bethesda in the first place. But  
4 nonetheless, I just don't think that that is  
5 the answer. I do think that an Oversight  
6 Board, which reports directly to DHA, Health  
7 Affairs Under Secretary is fine. It is fine.  
8 Get the oversight in there.

9 So, I am not opposed to DHA being  
10 responsible for propagating policy and putting  
11 it out and making it work. I just don't  
12 think, from a tactical perspective, it is the  
13 best thing to align them under VHA.

14 So, I am okay with just about all  
15 of the things that are in there except I agree  
16 the NIH, to me, is too specific. I mean if  
17 you are going to talk about the NIH, why not  
18 talk about the National Cancer Institute? Why  
19 not talk about Johns Hopkins? Why not talk  
20 about a million things?

21 So, I think the intent is good.  
22 Make it a more generic term of working with

1 private sector and federal centers of  
2 excellence or institutions of excellence and  
3 not telling them how exactly what to do -- not  
4 exactly how to do it but what to do.

5 And I am okay with anything except  
6 align the CoEs under the DHA.

7 MS. MALEBRANCHE: I'm with you on  
8 that. I just don't know how to word that  
9 piece but also as Sergeant Eudy said because  
10 when we go on our visits, people didn't know  
11 about the DCoEs. So, I am thinking this is  
12 another agency. Kick this can again, put it  
13 under another agency. Give it another three  
14 years. But the oversight piece, if someone  
15 else were to look at the oversight piece and  
16 make sure that that takes place, I think then  
17 we might get something of what we are looking  
18 for and that is to get this into practice.  
19 I'm just not sure how to word that. And then  
20 they would still continue as they are.

21 Because again, I don't think that  
22 from the VA standpoint we care where they are.

1 I know from the site visits people just didn't  
2 know about them. And I think the VHA is  
3 another entity people aren't sure how that is  
4 going to work or where that is going to work.  
5 The eMSMs aren't all aligned under the DHA.  
6 So, how does that really work on a day to day?

7 CO-CHAIR NATHAN: Right.

8 MS. DAILEY: Yes, and we have made  
9 a number of recommendations along those lines.  
10 The last recommendation we made, and Amber, I  
11 need you to pipe up here, what we did say in  
12 our findings? Did we recommend they do a  
13 DoDI? We did. We recommended. Is that  
14 right? So, we recommended that the Department  
15 of Defense do a DoDI that empowered these  
16 agencies. That was last year's.

17 CO-CHAIR NATHAN: That was last  
18 year's, right?

19 MS. DAILEY: Yes.

20 CO-CHAIR NATHAN: Yes.

21 MS. DAILEY: And in the years  
22 before that, we made the recommendation that

1           they be aligned under the Services and then in  
2           last year's recommendation, we talked about a  
3           DoDI empowering them. Did we talk about the  
4           Oversight Board exercising more authority?

5                       MS. BAKEMAN: I could double  
6           check. I believe so. We did. We wanted a  
7           DoDI to give them an executive agent and align  
8           them under the Services.

9                       MS. DAILEY: Okay, that is not  
10          what it said. Sorry.

11                      There were two racks. One, where  
12          we were for aligning them under the Services.  
13          Last year's was about empowering them with the  
14          DoDI. It was our first recommendation in that  
15          year. Do I have any of my staff here who is  
16          clear on what these processes were or what we  
17          put in the findings?

18                      This one takes it to another  
19          level. You have done everything else, I  
20          guess.

21                      CO-CHAIR NATHAN: Yes.

22                      LT COL WONG: It is under Tab G.

1           It is FY2013 recommendation. It is the very  
2           first one. Develop a DoDI to empower centers  
3           of excellence and Oversight Boards and direct  
4           services to translate centers of excellence  
5           discoveries into practice. So, it was a  
6           former recommendation.

7                         CO-CHAIR NATHAN: Yes, this is  
8           sort of deja vu all over again.

9                         MS. DAILEY: Yes. So, unless you  
10          go in this direction, you have said it before.

11                        CO-CHAIR NATHAN: Right, I agree.  
12          The minimalists here are starting to gain some  
13          traction, I think.

14                        MR. REHBEIN: My only comment  
15          here, having worked in this area, if we keep  
16          these centers of excellence separated both  
17          under different executive agents separated  
18          geographically, separated logistically, they  
19          never talk to each other, they don't draw any  
20          benefit from each other. And I really believe  
21          that there need to be some linkages between  
22          the various centers in order for them to learn



1 the lessons that if somebody does something  
2 well, the center of excellence does something  
3 well with the Fox Shield, how does how they  
4 implemented it get translated to the other  
5 centers as a lesson learned?

6 At this point, I don't think those  
7 kinds of linkages information paths exist.

8 MS. DAILEY: And essentially, that  
9 is what a DoDI does. It is supposed to  
10 establish, which is what they non-concurred  
11 with.

12 MR. REHBEIN: Right. And we  
13 recommended the DoDI and DoD said no, not  
14 needed.

15 CAPT SANDERS: So, is the end  
16 state from the group is that we are fighting  
17 this battle again because they said no and  
18 that is why we are adding this recommendation  
19 again?

20 CO-CHAIR CROCKETT-JONES: I think  
21 we said that we went with this recommendation  
22 because in the year that has ensued, since

1           they said they didn't think it was necessary,  
2           we also saw that they didn't solve the  
3           problems that we highlighted the DoDI as  
4           solving. When we recommended the DoDI, it was  
5           to solve some of these problems. They non-  
6           concurred. The problems still exist. They  
7           have not found alternate --

8                    CAPT SANDERS: So, does the  
9           recommendation go back at the problem?

10                   MS. DAILEY: The change in the  
11           environment is the standup of the DHA. So,  
12           the thought process was, back in May, okay, we  
13           have got a new agency here. Maybe if we  
14           recommend, we align them under DHA, we will  
15           get more integration of their efforts. That  
16           is the change in the environment is the  
17           standup of the DHA.

18                   MS. MALEBRANCHE: Did the DHA want  
19           these under them? I mean, they are taking on  
20           an awful lot in this year. But did they  
21           actually say yea or nay that they wanted it?  
22           It was already being looked at, wasn't it?

1 MS. DAILEY: They are doing  
2 studies right now. They have done task forces  
3 and they have done studies which are not  
4 public, which I cannot talk about here because  
5 they are all pre-decisional.

6 So, bringing them and aligning  
7 them, and doing something with them is all  
8 pre-decisional in the Department of Defense.  
9 We are too privy to it because they haven't  
10 given it to us. If they had given it to me,  
11 I would be able to give it to you. It would  
12 be public but it is all pre-decisional.

13 And your recommendation should be  
14 independent of that. It should be independent  
15 of what they are going to recommend  
16 internally. It is nice if they align. It  
17 helps them justify it. But you are an  
18 independent body with a base and a knowledge  
19 base that is different from there.

20 CSM DEJONG: Well, I was going  
21 through different ways of wording this but I  
22 am just going to speak out loud and maybe

1           throw some ideas out there. We talked about  
2           having the Oversight Board aligned under the  
3           DHA. So, when I was going through wording  
4           this, there was something along the lines of  
5           establishing an Oversight Board that aligns to  
6           or is with the DHA. My only fear of putting  
7           that in there was they were going to come back  
8           and say there is an Oversight Board. That  
9           Oversight Board doesn't appear to be working  
10          as it is right now.

11                        So, I was, like I said, I am just  
12          throwing some ideas out there, maybe jostle  
13          some ideas. And I was along the lines of  
14          establish an Oversight Board for CoEs under  
15          the direction of DHA, yadda, yadda, yadda.

16                        CO-CHAIR CROCKETT-JONES: So  
17          basically, you are saying that the Oversight  
18          Board should be under the purview of the DHA.

19                        CSM DEJONG: I thought it was.

20                        MS. DAILEY: It is Dr. Lockette,  
21          and works with the Assistant Secretary. He is  
22          the Chair of the Oversight Board. Right.

1 CO-CHAIR NATHAN: -- DHA but Dr.  
2 Woodson is the next VISN for the VHA.

3 MS. DAILEY: You might want to do  
4 an up and down on this and then try and figure  
5 out. If you go up and you want some change  
6 here, you need to figure out what the change  
7 is.

8 CO-CHAIR NATHAN: Right. So,  
9 summarizing what we have heard so far, you  
10 have heard that the intent of this was to,  
11 once again, try to gain traction from the  
12 presumably good work the CoEs are doing to 1)  
13 translate what they do quickly and effectively  
14 throughout the enterprise so it doesn't remain  
15 stove piped within a service or within an  
16 enterprise; 2) to allow them to crosswalk and  
17 cross-talk with each other, as they find  
18 better ways to get their research done and to  
19 get traction on it.

20 You have my concern. You have  
21 heard me that I think all that is wonderful.  
22 That was basically the intent of last year's

1 number one recommendation, which was to get  
2 them to work together and get them to have a  
3 common operating system or oversight system.  
4 This takes it a step further, where it says  
5 put them under the DHA, which I understand the  
6 spirit of that. The letter of it is very  
7 concerning to me because I think tactically  
8 the DHA is not ready to assume the day-to-day  
9 staffing issues, execution issues, HR issues  
10 of a CoE. I don't think they have to be under  
11 the DHA for the DHA and Health Affairs and the  
12 Services at the level of the SMAC to be able  
13 to see what they are doing. And that would be  
14 by a common operating system of an Oversight  
15 Board.

16 You have heard also that just  
17 about everything we put in here today, other  
18 than align the CoEs under the DHA was what was  
19 in last year's recommendation.

20 And so, the question before us is  
21 do we say to DoD, who non-concurred with this  
22 last year, oh yes, well, I see your non-concur

1           and I raise you this in your eye again. Do we  
2           go what others have said, which is look, we  
3           have made this point before. It hasn't really  
4           gained traction. Let's not dilute the other  
5           recommendations by running up the hill with  
6           our sword and breaking it against the same  
7           rock and the other summarizations of what you  
8           see as we prepare to vote on this.

9                           CO-CHAIR CROCKETT-JONES: If we  
10          decide to vote not to include this, we could  
11          reconsider language that targets the Oversight  
12          Board more specifically, if that was the will  
13          of the group.

14                          LT COL WONG: And although DoD  
15          non-concurred, they still had some action they  
16          were going to take through the fall of 2014  
17          based on that recommendation, which of course  
18          haven't come out yet. But the Oversight Board  
19          was going to do some additional work.

20                          CO-CHAIR NATHAN: Okay.

21                          CAPT SANDERS: So is there a  
22          principle here in the breaking the sword

1           against the rock again that needs to be  
2           brought forward here or is that beyond where  
3           we want to go as a group?

4                       CO-CHAIR NATHAN: Well, I think it  
5           depends on, you know for example, the Joint  
6           Staff took over the Fox Eye Shield because the  
7           Joint Staff saw that it was not universally  
8           applied. So, the Joint Staff took that for  
9           action. What a wonderful mechanism that is,  
10          right, when the Joint Chiefs of Staff take  
11          that for action, that guarantees all the  
12          Services are going to get it. But the Joint  
13          Chief of Staff happened to take the Fox Eye  
14          Shield because I think we lit it up.

15                      In other words, we lit it up.  
16          This Task Force was material in getting the  
17          Fox Eye Shield out to all the Services in all  
18          the ITACs.

19                      To answer your question, I think  
20          it comes down to do we believe that we have  
21          already made this recommendation, we feel  
22          passionately about it. It wasn't adopted as



1 we asked but they did come back and say we are  
2 not going to do that but we do have some  
3 things planned and there is goodness coming  
4 over the next year, so, trust but verify. Or  
5 do we say we don't accept your non-concurrence  
6 on that? We are coming back at you again,  
7 talking to you again, saying that we don't  
8 think you have hid it yet. We don't think you  
9 have actually met the intent of what this Task  
10 Force believes, which is getting traction and  
11 connectivity from and among your CoEs.

12 MS. DAILEY: One option might also  
13 be is to put this one in, isn't it the  
14 introduction, where we -- Chapter One where we  
15 -- pernicious issues. We have included a  
16 couple EHRs as a pernicious issue. What else?  
17 PTSD, treatment for PTSD. We could put it in  
18 there, in the introduction and say Congress  
19 and DoD, you need to continue to address these  
20 issues. Now, it is not a recommendation but  
21 we highlighted in the introduction as one of  
22 the chronically unresolved issues.

1 CO-CHAIR NATHAN: Thank you. That  
2 is a valuable piece of knowledge.

3 So, I think the choices before us  
4 are, we are eventually going to have a vote  
5 here up or down on this. But the choices  
6 before us are table this or remove it as a  
7 recommendation.

8 Option two is maintain it as a  
9 recommendation, as is, or with amendments to  
10 it. Either way, as Ms. Dailey point out, we  
11 can put it as one of the more pernicious  
12 issues in the beginning to say that these EHR  
13 and this kind of issue is something that we  
14 are still passionate about and we believe  
15 needs to be dealt with.

16 So, any more discussion before we  
17 call for a vote? So, based on that right now  
18 --

19 DR. PHILLIPS: Sorry. If we vote  
20 it down, can we then recommend it go into the  
21 introduction?

22 CO-CHAIR NATHAN: Sure.

1 DR. PHILLIPS: Okay.

2 CO-CHAIR NATHAN: If you vote it  
3 down, you can also, somebody can come back and  
4 say and I want a recommendation on it but I  
5 want a different recommendation or not.

6 So, I need a motion to vote on  
7 adoption of recommendation D7, is it, as  
8 reads. How does it read? Align the CoEs  
9 under the DHA to enable joint effort and  
10 direct links to governance processes within  
11 the military health system structure and to  
12 allow for translation of scientific findings  
13 to clinical settings. DHA Chief Medical  
14 Officer should work in concert with  
15 institutions of excellence in the private and  
16 federal sector.

17 So, do I have a motion to take  
18 that to a vote?

19 CSM DEJONG: So moved.

20 CO-CHAIR NATHAN: Any seconds?

21 CAPT SANDERS: I second it.

22 CO-CHAIR NATHAN: Okay, so a vote

1 of yea means you wish to adopt this as written  
2 as a recommendation. A vote of D means you do  
3 not -- a vote of nay means you do not.

4 All those in favor of making this  
5 a recommendation as written. Going once,  
6 going twice.

7 All those opposed.

8 (A show of hands.)

9 CO-CHAIR NATHAN: It looks like  
10 unanimous. Okay, so D7 as written, will not  
11 be a recommendation.

12 Is there any discussion or does  
13 anybody wish to entertain a motion to create  
14 a recommendation along those lines but  
15 differently?

16 Hearing none, is there any more  
17 discussion, and I don't know that we need a  
18 vote on this, Denise, but to bring it up as a  
19 pernicious item?

20 CAPT SANDERS: I would support  
21 that, moving forward, if we need to vote to do  
22 that.

1 LT COL KEANE: As would I.

2 CSM DEJONG: If we have to vote to  
3 do that, I would support that. I am using the  
4 metaphor that you so aptly put on the table,  
5 a sword against a rock. I think we should  
6 just draw our sword and not hit the rock.

7 LT COL KEANE: I would just add my  
8 two cents, sir. I'm not sure if you have ever  
9 quoted Rodney Dangerfield. I'm not sure if  
10 this even meets the pernicious enough for  
11 that. You know Rodney Dangerfield had someone  
12 do a paper for him and said oh, that feels  
13 like a C. A little bit more work.

14 I think this is like a C. I don't  
15 even know if this is pernicious enough to  
16 mention but I just put it out there. I just  
17 wanted to get that Rodney Dangerfield in  
18 there.

19 MS. DAILEY: And if there is  
20 someone who feels strongly, who feels more  
21 strongly that it is a pernicious issue, would  
22 you like to put your statement on the record?

1                   MR. REHBEIN: May I? Centers of  
2                   excellence have been a subject of discussion  
3                   in this Task Force over several years. Back  
4                   to the, I believe it was General Stone at one  
5                   point that said the centers of excellence  
6                   aren't. We have been concerned about how they  
7                   do their work, how they work, organized and  
8                   arranged, who administered them, why the  
9                   Oversight Board wasn't meeting. I think if  
10                  the centers of excellence are going to be what  
11                  they were intended to be, and that is truly  
12                  excellence, truly places of excellence, we  
13                  need to continue to shine a light on them.

14                  And I believe that the discussion  
15                  over the last several years has been  
16                  consistent enough that we have been  
17                  unimpressed with what has come out of them in  
18                  general with leaving out things like the Fox  
19                  Eye Shield but that we have been unimpressed  
20                  enough. I think we need to, in our last  
21                  report, continue to express that opinion that  
22                  they need to continue to improve.

1                   CSM DEJONG: I'd like to concur  
2                   with Mr. Rehbein. And to the point that we  
3                   have asked the hard questions to them, to  
4                   everyone of how they distribute their  
5                   information and their knowledge, we have  
6                   talked to mental health, asked them how they  
7                   take that to the private sector versus the  
8                   military sectors and the rest.

9                   We have asked a lot of hard  
10                  questions. We have tried to, in the past,  
11                  justify the funding to them versus the outcome  
12                  with that funding. And I like the way that  
13                  Mr. Rehbein put it, that we need to continue  
14                  to focus on them and put a light on them in  
15                  order to get what is expected and deserved out  
16                  of those agencies.

17                 DR. PHILLIPS: I agree. I mean,  
18                 the sentence themselves have expressed to us  
19                 during different briefings how frustrated they  
20                 are by the lack of coordination and the  
21                 ability to move things along. And right now,  
22                 the sum is less than all the parts. And I

1 think we should continue to push this.

2 CO-CHAIR CROCKETT-JONES: As  
3 usual, we are all finally in agreement. Yes,  
4 I think that if we could ever get a balance  
5 sheet that said cost man hours versus output  
6 and dissemination of their successes, everyone  
7 would question why they didn't balance. I  
8 think they have the potential to do great  
9 things but I think that they are not. I think  
10 we have experienced over and over again that  
11 they are not making it. There is something we  
12 hope the Oversight Board would do that.

13 So, I put my voice in it. It is  
14 pernicious.

15 MR. REHBEIN: My remarks, as they  
16 go into the record, may express, maybe taken  
17 for me to have been very critical of the  
18 leadership and personnel of the centers of  
19 excellence. I don't mean that. I agree with  
20 Suzanne. I think they have been struggling  
21 just as much as everybody else. So, if I am  
22 seen to be critical of individuals or the



1 leadership, that was not my intent.

2 CO-CHAIR NATHAN: No, I don't  
3 think anybody took it that way. I think you  
4 are in concert with everybody else.

5 You know my dramatic impact  
6 statement for the opening would be that the  
7 centers, I think most of us agree with this,  
8 the centers of excellence are potentially a  
9 national treasure which continues to go  
10 underutilized and fallow.

11 It doesn't mean they haven't done  
12 some good. It's just I think we all believe  
13 they could do so much more if they were given  
14 a more coherent organizational oversight and  
15 connectivity to the Services in general and to  
16 Health Affairs in general. That is the  
17 challenge of them.

18 We fed the beast by standing them  
19 up. In other words, Congress said hey, isn't  
20 there visual things going on that we have  
21 learned a great deal about with all the visual  
22 injuries in the war? And what about the blast

1 injuries and hearing? And how about all the  
2 TBI and the PTS. I mean, so we fed the beast  
3 and we stood up these centers of excellence  
4 and we hired staff. And we hired  
5 administrative staff and we bought them office  
6 space. And we brought in researchers and we  
7 gave them military personnel. And they  
8 started doing exactly what we wanted them to  
9 do.

10 They started researching all the  
11 various things and came up with new and novel  
12 ways to treat the various areas that Congress  
13 was concerned about. And then they didn't  
14 know what to do with it. And it was a tree  
15 fell in the forest and there was nobody there  
16 to hear it. Did it make any noise? And they  
17 weren't making any noise because there was  
18 nobody there to hear it.

19 So, we, as the Task Force, kept  
20 pounding our fists saying come on, you have  
21 got to get Oversight on this. And Oversight  
22 has got to A) provide connectivity in an

1 environment for them to talk with each other.  
2 And the last time they were here, they said  
3 there is that now. They do meet together.  
4 They did say they meet together on a fairly  
5 frequent basis and compare notes. But they  
6 all agree that they still weren't getting  
7 traction for their ideas and their research  
8 into the DoD or the VA.

9 So, I think we need to bring that  
10 up again.

11 MS. DAILEY: Okay, I will put it  
12 in the introduction. And you have given us a  
13 lot of good words. You have put a lot of  
14 information on the record. It is very good.  
15 It is a very good discussion and very fair.

16 CO-CHAIR NATHAN: So, I know we  
17 could go on forever but I think that is the  
18 last issue for the day.

19 Before we adjourn for today, any  
20 concerns, issues, protocol issues from the  
21 day's events that anybody would like to bring  
22 up or rehash?

1                   TSGT EUDY: Yes, those of you that  
2                   purchased mugs, they are here. If you don't  
3                   have money today, you can bring it tomorrow.  
4                   And they are sitting out at the front desk  
5                   with Mr. Booton.

6                   CO-CHAIR NATHAN: All right. And  
7                   Denise, are we still scheduled for a 1400  
8                   program?

9                   MS. DAILEY: Tomorrow, sir --

10                  CO-CHAIR NATHAN: No, today.

11                  MS. DAILEY: What is on the  
12                  agenda?

13                  CO-CHAIR NATHAN: You told me we  
14                  had something coming up today at 1400.

15                  MS. DAILEY: No, if I said that, I  
16                  was wrong.

17                  So, Dr. Guice will be here at 1400  
18                  tomorrow, --

19                  CO-CHAIR NATHAN: Tomorrow, okay.

20                  MS. DAILEY: -- and will be  
21                  presenting awards and appreciation.

22                  CO-CHAIR NATHAN: Got it.

1 MS. DAILEY: So, yes, I would like  
2 to stay on schedule, starting tomorrow morning  
3 with our next set. You are about an hour  
4 ahead, which is very good.

5 But I do want to give you a five-  
6 minute break, ladies and gentlemen. And I am  
7 going to bring you back and I want you to read  
8 through the approved -- can we do that Suzanne  
9 -- read through one more time the  
10 recommendations that you approved and voted on  
11 this day.

12 So, five minutes out and then I am  
13 going to bring you back and we are going to  
14 read through them one more time. And we don't  
15 get to change them. I just want you to be  
16 fresh with them. I might regret this but read  
17 through them one more time.

18 (Whereupon, the above-entitled  
19 matter went off the record at 1:51  
20 p.m. and resumed at 1:58 p.m.)

21 MS. DAILEY: Okay, ma'am, I'm  
22 going to get -- can you read that far?

1 CO-CHAIR CROCKETT-JONES: I can.

2 MS. DAILEY: Okay, so we are just  
3 going to read through your approved  
4 recommendations.

5 CO-CHAIR CROCKETT-JONES: All  
6 right, D1, the current IDES is fundamentally  
7 flawed and DoD should replace it. Emphasis  
8 should be placed on return to work as soon as  
9 possible after injury, including separation  
10 and transition to civilian employment, when  
11 injuries clearly indicate this service member  
12 cannot be retained in the military. The  
13 hallmarks of the new approach should include  
14 standardization across DoD, i.e., no service  
15 component variants in the new process;  
16 predictable and transparent processes;  
17 compensation for loss future pay or lot  
18 employment ability via a structured payment;  
19 lump sum or annuity that cannot be revoked by  
20 subsequent recovery; incentivizing work,  
21 wellness, education, and retraining  
22 opportunities; a patient- and family-centered

1 focus on what the patient and family need,  
2 rather than what the system needs.

3 And that was passed with a  
4 unanimous vote.

5 MS. DAILEY: This one we are going  
6 to see where it says requested agencies,  
7 ladies and gentlemen? We are going to send  
8 this one to Warrior Care Policy Office. This  
9 will be theirs to answer.

10 So, we deleted this second one.  
11 Suzanne, what are we doing here?

12 CO-CHAIR CROCKETT-JONES: Yes.

13 MR. DRACH: We okay? Good.

14 CO-CHAIR CROCKETT-JONES: So the  
15 new second recommendation will be publish a  
16 DoDI policy for addressing the needs of RW  
17 family members and caregivers and identifying  
18 baseline services to be delivered by all  
19 Services and Components.

20 MS. DAILEY: And this one is going  
21 to go to Warrior Care Policy Office also.

22 CO-CHAIR CROCKETT-JONES: The





1 don't we send it to both?

2 MS. DAILEY: Or you can direct it  
3 to Health Affairs. I mean, let's scroll back  
4 on it a little bit.

5 So, you didn't tell them where to  
6 realign it. You consciously did not tell them  
7 where to realign it in this recommendation.  
8 You left out where to realign it. And you  
9 didn't tell them where to re-grade, what to  
10 re-grade to.

11 CAPT SANDERS: So, if they were  
12 realigned or wanted to be realigned, who would  
13 they have to ask to allow themselves to be  
14 realigned?

15 MS. DAILEY: P&R. It is an  
16 internal decision of the P&R, of the Under  
17 Secretary of Defense P&R.

18 CAPT SANDERS: And would P&R have  
19 to go to anyone else? Is there another third  
20 party that would have to weigh in?

21 MS. DAILEY: No. No, there is --  
22 no. It is an internal P&R requirement.

1 CO-CHAIR CROCKETT-JONES: I think  
2 that P&R is probably who we --

3 MS. DAILEY: You want to a  
4 USD(P&R) on this one? Put USD. No, no, it  
5 has to be USD(P&R). The Under Secretary, Ms.  
6 Wright, and her staff.

7 Now, what do you want me to put in  
8 the findings on this? In the findings, do you  
9 want me to put realign under health affairs  
10 and then there is another grade of DASV?

11 CSM DEJONG: I think in a  
12 discussion it was just, and I can't think of  
13 all the acronyms that we used. But what Ms.  
14 Malebranche was saying is whatever aligns up  
15 with where VA is to keep them equal.

16 CO-CHAIR CROCKETT-JONES: Yes, and  
17 basically, the WCP leadership needs to have  
18 the same gravitas of leadership that parallels  
19 with the VA and has more impact.

20 MS. MALEBRANCHE: Because the WCP  
21 leadership now does align with our IC3, which  
22 is an SES. I mean I don't know the level of

1 the appointed person at WCP. So, that is the  
2 alignment. So, that is exactly it.

3 CO-CHAIR CROCKETT-JONES: That  
4 sounds to me that if the WCP aligns with the  
5 IC3, it doesn't have more authority. That  
6 makes me wonder.

7 MS. MALEBRANCHE: They both --  
8 well, ours reports to the secretary. This  
9 right now reports to the Assistant Secretary  
10 at Health Affairs. So, it is a level less,  
11 understanding the agencies down the line.

12 CO-CHAIR CROCKETT-JONES: Exactly.  
13 But what I think what we are saying is --

14 MS. MALEBRANCHE: If it goes to  
15 P&R that would be still less, wouldn't it?

16 CO-CHAIR CROCKETT-JONES: It would  
17 still be less but not as much. There wouldn't  
18 be as many layers. Right?

19 MS. MALEBRANCHE: That's true.

20 MS. DAILEY: Okay, we have got  
21 some work to do on this one, which we were not  
22 prepared for, basically. I don't know,

1           structurally, how this will play out. But you  
2           made your point which is you don't like it  
3           under Health Affairs.

4                       CO-CHAIR CROCKETT-JONES: We want  
5           to see that WCP's output affects more than  
6           Health Affairs. And so, we want to see less  
7           layers between that office and the relevant  
8           authority to disseminate the product.

9                       MS. DAILEY: All right, got it.

10                      CO-CHAIR CROCKETT-JONES: Okay, so  
11           the fifth recommendation. Secure enduring  
12           resources for maintaining the capability,  
13           infrastructure, and institutional knowledge  
14           for supporting RWs that has been developed  
15           over the last ten years.

16                      It was a unanimous vote and I  
17           think that we want everybody.

18                      MS. DAILEY: Yes, we will address  
19           this to the Services, to Warrior Care Policy.  
20           We can address it to Health Affairs. So,  
21           those would be the agencies that it would go  
22           to.

1 CO-CHAIR CROCKETT-JONES: The  
2 sixth recommendation, Congress should  
3 establish the requirement for interagency  
4 policy between DoD and VA on wounded, ill, and  
5 injured programs. Additionally, Congress  
6 should direct the JEC to write this policy.

7 MS. DAILEY: And let's make a  
8 note. Mr. Rehbein noted --

9 MR. REHBEIN: Yes, this is the  
10 one. To write this policy makes it sound like  
11 there is one policy. My suggestion would be  
12 to substitute the word such for this.

13 MS. DAILEY: And so let's just  
14 make a note we might want to do some word  
15 changes but we will do it tomorrow.

16 CO-CHAIR CROCKETT-JONES: Okay.

17 MS. DAILEY: We really should have  
18 everyone here. We just want to expand that  
19 last line so that it has got a larger  
20 capability than one policy. We need plural in  
21 there. We need a plural in there.

22 CO-CHAIR CROCKETT-JONES: This

1 would go to Congress and to the JEC, I would  
2 assume.

3 MS. DAILEY: Yes.

4 CO-CHAIR CROCKETT-JONES: The D7  
5 we did not --

6 MS. DAILEY: Is eliminated.

7 CO-CHAIR CROCKETT-JONES: It is  
8 eliminated.

9 MS. DAILEY: And then the first  
10 one you will hit tomorrow morning will be  
11 another family member recommendation. Now,  
12 your first family member recommendation was to  
13 write the DoDI. And I just want to create  
14 some distinction here. It was a  
15 recommendation that allows for the caregiver.  
16 I have got to get this right because if you  
17 want to combine them, you need to know what  
18 you are doing.

19 So your D8 allows the caregiver to  
20 take care of the service member. D8  
21 eliminates barriers to the caregiver to  
22 getting to the bedside and providing services

1 to the service member. So, there is a  
2 distinction here between and D3. This  
3 recommendation eliminates the barriers to the  
4 caregiver taking care of the service member.  
5 It has nothing to do with the caregiver's  
6 needs. It is eliminating the barriers like  
7 HIPAA. It is eliminating the barriers such as  
8 HIPAA is a very good example. It is centered  
9 mostly around HIPAA, to eliminating the  
10 barriers that caregivers' families, whoever is  
11 caring for the service member has in taking  
12 care of them.

13 D3 was about caregivers' needs,  
14 information needs, training needs, access. It  
15 is all about what the caregiver needs, whether  
16 it be even psychological health needs, care  
17 for their family members, their children.  
18 That is what D3 addresses.

19 D8 addresses the barriers to them  
20 taking care of the service member.

21 CO-CHAIR CROCKETT-JONES: Yes, if  
22 I might, this is about their participation in

1 the recovery process and the barriers to their  
2 full participation in the recovery process, as  
3 opposed to the resources they need during this  
4 process.

5 MS. DAILEY: Correct. So, there  
6 is a distinction. It doesn't mean you can't  
7 do something with that but just keep in mind  
8 the distinction. That is why you have two.

9 Okay. And then let's go real  
10 quickly through the rest of them so that we  
11 are fresh for tomorrow. Do you want to read  
12 this, ma'am?

13 CO-CHAIR CROCKETT-JONES: D9, pre-  
14 DD 214, facilitate the transfer of each  
15 service member to the Veteran Affairs by  
16 automatically enrolling him or her, scheduling  
17 an initial appointment, and providing  
18 information on how to fully utilize the  
19 Veterans Affairs benefit.

20 D10, identify the major Department  
21 of Defense and Service-level vocational and  
22 employment programs and systematically assess



1 to what extent, as a whole, they satisfy the  
2 needs of the RW population and family members.

3 D11, consider existing recruitment  
4 standards to ensure quality of future  
5 accessions.

6 D12, require health insurance as a  
7 condition of employment in the RC.

8 D13, in order to expand access to  
9 care for service members and veterans, provide  
10 an option to use Medicare, TRICARE, or Champ  
11 VA.

12 MS. DAILEY: Okay. All right,  
13 Suzanne, can we send this out in an email to  
14 everyone?

15 DR. LEDERER: That would be a  
16 Steven question.

17 MS. DAILEY: Okay. We are going  
18 to try and send this out to everyone in an  
19 email so that you have got it in your email  
20 tonight. Okay? All right.

21 CO-CHAIR CROCKETT-JONES: All  
22 right, see everybody in the morning at eight

1 o'clock. Is that correct?

2 MS. DAILEY: Is that right? Eight

3 o'clock. All right, thank you very much.

4 Well done, ladies and gentlemen. Very, very

5 well done.

6 (Whereupon, the above-entitled

7 matter went off the record at 2:11

8 p.m.)

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This is to certify that the foregoing transcript

In the matter of: Recovering Wounded Task Force

Before: US DOD

Date: 07-08-14

Place: Arlington, VA

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