U.S. DEPARTMENT OF DEFENSE

+ + + + +

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

+ + + + +

BUSINESS MEETING

+ + + + +

TUESDAY
JULY 8, 2014

+ + + + +

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

CONTENTS

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

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

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

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

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

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

DR. STONE: Rich Stone, civilian member.

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

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

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

representing the Navy.

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

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

I'll turn it over to you.

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

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

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

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

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

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

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

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

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

CAPT SANDERS: So moved.

MR. REHBEIN: Second, Rehbein.

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

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

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

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

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

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

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

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

Theoretically, people with sleep apnea have a higher morbidity and mortality as they age than people without; higher incidence of stroke and don't live as long. Theoretically, that is what the actuaries would say.

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

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

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

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

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

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

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

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

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

DR. STONE: Suzanne, I think you

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

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

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

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

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

MR. DRACH: The four bullet

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

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

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

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

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

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

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

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

MR. REHBEIN: Madam Chairman, now that --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Now that is, as I think, Rich, you

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

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

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

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

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

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

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

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

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

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

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

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

DR. PHILLIPS: I don't know.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Otherwise, I think we should stop messing with it.

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

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

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

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

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

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

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

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

CO-CHAIR CROCKETT-JONES: Is that good?

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

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

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

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

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

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

So, concerns with that?

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

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

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

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

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

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

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

And it was well stated there are

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

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

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

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

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

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

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

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

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

stuff.

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

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

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

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

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

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

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

integration and that somehow this needs to be integrated.

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

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

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

Moving to incentivization of work

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

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

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

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

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

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

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

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

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

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

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

Any comments for or against that?

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

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

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

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

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

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

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

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

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

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

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

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

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

I think that that is better than saying single.

MR. DRACH: Well, we currently,

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

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

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

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

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

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

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

CO-CHAIR NATHAN: That's fine.

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

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

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

need that?

MS. DAILEY: No, take possibly out.

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

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

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

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

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

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

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

Okay?

CO-CHAIR CROCKETT-JONES: Okay.

CO-CHAIR NATHAN: All right. Let's move to --

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR CROCKETT-JONES: And transparency.

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

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

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

LT COL WONG: Yes, sir.

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

that in because we have really struggled with that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If you walk up to most people and

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

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

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

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

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

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

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

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

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

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

CAPT SANDERS: I would start with --

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

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

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

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

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

either the combined or the separate.

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

MS. DAILEY: Okay.

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

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

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

CAPT SANDERS: I went down to the five hallmarks.

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

Ability over disability, return to

work --

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

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

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

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

CO-CHAIR CROCKETT-JONES: Okay.

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

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

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

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

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

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

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

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

LT COL WONG: Right. And they

started at the word system.

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

CAPT SANDERS: There you go.

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR CROCKETT-JONES: Well

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

CO-CHAIR NATHAN: No, I understand.

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

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

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

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

altogether.

DR. STONE: Yes.

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

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

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

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

and have it be a real word?

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

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

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

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

integrated care. That is what it would sound like.

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

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

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

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

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

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

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

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

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

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

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

order.

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

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

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

MS. MALEBRANCHE: Well, it is but --

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

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

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

MS. MALEBRANCHE: It's part of the

hallmarks of the redesigned approach.

CO-CHAIR CROCKETT-JONES: Hallmarks should be nouns. And so, predictable and transparent has to have a noun. There you go. Predictable and transparent processes.

MS. MALEBRANCHE: Processes, that's good.

CO-CHAIR NATHAN: Okay.

All right, any other comments? Going once.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

that we assume this will be ongoing at that time.

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

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

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

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

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

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

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

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

LT COL WONG: Or returning to work?

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

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

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

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

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

CO-CHAIR NATHAN: Process?

MS. MALEBRANCHE: -- process or --

CO-CHAIR NATHAN: System?

MS. MALEBRANCHE: -- focus.

CO-CHAIR NATHAN: Focus?

CAPT SANDERS: Focus.

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

MS. DAILEY: Okay, do you want the

rest of the language in there?

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

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

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

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

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

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

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

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

MS. MALEBRANCHE: That's okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of the language is too fine a grain.

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

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

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

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

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

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

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

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

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

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

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

DR. PHILLIPS: Well, you can argue that.

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

DR. PHILLIPS: I agree with removing everything else.

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

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

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

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

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

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

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

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

MS. DAILEY: Possibly a period after approach.

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

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

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

appropriate to put here or in the findings.

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

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

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

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

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

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

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

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

DR. PHILLIPS: Just take the word redesign out.

CO-CHAIR CROCKETT-JONES: Five minutes.

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

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

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

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

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

DR. PHILLIPS: I so move.

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

MS. MALEBRANCHE: Second.

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

Before -- point of order. I think

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

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

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

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

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

(A show of hands.)

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

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

this once.

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

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

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

DR. PHILLIPS: I have a question.

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

DR. PHILLIPS: I move to discuss.

CAPT SANDERS: Second.

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

CO-CHAIR NATHAN: Discuss away.

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

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

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

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

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

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

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

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

LT COL KEANE: I would suggest

that the bulk of D2 become findings for D2.

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

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

MS. DAILEY: It is overall.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Now, our report is going to go

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

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

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

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

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

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

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

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

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

DR. STONE: And then --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. PHILLIPS: But maybe someone

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

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

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

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

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

they would not fix the system.

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

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

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

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

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

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

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

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

CSM DEJONG: Bogging the system down?

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

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

CSM DEJONG: Okay.

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

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

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

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

MS. MALEBRANCHE: I'll second.

CO-CHAIR CROCKETT-JONES: Okay.

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

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

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

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

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

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

(Show of hands.)

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

CO-CHAIR CROCKETT-JONES: All those opposed?

(Show of hands.)

CO-CHAIR CROCKETT-JONES: Are we

ready?

Any abstaining?

(Show of hands.)

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

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

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

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

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

baseline services to be delivered by each service and component.

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

DR. PHILLIPS: So moved.

MR. DRACH: Second.

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

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

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

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

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

is how you are going to do it.

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

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

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

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

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

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

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

CO-CHAIR NATHAN: Any more discussion on this?

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

not.

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

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

Does anyone want to move to vote?

CAPT SANDERS: I so move.

LT COL KEANE: Second.

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

(Show of hands.)

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

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

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

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

MR. REHBEIN: So moved.

TSGT EUDY: I second.

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

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

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

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

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

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

MS. DAILEY: Sorry, sir.

DR. STONE: Suzanne, did you?

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

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

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

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

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

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

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

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

That is sort of the genesis behind

this recommendation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

exactly sure, again, how you phrase it.

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

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

MS. MALEBRANCHE: Well, Denise,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR NATHAN: We need a motion.

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

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

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

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

CSM DEJONG: So moved.

CO-CHAIR NATHAN: A second?

MR. REHBEIN: I'll second.

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

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

(A show of hands.)

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

And so what is my count here?

CO-CHAIR CROCKETT-JONES: Eight.

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

raise your hands.

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

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

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

(Laughter.)

(A show of hands.)

MS. DAILEY: Good.

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

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

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

MR. REHBEIN: Okay, because I have a couple of questions along those lines as we --

CO-CHAIR NATHAN: Right. So, all that does is that codifies this as a recommendation. And then if the Task Force is so moved to want to call an audible and say hey, I move that we consider another, an additional recommendation that we haven't teed up for, that is a different motion. And that is saying hey, but I would like to, above and beyond what we have adopted before, I would like to make a motion that we create a new recommendation, either a new D5 and everything moves down or a D4.1 that says something about the organization.

DR. STONE: I'd like to make a motion to introduce a new recommendation as D4.1, based on my previous comments of the placement of the Office of Warrior Care Policy within the Department of Defense.

CO-CHAIR NATHAN: Do I have a

second to that motion?

DR. PHILLIPS: Second.

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

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

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

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

be there two to three years.

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

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

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

policy when necessary?

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

Is there any further discussion? Does anyone --

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

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

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

officially appointed 2 July.

CO-CHAIR NATHAN: Okay.

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

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

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

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

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

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

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

CO-CHAIR CROCKETT-JONES: Well, I

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

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

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

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

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

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

it comes to this.

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

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

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

CO-CHAIR NATHAN: Any further, discussion?

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

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

MS. DAILEY: We can do it now.

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

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

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

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

-- the service --

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

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

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

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

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

CO-CHAIR NATHAN: So, that

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

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

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

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

CO-CHAIR NATHAN: Right.

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

MS. DAILEY: The findings.

CAPT SANDERS: -- the findings in D4.

MS. DAILEY: Yes.

CAPT SANDERS: Then, my point is

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

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

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

What was the genesis in the first

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

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

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

CAPT SANDERS: Sorry.

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

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

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

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

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

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

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

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

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

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

CAPT SANDERS: Thank you.

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

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

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

CO-CHAIR NATHAN: Okay.

MR. REHBEIN: In place of to

better work, I would substitute to increase effectiveness.

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

CO-CHAIR NATHAN: Any further discussion?

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

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

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

MS. MALEBRANCHE: I think the

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

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

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

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

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

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

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

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

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

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

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

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

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

I am saying.

CO-CHAIR NATHAN: Okay.

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

CO-CHAIR NATHAN: Okay.

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

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

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

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

this in the past.

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

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

again.

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

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

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

may not be -- may or may not deliver that. So, those are some of the points for and against it.

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

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

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

DR. STONE: Another week.

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

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

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

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

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

(A show of hands.)

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

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

CO-CHAIR NATHAN: All those opposed.

(A show of hands.)

CO-CHAIR NATHAN: The Naval Maritime Forces.

MS. DAILEY: Did you vote, sir?

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

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

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

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

MS. DAILEY: Is that what my agenda says?

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

MS. DAILEY: Okay, then 12:20 it

is, ladies and gentlemen.

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

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

(12:30 p.m.)

CO-CHAIR CROCKETT-JONES: All right, welcome back. The next recommendation for discussion covers enduring resources for Recovering Warrior programs, D5, which states secure enduring resources for maintaining the capability, infrastructure, and institutional knowledge in support Recovering Warrior programs developed over the last ten years. I invite anyone to move to adopt this recommendation for discussion.

DR. PHILLIPS: So moved.

TSGT EUDY: Second.

CO-CHAIR CROCKETT-JONES: Does anyone want to start the discussion? Is anyone unclear on why we made this recommendation or what its intended purpose is?

Colonel Keane might be delayed by just a little because I know he was dropping someone off. We are waiting for Ms.

Malebranche.

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

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

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

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

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

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

TSGT EUDY: Second.

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

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

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

(A show of hands.)

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

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

CO-CHAIR NATHAN: Good observation. Thanks.

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

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

Do we have a motion to adopt this for discussion?

MR. REHBEIN: So moved.

MR. DRACH: Second.

CO-CHAIR NATHAN: Okay, thank you.

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

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

Executive Branch to produce interagency policies.

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

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

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

appropriate agency to make it.

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

MS. DAILEY: The word would be legislation.

LT COL WONG: So, create legislation or legislate?

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

MS. DAILEY: They have to legislate.

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

LT COL WONG: Now that we have had

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

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

memorandums of agreement can go away.

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

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

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

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

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

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

CO-CHAIR CROCKETT-JONES: I think

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

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

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

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

MS. MALEBRANCHE: Has the --

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

MS. MALEBRANCHE: -- Deputy Secretary --

CO-CHAIR NATHAN: Deputy Secretary.

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

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

MS. MALEBRANCHE: Right. So, that

is a mechanism.

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

MS. MALEBRANCHE: Right.

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

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

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

warriors.

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

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

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

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

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

MS. MALEBRANCHE: The offices in our different committees.

CO-CHAIR NATHAN: I guess of the legislation.

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

CO-CHAIR CROCKETT-JONES: Right. They are legislated to make recommendations already. What we want is a method, an agency, or a legislation that allows them to have an authority that takes the recommendations and

makes them policy.

MS. MALEBRANCHE: Well, I have to tell you, too, I think it also gives added, I don't know what the word is, to one of our previous recommendations that the JEC be co-chaired by the two deputies. I think that that is a significant issue. And we didn't get that but if we could get through a policy, there might be renewed interest. Just a thought.

CO-CHAIR NATHAN: So, Suzanne, what is the deliverable from this? In other words, what actually appears if DoD and the VA buy off on this, Congress buys off on this? What actually --

CO-CHAIR CROCKETT-JONES: Basically, the current system is that anytime they seem to overlap, that there are memorandums of agreement, or memorandums of understanding. They can be local. They can be regional but they are always not permanent and non-binding, if one of the agencies, say

the head of one of the agencies changes, they can say 30 days' from now this is over. And policy changes. And if the head of the agency changed every six months for a while because of issues, then every six months that memorandum could go away and the memorandum that replaced it could go away. And some of these issues, as they go forward, need the level of permanence and predictability of a policy that doesn't go away with every leadership change.

And so, and there is only going to be more interagency operations in programming. Agencies are moving together more and more to share resources and Department of Labor gets pulled in, all these. And we are saying that when we look at with just the last recommendation was to say we want longevity. And we don't want to have the wheel reinvented every time. This is part of that as well.

CO-CHAIR NATHAN: No, I understand. I understand the concept and the

sentiment. I just don't understand what would be different at the end of the day. What is the product that would happen if Congress buys off on this? A law?

CO-CHAIR CROCKETT-JONES: Well, Congress can only legislate. So, it would seem that there would be a named office at the executive level for signing off on policy. I mean I am confused by what the limitations are.

MS. DAILEY: So, the visual is that Congress tells the DoD and the VA to make interagency policy covering these areas that we have outlined in the findings. So, they legislate. DoD and VA will develop interagency policy. It is not the MOU. It is not the MOA but they direct them to create interagency policy.

MS. MALEBRANCHE: And part of the -- when we talked about this, this was in relation to the IC3 and a lot of the things we talked about the MOA that is currently going.

But then there was also, remember, the added benefit. Because had we policy before with the DES system, we wouldn't have created an MOU at every site where we had every DES system going in place and every time a commander and/or a VISN Director or a facility person left, they may say my priorities have changed. I no longer want this MOA. I want something else. So, that was the second example.

I think the third one was like in separation health assessments, where we need to be able to do those things together in concert. So, we have a lot of things that could lend itself well to joint policy. And through the JEC --

MS. DAILEY: Interagency policy?

MS. MALEBRANCHE: Interagency policy. But where you have the JEC, which is an interagency group, you also have the General Counsel, the legislative folks that sit on that on the highest levels of the

Services that that was, I think that is the place to have that discussion. They might say no, we don't want a policy on this. We don't need it. But it also is a place that hey, this is a long-lasting sort of thing for the DES.

CO-CHAIR NATHAN: So, I'm just looking for a little more clarity. In other words, I understand the intent completely and I think it is a good intent. Hey, VA, hey, DoD, you will go beyond just your local all politics or local MOAs, MOUs. You will craft interagency policy together that is binding across the agencies. We, Congress, dictate that. I guess.

So, I asked Suzanne. And she said it might be in the form of an office or a person who oversees that.

CO-CHAIR CROCKETT-JONES: I only say that because I didn't --

CO-CHAIR NATHAN: As an example. So, now I am asking Denise, how would you see

it? If this is adopted --

MS. DAILEY: I see it being done in the JEC. And I see it being a combination of a VA regulation, whatever word they use, and a DoDI or a DoDD. These two documents would come together. It would come together in a unique interagency policy document that has maybe a different name. It is not a DoDI and it is not whatever you call your administrative regulations.

CO-CHAIR NATHAN: So, if this recommendation is adopted by Congress and everybody signs up for it, what you see then as the deliverable is -- admonition is probably the wrong word but a direction from Congress to the JEC saying you will create joint policy, where appropriate. Okay.

CO-CHAIR CROCKETT-JONES: Okay, so this is what I did. Congress can say that the JEC is going to do that. Congress can legislate that the JEC will consider and craft interagency policy. It is what -- okay. So,

they don't need to be -- there doesn't need to be that higher level every time a policy is written. That can be directed as a function of the JEC by legislation in Congress.

MS. MALEBRANCHE: That's what I hear you saying. So, it can be the ability to do that as conferred or given to the JEC or policy because it is not --

CO-CHAIR CROCKETT-JONES: I didn't understand that.

MS. MALEBRANCHE: It is the legislation for the policy that has to come from Congress and the JEC can determine what can be done in policy. Is that what I am hearing?

MS. DAILEY: Yes.

MS. MALEBRANCHE: Okay.

MS. DAILEY: Yes.

MS. MALEBRANCHE: Okay, and then from policy, I think the way it goes, actually DoDI and for the VA its directives flow from that. So, then that could in synch because

they have the same policy they are referring to.

CO-CHAIR NATHAN: Okay, any further questions, concerns, discussion?

Hearing none, we will call for -- do I have a motion to adopt D6 as a recommendation?

MS. MALEBRANCHE: I move we adopt D6.

CO-CHAIR NATHAN: Okay, so we have a movement. Second?

MR. DRACH: Second.

CO-CHAIR NATHAN: Okay. So, the motion before us is to vote on the adoption of D6.

MS. DAILEY: Can we read it out loud, please?

CO-CHAIR NATHAN: We will do it. Great minds think alike. I was just about to do that. You don't happen to know the lottery numbers for tomorrow, do you?

CO-CHAIR CROCKETT-JONES:

Highlight the final wording.

CO-CHAIR NATHAN: Congress should create legislation directing DoD and VA to develop interagency/cross-agency DoD-VA policy that binds and commits both agencies to implement and institutionalize programs that span departments.

As I read it, I know what the intent of that span departments means but should it be that spans both departments or that spans both agencies or that is common to both agencies or that -- because programs that span both departments -- I know the intent. Maybe I am trying to make it too articulate.

MR. REHBEIN: No, I think the words that are common to both departments would express it better, yes.

MS. DAILEY: And we may want to put wounded, ill, and injured before programs.

CO-CHAIR NATHAN: Okay.

MS. MALEBRANCHE: Congress should create legislation conferring -- I don't know

if it is conferring upon the JEC the authority to develop. Our lawyer is here. I am going to ask. I am going to call a friend.

Captain Sanders, what would be the appropriate language for Congress should create legislation conferring to the JEC, upon the JEC the authority to develop interagency/cross-agency DoD-VA policy, what is the appropriate language for that?

MR. REHBEIN: Is the JEC a permanent body?

MS. DAILEY: The JEC is a legislative body.

MS. MALEBRANCHE: The JEC is a legislative body.

CAPT SANDERS: They already have authority to do it. They just need this specific authority?

MS. MALEBRANCHE: I don't know they have the authority to create legislation. What this is doing is saying you can come to us with a proposed legislation proposing this.

I guess I am just not sure.

CAPT SANDERS: So, are you asking the JEC to provide Congress with legislation?

MS. MALEBRANCHE: Yes.

CO-CHAIR CROCKETT-JONES: No, no, no. We are saying that Congress should give the JEC the authority to create interagency policy.

CAPT SANDERS: Policy not legislation.

CO-CHAIR CROCKETT-JONES: Not memorandums of understanding, not parallel MOUs but a policy that binds the agencies to permanent policy and programs.

CAPT SANDERS: Then I guess I would just simplify it and just say Congress should confer to the JEC authority to develop interagency DoD-VA policies in the area you want.

CO-CHAIR CROCKETT-JONES: We want them to choose. We want the JEC to be able to say this needs to be a matter of interagency

policy.

Okay, so Congress should confer to the JEC --

CAPT SANDERS: Authority. I would simplify it.

MS. DAILEY: Ladies and gentlemen, it is two parts. Congress must establish the requirement for interagency policy to be written. Then, in the recommendation, we are asking them to establish the requirement for interagency policy. And then, we say the JEC should be writing that interagency policy.

CAPT SANDERS: So for part 1, do we need to specify that?

MS. DAILEY: Yes.

CAPT SANDERS: And we should do that separately, then, right, if it is two parts, as opposed to mushing it into one statement.

MS. DAILEY: We have mushed before. So, it is however you want to do it but it has got to be two. Congress has to

establish the requirement for the interagency policy.

CAPT SANDERS: Well, I think that really says it, if you are going to break it up into two parts or at least make it distinctly --

CO-CHAIR CROCKETT-JONES: Yes, Denise's language was just right then. I get it. I get what you are saying, Denise.

CAPT SANDERS: To make it distinct as two parts.

CO-CHAIR CROCKETT-JONES: Say it again, Denise.

MS. DAILEY: Congress needs to establish the requirement for interagency policy between DoD and VA on wounded, ill, and injured programs. Additionally, direct the JEC to write this policy.

CAPT SANDERS: Thank you, counsel.

(Laughter.)

CO-CHAIR NATHAN: Very good.

DR. PHILLIPS: Do we need to

specify that this policy should be in concert or harmonized? I mean what if the JEC just says we recommend one policy for the VA and one policy for the DoD? Or am I just being too picky?

CO-CHAIR CROCKETT-JONES: No, I think this is --

CO-CHAIR NATHAN: Well, it says interagency policy.

CO-CHAIR CROCKETT-JONES: Interagency policy is assumed.

CO-CHAIR NATHAN: It means the two, two issues.

So, that is the latest and greatest that you see there at the bottom. Any questions, concerns, more discussion? Anybody want to add the right to bear arms or anything like that?

So, we have changed the wording. I will need a motion to adopt as written for Recommendation D6.

CAPT SANDERS: So moved.

DR. PHILLIPS: Second.

CO-CHAIR NATHAN: So, the motion before us is to vote on the adoption of D6, revised as following: Congress should establish the requirement for interagency policy between DoD and VA on wounded, ill, and injured programs. Additionally, Congress should direct the JEC, the Joint Executive Council, to write this policy.

All those in favor of adopting this language as D6, signify by raising your hands.

(Show of hands.)

CO-CHAIR NATHAN: All those opposed?

(Show of hands.)

CO-CHAIR NATHAN: One opposition. Okay, so the motion carries.

CO-CHAIR CROCKETT-JONES: That was tenuous.

LT COL KEANE: I'm sorry, I need to clarify a point. I thought the Admiral was

asking if we accept this the way it is written. I was expecting him to then say are we going to vote on it. So, I misunderstood. I also would like to say no. I am sorry about the misunderstanding.

CO-CHAIR NATHAN: Okay, just so we are clear, why don't we do this again, just to be correct?

MS. DAILEY: I would like to hear the nos. I'm not sure I got a good no understanding. So maybe we might even want to reopen discussion.

CO-CHAIR NATHAN: Yes, we will. We will.

MS. DAILEY: Okay.

CO-CHAIR NATHAN: I think there is enough confusion that we will reopen.

So, is there any more discussion? Because the next vote we are going to take is not in the wording of this. The next vote we are going to take is should this be adopted as Recommendation D6. So, before that, is there

any discussion on this recommendation as currently written?

LT COL KEANE: As I mentioned before, this is our last shot. I believe this is going to fall on deaf ears. I think by adding this one and others takes away from the ones that I feel are important. I think we need to hammer, I was thinking a one-two-three punch but I am up to one-two-three-four-five possibly six punch. This doesn't meet my level.

This, I think, would be a great one for last year or the year before because we could follow-up on it. This is going to fall on deaf ears, I believe.

CO-CHAIR NATHAN: So, if I understand you correctly, Colonel, you are saying that this doesn't add that much to the mix. You don't think it will really change things substantially. And as such, dilutes the attention from some of the other recommendations that you believe are more

critical and actionable.

LT COL KEANE: Exactly, sir.

CO-CHAIR NATHAN: Any other comments on discussion or concern?

MS. DAILEY: If you voted no, you need to put your voice up on the record.

CO-CHAIR NATHAN: You don't have to put your voice up on the record.

LT COL WONG: I mean I am just reiterating what Lieutenant Colonel Keane mentioned. And again, I feel the same. I think although this is within our lane, I still think it is a little bit outside of our lane. I think it dilutes from the other two recommendations as we have talked about during processes. And the JEC is already operational and I understanding they are writing MOAs and MOUs. But as they move further into their comfort zone, they will already start doing this type of stuff. And I think we are getting more into the sausage making, telling people how to do their job.

And again, less is sometimes more. And I don't know if this rises to the level of official recommendations on this Task Force.

CO-CHAIR NATHAN: So, my two cents would be, and you guys are fairly persuasive because you made me reconsider what I was thinking, but my two cents would be that the genesis of this would have been that this task force believed, based on its visits and/or its briefs over the working sessions, that a lack of interagency policy was hampering the ability to provide the best support for recovering warriors, for wounded, ill, and injured warriors. That would be the genesis of this.

In other words, because there is not interagency joint policy, there is either inefficiency or lack of optimal action that is common to the VA and DoD to support recovering, wounded, ill, and injured warriors.

Your premise being, Colonel, that

A) there is already a JEC going on and they are coordinating things there as needed. And that this really is telling Congress how to do their job or what they need. I agree with that aspect of it. It is telling Congress here is what you need to do. So, we are telling them. Is it outside of our lane? Only if we believe that -- is it out of our lane? Not if we believe that this recommendation or lack of it has material effect on the effective support and care of wounded warriors, ill, injured, and their families.

CO-CHAIR CROCKETT-JONES: I think that both the JEC and the Interagency Program Office were given to us as specific lanes of our interest. So, I think that it would be really hard to say that this is out of our lane.

These are part of our -- it falls under more than one of the topics that we were given specifically. So, I think -- I

understand it might still be objectionable but there is nothing out of our lane about this.

And I also would say right now the JEC doesn't have this authority. And when we have talked to them about interagency policies before, they have said that they don't have this authority.

So, I get that this might be something that a person feels we shouldn't tackle or that it is not going to be received well. But I think that we can rest assured that we are comfortably within our lane.

MR. DRACH: I'm also not sure that the legislation to do this doesn't already exist. The JEC is codified -- shoot, I just lost it -- is codified at Section 320 of Title 38. And I just lost it. There are a couple of things in there that allows them to do in terms of policies and procedures and recommendations.

MS. DAILEY: Okay.

MR. DRACH: So, I'm not sure.

MS. DAILEY: Yes, we tried to be very clear in the research on this. And we were very clear that the JEC does not have this authority at this time. Now, if you want to argue with me, which is fine, I need to go back and do more research. But I am pretty sure, based on our research that --

MS. MALEBRANCHE: They don't.

MS. DAILEY: Okay.

MS. MALEBRANCHE: We briefed, as the IC3, because I am a co-chair on the IC3, we briefed. And at the time, Dr. Guice and Mr. Riojas, our Chief of Staff, said I hope you are going to pursue this policy issue because it is an MLA. And right now I can tell you that one of the Services is not working on this model of this coordinated care because they want an MOU in place and DoDI and/or whatever follows that MOU in the VA for the directive piece to start on this lead coordinator piece. They will not start without the DoDI. And they said the DoDI has

to come from either an MOA or a policy. The MOA has been taking an inordinate amount of time.

So, we were asked to pursue. And so each of the agencies, in their own way, I don't know how DoD is, but VA is pursuing the issue of the policy, trying to get so we have the counterpart to work with.

CO-CHAIR NATHAN: Okay, so to summarize what I have heard, the JEC does not have the authority to create interagency policy. The JEC has the ability to reconcile and bring together various ideas on where joint or interagency policy might be beneficial and then send that up for a DoDI for directive from the agency. They would have to send it up to their respective agencies. They would have to do it at the cabinet level, I am guessing, or suggest it as a law, legislative and then Congress legislate.

The intent on this, I think, I

personally am less worried about the letter of it and more about the spirit of it. I like the spirit of it, which is Congress put pressure on the VA and the DoD to find joint policy that deals with commonalities for wounded warriors.

Other questions, issues, concerns?

LT COL WONG: I do think there is a point that we capture as part of the record. And I think a better place for it is when we did the summary of past actions and past reports where we are with the JEC and maybe relate what strength they don't have and identify that on a past recommendation in our summary of the report.

MS. DAILEY: We don't have any past recommendations on the JEC.

CO-CHAIR NATHAN: Right. But are you talking about in the findings maybe? Are you talking about in the findings what the JEC is and what it isn't?

LT COL WONG: I don't know if we

can include it in findings if it is not a recommendation, how the format is.

CO-CHAIR NATHAN: Oh, you are saying if it is not a recommendation. Right, you are correct, you wouldn't.

Okay. The dead horsey is not going to get any deader. Right? Although, I never cease to be amazed.

Congress should establish the requirements for interagency policy between DoD and VA on wounded, ill, and injured programs. Additionally, Congress should direct the JEC to write this policy.

If there is one, I need a motion to take this wording to a recommendation.

MR. DRACH: So moved.

CO-CHAIR NATHAN: Second?

MR. REHBEIN: I'll second.

CO-CHAIR NATHAN: Okay. So, if you vote, a vote in the affirmative, or voting aye or raising your hand for this, means you are voting to make this, and not just this

wording, but you are voting to make this wording a recommendation for the record.

All those in favor of making that wording that I just read a recommendation D6 for the record, please raise your hands.

(A show of hands.)

CO-CHAIR NATHAN: Got it? All those opposed, please raise your hands.

(A show of hands.)

CO-CHAIR NATHAN: Okay. Thank you. All right, the recommendation carries and D6 will be approved as a recommendation.

CO-CHAIR CROCKETT-JONES: Do we need a break or are we going to move on to D7?

Okay, Task Force Consolidated Voting Session Center of Excellence Alignment. The next recommendation for discussion addresses the alignment of the centers of excellence. The recommendation states align the centers of excellence under the Defense Health Agency to enable joint effort and direct links to governance processes within

the military health system structure and to allow for translation of scientific findings to clinical settings. The Defense Health Agency Chief Medical Officer should work in concert with the Medical Director of the National Institute of Health.

In invite anyone to move this recommendation for discussion.

MR. REHBEIN: So moved.

MR. DRACH: Second.

CO-CHAIR NATHAN: What was the genesis of the NIH in this?

DR. PHILLIPS: I think basically, if I remember correctly, there was a lot going on in centers of excellence but there was no translation toward the civilian sector or bidirectional translation. And so I think, I am not sure who generated the words, I don't know if I did or if someone else did but to connect it up to the Department of Health and Human Services, I mean to get the two departments together.

I'm not sure if the word concert works. I don't know what that means. If I had my druthers, I would say that they should meet periodically or develop a common committee or something like that, rather than just leave it hanging there.

LT COL WONG: Again, I think a lot of the information in the findings that we have included on this are important to capture. And I think the centers of excellence have done some great things in their best practices. I believe that is probably the best place for it. And then we can in summary add a statement like the recommendation is under best practices I think would improve it for the future. But I don't think this bubbles up to the level of a recommendation. It dilutes the strength over the other recommendations.

MR. DRACH: In my original comment, I raised the question as to and I have no objection to the recommendation as per

se, but whether or not we should include the Under Secretary for Health at VA after NIH. I think if we are going to include NIH, I don't know how we can exclude VA.

CO-CHAIR CROCKETT-JONES: I believe the centers of excellence already have the interagency staffing from both DoD and VA. The centers of excellence, at least some of them, have VA co-directors.

CO-CHAIR NATHAN: Yes, so for instance, the Visual Center of Excellence has a DoD chairman or director and a VA deputy director and so do some of the others.

So, I think they are trying to cross-link the two agencies by putting the mixed governance in each CoE.

Now, when it says align CoEs under DHA, that means viz the executive agencies that they belong to now, for instance, Army has the DCoE.

MS. DAILEY: Correct, sir.

CO-CHAIR NATHAN: Okay.

CO-CHAIR CROCKETT-JONES: And I think that when we started realizing that the executive agency for any particular center of excellence was the one who was getting the product and it was no moving up to other services very well, for instance the Fox Shield issue, that we started to think that although the executive agency finally gave them authority and a guaranteed sort of funding and an understanding of their structure, it started limiting their dissemination of the product.

TSGT EUDY: And that was last year's first recommendation, the translation of outcomes. But one of the things highlighted within the past year was the Oversight Board and the lack of oversight from the Oversight Board. And I think that is the generation of this recommendation come from to greater enable them into the future and have some oversight.

MS. MALEBRANCHE: Actually, yes.

MR. REHBEIN: That and I believe that there is some administrative practices. I sent in some words about establishing some linkages between the various CoEs. And this is a much better idea to bring them under DHA. But they are beyond just a better idea than I had.

Beyond just the translation of results into practice, I think there are some administrative practices that they can learn from each other in order for the centers to become more effective.

MS. MALEBRANCHE: I'm not exactly sure of the answer to this but you are right about the Oversight Board. And by the way, they haven't met since last September. And I think since they came here, they have since met.

And then I agree with Mr. Drach as far as the Under Secretary for Health because the extremity and the amputation DCoE is the only legislated joint CoE for VA and DoD. So,

I think we had to acknowledge that and the putting things into practice.

I don't know about the administrative efficiencies under DHA because it is so new. But understanding that we had always thought that there should be some linkages, for example, if there were the registry issues because there are some co-morbidities amongst these different issues but I don't know. I mean I don't know about the DHA is new and out there but it is kind of hard to tell.

I guess I don't know. The Services probably have more to venture under that. For VA, we have the one joint and we work with wherever they are placed we are going to work with them. So, I guess I just don't know what the best place is.

CO-CHAIR NATHAN: So, here is my fairly parochial take on this. Number one, I am a zealot about trying to get more translational research and action from the

CoEs. As you know, I have been, depending on how you look at it, either a fan or a screamer for a long time that the CoEs come up with good stuff but somehow it does not get propagated either at all or it doesn't get propagated quickly throughout the entire spectrum of the DoD VA, such as the Fox Eye Shield.

So, that is where we really wanted to have the Oversight Board to have the common operating picture of these CoEs to be able to gather this stuff up and move it out.

I'm not a fan of the DHA oversight for it. And again, this is full disclosure. I represent the Services. The Services currently service the executive agents for each CoE. The Army has one, Navy has a couple, Air Force has a couple.

I believe that is the best relationship right now because the Services have the bench and the execution arms to hire to a staff, to fund, to make sure the lights

are on and the trains are running on time.

The DHA is not so equipped to do that. We learned this the hard way when we had the DCoE, which was a DHA, which was a TMA, Health Affairs Agency, running the NICoE center of excellence and the NICoE floundered, not because the people in the DCoE weren't wonderful in their expertise of policy and of knowledge and research but they weren't executioners. They didn't know how to hire and put a staff together and deal with some of the nuances of human resources and all those things. I don't believe the DHA has that as a core competency either. And so, which and you haven't thought of this, but if you wanted to you could combat my argument with well the DHA only owns the biggest flagship military hospital in history, which is Walter Reed-Bethesda. So you are saying they can own Walter Reed-Bethesda but they can't own the Visual Center of Excellence. Correct.

(Laughter.)

CO-CHAIR NATHAN: And one must make the presumption they should own Walter Reed-Bethesda in the first place. But nonetheless, I just don't think that that is the answer. I do think that an Oversight Board, which reports directly to DHA, Health Affairs Under Secretary is fine. It is fine. Get the oversight in there.

So, I am not opposed to DHA being responsible for propagating policy and putting it out and making it work. I just don't think, from a tactical perspective, it is the best thing to align them under VHA.

So, I am okay with just about all of the things that are in there except I agree the NIH, to me, is too specific. I mean if you are going to talk about the NIH, why not talk about the National Cancer Institute? Why not talk about Johns Hopkins? Why not talk about a million things?

So, I think the intent is good. Make it a more generic term of working with

private sector and federal centers of excellence or institutions of excellence and not telling them how exactly what to do -- not exactly how to do it but what to do.

And I am okay with anything except align the CoEs under the DHA.

MS. MALEBRANCHE: I'm with you on that. I just don't know how to word that piece but also as Sergeant Eudy said because when we go on our visits, people didn't know about the DCoEs. So, I am thinking this is another agency. Kick this can again, put it under another agency. Give it another three years. But the oversight piece, if someone else were to look at the oversight piece and make sure that that takes place, I think then we might get something of what we are looking for and that is to get this into practice. I'm just not sure how to word that. And then they would still continue as they are.

Because again, I don't think that from the VA standpoint we care where they are.

I know from the site visits people just didn't know about them. And I think the VHA is another entity people aren't sure how that is going to work or where that is going to work. The eMSMs aren't all aligned under the DHA. So, how does that really work on a day to day?

CO-CHAIR NATHAN: Right.

MS. DAILEY: Yes, and we have made a number of recommendations along those lines. The last recommendation we made, and Amber, I need you to pipe up here, what we did say in our findings? Did we recommend they do a DoDI? We did. We recommended. Is that right? So, we recommended that the Department of Defense do a DoDI that empowered these agencies. That was last year's.

CO-CHAIR NATHAN: That was last year's, right?

MS. DAILEY: Yes.

CO-CHAIR NATHAN: Yes.

MS. DAILEY: And in the years before that, we made the recommendation that

they be aligned under the Services and then in last year's recommendation, we talked about a DoDI empowering them. Did we talk about the Oversight Board exercising more authority?

MS. BAKEMAN: I could double check. I believe so. We did. We wanted a DoDI to give them an executive agent and align them under the Services.

MS. DAILEY: Okay, that is not what it said. Sorry.

There were two racks. One, where we were for aligning them under the Services. Last year's was about empowering them with the DoDI. It was our first recommendation in that year. Do I have any of my staff here who is clear on what these processes were or what we put in the findings?

This one takes it to another level. You have done everything else, I guess.

CO-CHAIR NATHAN: Yes.

LT COL WONG: It is under Tab G.

It is FY2013 recommendation. It is the very first one. Develop a DoDI to empower centers of excellence and Oversight Boards and direct services to translate centers of excellence discoveries into practice. So, it was a former recommendation.

CO-CHAIR NATHAN: Yes, this is sort of deja vu all over again.

MS. DAILEY: Yes. So, unless you go in this direction, you have said it before.

CO-CHAIR NATHAN: Right, I agree. The minimalists here are starting to gain some traction, I think.

MR. REHBEIN: My only comment here, having worked in this area, if we keep these centers of excellence separated both under different executive agents separated geographically, separated logistically, they never talk to each other, they don't draw any benefit from each other. And I really believe that there need to be some linkages between the various centers in order for them to learn

the lessons that if somebody does something well, the center of excellence does something well with the Fox Shield, how does how they implemented it get translated to the other centers as a lesson learned?

At this point, I don't think those kinds of linkages information paths exist.

MS. DAILEY: And essentially, that is what a DoDI does. It is supposed to establish, which is what they non-concurred with.

MR. REHBEIN: Right. And we recommended the DoDI and DoD said no, not needed.

CAPT SANDERS: So, is the end state from the group is that we are fighting this battle again because they said no and that is why we are adding this recommendation again?

CO-CHAIR CROCKETT-JONES: I think we said that we went with this recommendation because in the year that has ensued, since

they said they didn't think it was necessary, we also saw that they didn't solve the problems that we highlighted the DoDI as solving. When we recommended the DoDI, it was to solve some of these problems. They non-concurred. The problems still exist. They have not found alternate --

CAPT SANDERS: So, does the recommendation go back at the problem?

MS. DAILEY: The change in the environment is the standup of the DHA. So, the thought process was, back in May, okay, we have got a new agency here. Maybe if we recommend, we align them under DHA, we will get more integration of their efforts. That is the change in the environment is the standup of the DHA.

MS. MALEBRANCHE: Did the DHA want these under them? I mean, they are taking on an awful lot in this year. But did they actually say yea or nay that they wanted it? It was already being looked at, wasn't it?

MS. DAILEY: They are doing studies right now. They have done task forces and they have done studies which are not public, which I cannot talk about here because they are all pre-decisional.

So, bringing them and aligning them, and doing something with them is all pre-decisional in the Department of Defense. We are to privy to it because they haven't given it to us. If they had given it to me, I would be able to give it to you. It would be public but it is all pre-decisional.

And your recommendation should be independent of that. It should be independent of what they are going to recommend internally. It is nice if they align. It helps them justify it. But you are an independent body with a base and a knowledge base that is different from there.

CSM DEJONG: Well, I was going through different ways of wording this but I am just going to speak out loud and maybe

throw some ideas out there. We talked about having the Oversight Board aligned under the DHA. So, when I was going through wording this, there was something along the lines of establishing an Oversight Board that aligns to or is with the DHA. My only fear of putting that in there was they were going to come back and say there is an Oversight Board. That Oversight Board doesn't appear to be working as it is right now.

So, I was, like I said, I am just throwing some ideas out there, maybe jostle some ideas. And I was along the lines of establish an Oversight Board for CoEs under the direction of DHA, yadda, yadda, yadda.

CO-CHAIR CROCKETT-JONES: So basically, you are saying that the Oversight Board should be under the purview of the DHA.

CSM DEJONG: I thought it was.

MS. DAILEY: It is Dr. Lockette, and works with the Assistant Secretary. He is the Chair of the Oversight Board. Right.

CO-CHAIR NATHAN: -- DHA but Dr. Woodson is the next VISN for the VHA.

MS. DAILEY: You might want to do an up and down on this and then try and figure out. If you go up and you want some change here, you need to figure out what the change is.

CO-CHAIR NATHAN: Right. So, summarizing what we have heard so far, you have heard that the intent of this was to, once again, try to gain traction from the presumably good work the CoEs are doing to 1) translate what they do quickly and effectively throughout the enterprise so it doesn't remain stove piped within a service or within an enterprise; 2) to allow them to crosswalk and cross-talk with each other, as they find better ways to get their research done and to get traction on it.

You have my concern. You have heard me that I think all that is wonderful. That was basically the intent of last year's

number one recommendation, which was to get them to work together and get them to have a common operating system or oversight system. This takes it a step further, where it says put them under the DHA, which I understand the spirit of that. The letter of it is very concerning to me because I think tactically the DHA is not ready to assume the day-to-day staffing issues, execution issues, HR issues of a CoE. I don't think they have to be under the DHA for the DHA and Health Affairs and the Services at the level of the SMAC to be able to see what they are doing. And that would be by a common operating system of an Oversight Board.

You have heard also that just about everything we put in here today, other than align the CoEs under the DHA was what was in last year's recommendation.

And so, the question before us is do we say to DoD, who non-concurred with this last year, oh yes, well, I see your non-concur

and I raise you this in your eye again. Do we go what others have said, which is look, we have made this point before. It hasn't really gained traction. Let's not dilute the other recommendations by running up the hill with our sword and breaking it against the same rock and the other summarizations of what you see as we prepare to vote on this.

CO-CHAIR CROCKETT-JONES: If we decide to vote not to include this, we could reconsider language that targets the Oversight Board more specifically, if that was the will of the group.

LT COL WONG: And although DoD non-concurred, they still had some action they were going to take through the fall of 2014 based on that recommendation, which of course haven't come out yet. But the Oversight Board was going to do some additional work.

CO-CHAIR NATHAN: Okay.

CAPT SANDERS: So is there a principle here in the breaking the sword

against the rock again that needs to be brought forward here or is that beyond where we want to go as a group?

CO-CHAIR NATHAN: Well, I think it depends on, you know for example, the Joint Staff took over the Fox Eye Shield because the Joint Staff saw that it was not universally applied. So, the Joint Staff took that for action. What a wonderful mechanism that is, right, when the Joint Chiefs of Staff take that for action, that guarantees all the Services are going to get it. But the Joint Chief of Staff happened to take the Fox Eye Shield because I think we lit it up.

In other words, we lit it up. This Task Force was material in getting the Fox Eye Shield out to all the Services in all the ITACs.

To answer your question, I think it comes down to do we believe that we have already made this recommendation, we feel passionately about it. It wasn't adopted as

we asked but they did come back and say we are not going to do that but we do have some things planned and there is goodness coming over the next year, so, trust but verify. Or do we say we don't accept your non-concurrence on that? We are coming back at you again, talking to you again, saying that we don't think you have hid it yet. We don't think you have actually met the intent of what this Task Force believes, which is getting traction and connectivity from and among your CoEs.

MS. DAILEY: One option might also be is to put this one in, isn't it the introduction, where we -- Chapter One where we -- pernicious issues. We have included a couple EHRs as a pernicious issue. What else? PTSD, treatment for PTSD. We could put it in there, in the introduction and say Congress and DoD, you need to continue to address these issues. Now, it is not a recommendation but we highlighted in the introduction as one of the chronically unresolved issues.

CO-CHAIR NATHAN: Thank you. That is a valuable piece of knowledge.

So, I think the choices before us are, we are eventually going to have a vote here up or down on this. But the choices before us are table this or remove it as a recommendation.

Option two is maintain it as a recommendation, as is, or with amendments to it. Either way, as Ms. Dailey point out, we can put it as one of the more pernicious issues in the beginning to say that these EHR and this kind of issue is something that we are still passionate about and we believe needs to be dealt with.

So, any more discussion before we call for a vote? So, based on that right now --

DR. PHILLIPS: Sorry. If we vote it down, can we then recommend it go into the introduction?

CO-CHAIR NATHAN: Sure.

DR. PHILLIPS: Okay.

CO-CHAIR NATHAN: If you vote it down, you can also, somebody can come back and say and I want a recommendation on it but I want a different recommendation or not.

So, I need a motion to vote on adoption of recommendation D7, is it, as reads. How does it read? Align the CoEs under the DHA to enable joint effort and direct links to governance processes within the military health system structure and to allow for translation of scientific findings to clinical settings. DHA Chief Medical Officer should work in concert with institutions of excellence in the private and federal sector.

So, do I have a motion to take that to a vote?

CSM DEJONG: So moved.

CO-CHAIR NATHAN: Any seconds?

CAPT SANDERS: I second it.

CO-CHAIR NATHAN: Okay, so a vote

of yea means you wish to adopt this as written as a recommendation. A vote of D means you do not -- a vote of nay means you do not.

All those in favor of making this a recommendation as written. Going once, going twice.

All those opposed.

(A show of hands.)

CO-CHAIR NATHAN: It looks like unanimous. Okay, so D7 as written, will not be a recommendation.

Is there any discussion or does anybody wish to entertain a motion to create a recommendation along those lines but differently?

Hearing none, is there any more discussion, and I don't know that we need a vote on this, Denise, but to bring it up as a pernicious item?

CAPT SANDERS: I would support that, moving forward, if we need to vote to do that.

LT COL KEANE: As would I.

CSM DEJONG: If we have to vote to do that, I would support that. I am using the metaphor that you so aptly put on the table, a sword against a rock. I think we should just draw our sword and not hit the rock.

LT COL KEANE: I would just add my two cents, sir. I'm not sure if you have ever quoted Rodney Dangerfield. I'm not sure if this even meets the pernicious enough for that. You know Rodney Dangerfield had someone do a paper for him and said oh, that feels like a C. A little bit more work.

I think this is like a C. I don't even know if this is pernicious enough to mention but I just put it out there. I just wanted to get that Rodney Dangerfield in there.

MS. DAILEY: And if there is someone who feels strongly, who feels more strongly that it is a pernicious issue, would you like to put your statement on the record?

MR. REHBEIN: May I? Centers of excellence have been a subject of discussion in this Task Force over several years. Back to the, I believe it was General Stone at one point that said the centers of excellence aren't. We have been concerned about how they do their work, how they work, organized and arranged, who administered them, why the Oversight Board wasn't meeting. I think if the centers of excellence are going to be what they were intended to be, and that is truly excellence, truly places of excellence, we need to continue to shine a light on them.

And I believe that the discussion over the last several years has been consistent enough that we have been unimpressed with what has come out of them in general with leaving out things like the Fox Eye Shield but that we have been unimpressed enough. I think we need to, in our last report, continue to express that opinion that they need to continue to improve.

CSM DEJONG: I'd like to concur with Mr. Rehbein. And to the point that we have asked the hard questions to them, to everyone of how they distribute their information and their knowledge, we have talked to mental health, asked them how they take that to the private sector versus the military sectors and the rest.

We have asked a lot of hard questions. We have tried to, in the past, justify the funding to them versus the outcome with that funding. And I like the way that Mr. Rehbein put it, that we need to continue to focus on them and put a light on them in order to get what is expected and deserved out of those agencies.

DR. PHILLIPS: I agree. I mean, the sentence themselves have expressed to us during different briefings how frustrated they are by the lack of coordination and the ability to move things along. And right now, the sum is less than all the parts. And I

think we should continue to push this.

CO-CHAIR CROCKETT-JONES: As usual, we are all finally in agreement. Yes, I think that if we could ever get a balance sheet that said cost man hours versus output and dissemination of their successes, everyone would question why they didn't balance. I think they have the potential to do great things but I think that they are not. I think we have experienced over and over again that they are not making it. There is something we hope the Oversight Board would do that.

So, I put my voice in it. It is pernicious.

MR. REHBEIN: My remarks, as they go into the record, may express, maybe taken for me to have been very critical of the leadership and personnel of the centers of excellence. I don't mean that. I agree with Suzanne. I think they have been struggling just as much as everybody else. So, if I am seen to be critical of individuals or the

leadership, that was not my intent.

CO-CHAIR NATHAN: No, I don't think anybody took it that way. I think you are in concert with everybody else.

You know my dramatic impact statement for the opening would be that the centers, I think most of us agree with this, the centers of excellence are potentially a national treasure which continues to go underutilized and fallow.

It doesn't mean they haven't done some good. It's just I think we all believe they could do so much more if they were given a more coherent organizational oversight and connectivity to the Services in general and to Health Affairs in general. That is the challenge of them.

We fed the beast by standing them up. In other words, Congress said hey, isn't there visual things going on that we have learned a great deal about with all the visual injuries in the war? And what about the blast

injuries and hearing? And how about all the TBI and the PTS. I mean, so we fed the beast and we stood up these centers of excellence and we hired staff. And we hired administrative staff and we bought them office space. And we brought in researchers and we gave them military personnel. And they started doing exactly what we wanted them to do.

They started researching all the various things and came up with new and novel ways to treat the various areas that Congress was concerned about. And then they didn't know what to do with it. And it was a tree fell in the forest and there was nobody there to hear it. Did it make any noise? And they weren't making any noise because there was nobody there to hear it.

So, we, as the Task Force, kept pounding our fists saying come on, you have got to get Oversight on this. And Oversight has got to A) provide connectivity in an

environment for them to talk with each other. And the last time they were here, they said there is that now. They do meet together. They did say they meet together on a fairly frequent basis and compare notes. But they all agree that they still weren't getting traction for their ideas and their research into the DoD or the VA.

So, I think we need to bring that up again.

MS. DAILEY: Okay, I will put it in the introduction. And you have given us a lot of good words. You have put a lot of information on the record. It is very good. It is a very good discussion and very fair.

CO-CHAIR NATHAN: So, I know we could go on forever but I think that is the last issue for the day.

Before we adjourn for today, any concerns, issues, protocol issues from the day's events that anybody would like to bring up or rehash?

TSGT EUDY: Yes, those of you that purchased mugs, they are here. If you don't have money today, you can bring it tomorrow. And they are sitting out at the front desk with Mr. Booton.

CO-CHAIR NATHAN: All right. And Denise, are we still scheduled for a 1400 program?

MS. DAILEY: Tomorrow, sir --

CO-CHAIR NATHAN: No, today.

MS. DAILEY: What is on the agenda?

CO-CHAIR NATHAN: You told me we had something coming up today at 1400.

MS. DAILEY: No, if I said that, I was wrong.

So, Dr. Guice will be here at 1400 tomorrow, --

CO-CHAIR NATHAN: Tomorrow, okay.

MS. DAILEY: -- and will be presenting awards and appreciation.

CO-CHAIR NATHAN: Got it.

MS. DAILEY: So, yes, I would like to stay on schedule, starting tomorrow morning with our next set. You are about an hour ahead, which is very good.

But I do want to give you a five-minute break, ladies and gentlemen. And I am going to bring you back and I want you to read through the approved -- can we do that Suzanne -- read through one more time the recommendations that you approved and voted on this day.

So, five minutes out and then I am going to bring you back and we are going to read through them one more time. And we don't get to change them. I just want you to be fresh with them. I might regret this but read through them one more time.

(Whereupon, the above-entitled matter went off the record at 1:51 p.m. and resumed at 1:58 p.m.)

MS. DAILEY: Okay, ma'am, I'm going to get -- can you read that far?

CO-CHAIR CROCKETT-JONES: I can.

MS. DAILEY: Okay, so we are just going to read through your approved recommendations.

CO-CHAIR CROCKETT-JONES: All right, D1, the current IDES is fundamentally flawed and DoD should replace it. Emphasis should be placed on return to work as soon as possible after injury, including separation and transition to civilian employment, when injuries clearly indicate this service member cannot be retained in the military. The hallmarks of the new approach should include standardization across DoD, i.e., no service component variants in the new process; predictable and transparent processes; compensation for loss future pay or lot employment ability via a structured payment; lump sum or annuity that cannot be revoked by subsequent recovery; incentivizing work, wellness, education, and retraining opportunities; a patient- and family-centered

focus on what the patient and family need, rather than what the system needs.

And that was passed with a unanimous vote.

MS. DAILEY: This one we are going to see where it says requested agencies, ladies and gentlemen? We are going to send this one to Warrior Care Policy Office. This will be theirs to answer.

So, we deleted this second one. Suzanne, what are we doing here?

CO-CHAIR CROCKETT-JONES: Yes.

MR. DRACH: We okay? Good.

CO-CHAIR CROCKETT-JONES: So the new second recommendation will be publish a DoDI policy for addressing the needs of RW family members and caregivers and identifying baseline services to be delivered by all Services and Components.

MS. DAILEY: And this one is going to go to Warrior Care Policy Office also.

CO-CHAIR CROCKETT-JONES: The

third recommendation, D4, establish a uniformed representative from each service at WCP.

MS. DAILEY: And this will also be a Warrior Care Policy Office agency responsibility. I think that might be an important point. Do you want to get feedback from the Services on this one also? Yes, it might be good info. Okay, I will send this to each one of the Army, Air Force, Navy Marine.

CO-CHAIR CROCKETT-JONES: The fourth recommendation realign WCP and re-grade the DASD WCP leadership position to increase effectiveness in the interagency environment and to better create policy within the DoD.

MS. DAILEY: This will be a Warrior Care Policy Office recommendation also. I mean there isn't anyone else to answer. You can direct to the P&R but they will tell the Warrior Care Policy Office to do it.

CO-CHAIR CROCKETT-JONES: Why

don't we send it to both?

MS. DAILEY: Or you can direct it to Health Affairs. I mean, let's scroll back on it a little bit.

So, you didn't tell them where to realign it. You consciously did not tell them where to realign it in this recommendation. You left out where to realign it. And you didn't tell them where to re-grade, what to re-grade to.

CAPT SANDERS: So, if they were realigned or wanted to be realigned, who would they have to ask to allow themselves to be realigned?

MS. DAILEY: P&R. It is an internal decision of the P&R, of the Under Secretary of Defense P&R.

CAPT SANDERS: And would P&R have to go to anyone else? Is there another third party that would have to weigh in?

MS. DAILEY: No. No, there is -- no. It is an internal P&R requirement.

CO-CHAIR CROCKETT-JONES: I think that P&R is probably who we --

MS. DAILEY: You want to a USD(P&R) on this one? Put USD. No, no, it has to be USD(P&R). The Under Secretary, Ms. Wright, and her staff.

Now, what do you want me to put in the findings on this? In the findings, do you want me to put realign under health affairs and then there is another grade of DASV?

CSM DEJONG: I think in a discussion it was just, and I can't think of all the acronyms that we used. But what Ms. Malebranche was saying is whatever aligns up with where VA is to keep them equal.

CO-CHAIR CROCKETT-JONES: Yes, and basically, the WCP leadership needs to have the same gravitas of leadership that parallels with the VA and has more impact.

MS. MALEBRANCHE: Because the WCP leadership now does align with our IC3, which is an SES. I mean I don't know the level of

the appointed person at WCP. So, that is the alignment. So, that is exactly it.

CO-CHAIR CROCKETT-JONES: That sounds to me that if the WCP aligns with the IC3, it doesn't have more authority. That makes me wonder.

MS. MALEBRANCHE: They both -- well, ours reports to the secretary. This right now reports to the Assistant Secretary at Health Affairs. So, it is a level less, understanding the agencies down the line.

CO-CHAIR CROCKETT-JONES: Exactly. But what I think what we are saying is --

MS. MALEBRANCHE: If it goes to P&R that would be still less, wouldn't it?

CO-CHAIR CROCKETT-JONES: It would still be less but not as much. There wouldn't be as many layers. Right?

MS. MALEBRANCHE: That's true.

MS. DAILEY: Okay, we have got some work to do on this one, which we were not prepared for, basically. I don't know,

structurally, how this will play out. But you made your point which is you don't like it under Health Affairs.

CO-CHAIR CROCKETT-JONES: We want to see that WCP's output affects more than Health Affairs. And so, we want to see less layers between that office and the relevant authority to disseminate the product.

MS. DAILEY: All right, got it.

CO-CHAIR CROCKETT-JONES: Okay, so the fifth recommendation. Secure enduring resources for maintaining the capability, infrastructure, and institutional knowledge for supporting RWs that has been developed over the last ten years.

It was a unanimous vote and I think that we want everybody.

MS. DAILEY: Yes, we will address this to the Services, to Warrior Care Policy. We can address it to Health Affairs. So, those would be the agencies that it would go to.

CO-CHAIR CROCKETT-JONES: The sixth recommendation, Congress should establish the requirement for interagency policy between DoD and VA on wounded, ill, and injured programs. Additionally, Congress should direct the JEC to write this policy.

MS. DAILEY: And let's make a note. Mr. Rehbein noted --

MR. REHBEIN: Yes, this is the one. To write this policy makes it sound like there is one policy. My suggestion would be to substitute the word such for this.

MS. DAILEY: And so let's just make a note we might want to do some word changes but we will do it tomorrow.

CO-CHAIR CROCKETT-JONES: Okay.

MS. DAILEY: We really should have everyone here. We just want to expand that last line so that it has got a larger capability than one policy. We need plural in there. We need a plural in there.

CO-CHAIR CROCKETT-JONES: This

would go to Congress and to the JEC, I would assume.

MS. DAILEY: Yes.

CO-CHAIR CROCKETT-JONES: The D7 we did not --

MS. DAILEY: Is eliminated.

CO-CHAIR CROCKETT-JONES: It is eliminated.

MS. DAILEY: And then the first one you will hit tomorrow morning will be another family member recommendation. Now, your first family member recommendation was to write the DoDI. And I just want to create some distinction here. It was a recommendation that allows for the caregiver. I have got to get this right because if you want to combine them, you need to know what you are doing.

So your D8 allows the caregiver to take care of the service member. D8 eliminates barriers to the caregiver to getting to the bedside and providing services

to the service member. So, there is a distinction here between and D3. This recommendation eliminates the barriers to the caregiver taking care of the service member. It has nothing to do with the caregiver's needs. It is eliminating the barriers like HIPAA. It is eliminating the barriers such as HIPAA is a very good example. It is centered mostly around HIPAA, to eliminating the barriers that caregivers' families, whoever is caring for the service member has in taking care of them.

D3 was about caregivers' needs, information needs, training needs, access. It is all about what the caregiver needs, whether it be even psychological health needs, care for their family members, their children. That is what D3 addresses.

D8 addresses the barriers to them taking care of the service member.

CO-CHAIR CROCKETT-JONES: Yes, if I might, this is about their participation in

the recovery process and the barriers to their full participation in the recovery process, as opposed to the resources they need during this process.

MS. DAILEY: Correct. So, there is a distinction. It doesn't mean you can't do something with that but just keep in mind the distinction. That is why you have two.

Okay. And then let's go real quickly through the rest of them so that we are fresh for tomorrow. Do you want to read this, ma'am?

CO-CHAIR CROCKETT-JONES: D9, pre-DD 214, facilitate the transfer of each service member to the Veteran Affairs by automatically enrolling him or her, scheduling an initial appointment, and providing information on how to fully utilize the Veterans Affairs benefit.

D10, identify the major Department of Defense and Service-level vocational and employment programs and systematically assess

to what extent, as a whole, they satisfy the needs of the RW population and family members.

D11, consider existing recruitment standards to ensure quality of future accessions.

D12, require health insurance as a condition of employment in the RC.

D13, in order to expand access to care for service members and veterans, provide an option to use Medicare, TRICARE, or Champ VA.

MS. DAILEY: Okay. All right, Suzanne, can we send this out in an email to everyone?

DR. LEDERER: That would be a Steven question.

MS. DAILEY: Okay. We are going to try and send this out to everyone in an email so that you have got it in your email tonight. Okay? All right.

CO-CHAIR CROCKETT-JONES: All right, see everybody in the morning at eight

o'clock. Is that correct?

MS. DAILEY: Is that right? Eight o'clock. All right, thank you very much. Well done, ladies and gentlemen. Very, very well done.

(Whereupon, the above-entitled matter went off the record at 2:11 p.m.)

B

C

G

H

Q

T

C E R T I F I C A T E

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

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter