DEPARTMENT OF DEFENSE

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

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BUSINESS MEETING

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WEDNESDAY
JULY 9, 2014

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

PRESENT

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

ALSO PRESENT

DENISE F. DAILEY, Executive Director
PAUL T. RIEKER, Practicing Hypnotherapist
KAREN GUICE, SES

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

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

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

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

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

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

8:16 a.m.

CO-CHAIR NATHAN: All right. I think we are ready to rock and roll.

I will just quickly summarize the process again. Recall, if you want to make an administrative change, grammatical, whatever, it is technically a point of order. And then, for things that you want to see put into play, it would be a motion which requires seconds.

If I bring the gavel or Suzanne brings the gavel down more than three times, it means you have exceeded your time.

Other than that, I think, Suzanne, we're ready to start.

CO-CHAIR CROCKETT-JONES: All right. At this time I would like to welcome Mr. Paul Rieker, a hypnotherapist, to provide an oral statement for the public forum. Members, please turn to Tab D in the briefing book for Mr. Rieker's information.

And I will turn it over to you Dr.

Rieker.

MR. RIEKER: Good morning.

My name is Paul Rieker. Thank you for this opportunity for my comments to be presented.

October 8th, 1976, my mother committed suicide. I was active duty, United States Air Force, attending Crypto School at Lackland Air Force Base, later, then, stationed at 2044th Communications Group, Pentagon.

In the fall of 1984, I had escalated my depression to become suicidal. El Paso County, Pike's Peak Mental Health, informed me of their intent to take me to some safe place. Because I saw mother in a padded facility prior to her suicide, I made a decision to take a different path.

Working with Dan Roden, practicing hypnotherapist of 20 years' experience, in some 12 sessions in two weeks, my depression cleared. Optimism was found, forgiveness and

self-love realized.

Since then, neither depression nor thoughts of a self-damaging nature have occurred to me, not made perfect, but free of multiple, compound emotional fixations which pushed me to that depth, have never revisited me.

I have extended my understanding of Dan's processes, as evidenced by Lieutenant Colonel Moore's video statements. I believe a process of learning causes depression. With Dr. Roger Russell, formerly Chair of the Psychology Department at La Verne University, we authored "Complicated Grief," a discussion of these points.

Accumulation of similar emotions appears to be a mechanism by some association of focus of attention which causes depression and post-trauma behaviors. Optimism, positive accomplishments, forgiveness, elimination of nightmares, focusing on love, family, and career are the outcome objectives of this

therapy process.

I ask these statements to be qualified through a medical study of abreaction desensitization and emotional reframing.

Thank you for hearing my comments.

CO-CHAIR CROCKETT-JONES: Can I ask you, have there been any studies from the general technique of hynotherapy for behavioral health treatment that you know of, as a technique in behavioral health, not necessarily on this particular topic?

MR. RIEKER: Well, the medical literature supports hypnotherapy in many different forms. But, specifically, to access the underlying emotional fixation and change the emotional fixation is part of the material I'm trying to bring forward. I have not found significant research to compel deployment of this process. So, that's why I'm here.

CO-CHAIR CROCKETT-JONES: Do you know has it been tried on a small cohort that

indicates like a push for more research?

MR. RIEKER: I have been asked if that small group has been done before, and I have not been able to bring a medical study beyond the documents of my own clients that I have worked with over the years.

CO-CHAIR CROCKETT-JONES: So, how many clients have you worked with specifically in the area of PTSD? Do you have

MR. RIEKER: The definition of PTSD, some people would say PTSD is a war or a military function, but PTSD I have worked with hundreds of people, primarily rape and molestation survivors and victims where a family member has been murdered.

CO-CHAIR CROCKETT-JONES: Yes, we're aware of the civilian Post Traumatic Stress. And so, you've had hundreds of clients. Did you have a pretty good success rate?

MR. RIEKER: Well, of those people who agreed to become relaxed, the success rate

is greater for those people who agree to become relaxed to the profound nature, so that they can access the underlying emotional component. But not everyone wants to become relaxed, in the same way as not everyone wants to eat broccoli.

So, the success rate is much higher with those people who have a propensity or a capability to become relaxed and just say, "I'm just going to relax and let go." And when that occurs, we can access the underlying emotional assignment and change the emotional assignment to that event, which is what we term the "effect bridge". We are breaking the bridge where this effect continues to play forward and back.

DR. STONE: Paul, I appreciate your coming.

Studying alternative delivery models like this often requires subject matter experts who are available and who help direct where this research might best be done. Have

you reached out into any specific community looking for substantive research that could be funded?

MR. RIEKER: In June I passed a new product introduction review by Fort Detrick. They assigned a subject matter expert to that review, saying that they were going to, out of that diligence, then I was available to apply for BAA funding.

Now I don't have the credential for research. So, therefore, the team that would be necessary for that needs to come together. I have not been able to build that team because of the obvious chicken-and-egg problem. Until you have funding, the team doesn't come together, and the team doesn't come together until there is funding.

So, I have been at this for some five years, either speaking to the National Institute of Health or other organizations. There are emails that have been supplied to the Task Force of review previously by

Behavioral Health MEDCOM.

DR. STONE: Thank you.

CO-CHAIR CROCKETT-JONES: Thank you.

CO-CHAIR NATHAN: Paul, thank you for sharing your story.

Hypnotherapy has been around for a long, long time. Are you familiar with something called ART therapy, A-R-T?

MR. RIEKER: Is that a form of hypnotherapy? If it's a form of hypnotherapy

CO-CHAIR NATHAN: It's not a form of hypnotherapy.

MR. RIEKER: No.

CO-CHAIR NATHAN: And I'm not an expert in it. It's a form of people with traumatic issues who substitute they sort of put themselves into a state where they substitute imagery for the event. They force themselves to think of the event, and then, they think of it -- I'm simplifying it -- and

then, they think of some other image that's more serene. And eventually, they replace the event with the serenity of the image they have.

The people who are passionate, or you might call them zealots of it, believe that they can sort of cure PTS in a matter of a few sessions in refractory people.

But I'm happy to bring this information to our M9 cell or our Recovering Warriors Cell at the Bureau of Medicine, who connects with the NICoE and looks at the vast array of what we call complementary alternative medical ways.

Was your depression classified mostly as intrinsic or extrinsic? In other words, it sort of just developed out of the blue or was there a life event that put you into a tailspin?

MR. RIEKER: There were multiple life events where this effect bridge linked to that event. And what Mr. Roden was able to do

was to provide sufficient profound relaxation, to understand this, to eliminate peripheral distractions to achieve a single thought. And that's what is profound. In that single thought to be able to open the emotionalized component of the original event and, then, replace that event with another emotional assignment, in the way that you are speaking of the ART.

This is profound in that I believe in the video that was provided, that is referred to in the emails, we are looking at changing these events at perhaps a rate of four to six minutes of each emotional assignment of the past. This is the difference.

CO-CHAIR NATHAN: Right. Well, thank you.

Other comments, questions?

LTCOL WONG: Sir, if you are going to bring this to M9, I'm not sure if you're familiar with the process. And we have done

similar stuff with HBOT, hyperbaric chamber therapy, acupuncture, yoga through M9. And BUMED does assignment for a preliminary study or approval of this modality. A bunch of evidence-based material will be needed before it is brought up.

And I see that your location is Temecula. It's fairly close to the Wounded Warrior Battalion West. That could potentially be a test site, if you can get through that process, if that is what your intent is.

MR. RIEKER: I would be happy to work to that outcome.

CO-CHAIR NATHAN: Right. Now you're motivated by your passion, your own personal story, and the changes it made. The good news is that these kinds of -- "one-off" is too simplistic a term -- but of these personal anecdotal sort of things that people discover, they're coming in almost in droves. The bad news is they're coming in almost in

droves.

And so, not a week goes by where I don't get a call from a couple of people who say, "I've just discovered this," or "I found this guy," or "I found this" or "I found that." And the frustrating part is that, out of all of them, some are probably are very, very good.

And so, how do we sift those? How do we vet them? All of them want seed money because they have had a revelation in what they believe is a new therapeutic approach to either Post Traumatic Stress or TBI or chronic depression or all the above. And there's limited resources.

So, what I tell everybody who is involved in this is we can't even begin to look at it if we don't know about it. So, you have now made us aware of it. I appreciate it. We will explore this with some people who can look at it through other lenses and see what they say.

MR. RIEKER: Thank you.

CO-CHAIR NATHAN: So, thank you for sharing your story.

MR. RIEKER: I'm just most happy to be here, and the staff, and so forth, is most gracious.

CO-CHAIR NATHAN: Very good. Thank you.

CO-CHAIR CROCKETT-JONES: We also have a written statement at Tab D from Mr. Parker, who could not be here today.

CO-CHAIR NATHAN: We will now take a 15-minute break. I'm just kidding. I got ahead of myself.

(Laughter.)

Our first discussion today covers a recommendation specific to optimizing family contributions to recovering warrior recovery. The recommendation states that, "To optimize the family and significant other contribution to warriors' recovery, facilitate their participation and socialization throughout the

continuum of care, management, and transition, HIPAA rules that potentially constrained family involvement should be mitigated."

I invite the members to move to adopt this recommendation for discussion. Anybody move to discuss?

(Moved.)

Any seconds?

DR. PHILLIPS: Second.

CO-CHAIR NATHAN: The recommendation is up for discussion.

LTCOL WONG: Sir, I believe that this is very well-written the way it stands out. I would actually move to vote to accept this recommendation.

CO-CHAIR NATHAN: Any further discussion?

I can't help but add that we have been, I think all of us have heard from different factions, but I certainly have in my capacity more often than not from families, parents of individuals who have gone on to

catastrophic events, who felt that they needed to be more enlightened as to what was happening, and there were HIPAA restrictions in sharing that information if the individual didn't want it.

I just want to everybody to go into this with understanding, I think, where the genesis of this comes from. This is a very challenging issue in my mind and for the following reason. I will give you an example.

There has been a family out of San Diego whose son had multiple deployments. He was in the Army. He was in the National Guard, had multiple deployments, came back. Started in a downward spiral of Post Traumatic Stress. He was married. He lived in Phoenix. The family lived in San Diego.

For all they knew, he was doing well. When he would talk to them on the phone, he wouldn't really relate anything that was going on, but he was spiraling farther and farther down. And he was being followed

through the VA system.

And the family would call the wife, but the wife and the family didn't really get along that well. And I think the wife was trying to honor his concerns.

And so, anyway, he eventually took his life, took his own life. Devastated his mother and father who believed that, if they could have called his care personnel at the VA and gotten more information as to how he was doing or not doing, they could have made a difference.

They are very good people, very well-educated. His father is a physician in private practice in San Diego.

So, they have gone to the Capitol and enlisted the aid/support of several Senators and Congressmen. They have been to the Pentagon. They have met with Dr. Woodson and people on the Joint Staff.

Here's the challenge. And I'm not saying to vote for or against this, but here

is the challenge: we know that if we loosen the rules too much and just simply say, anybody who wants to, or any family member, or whatever, your wife, your husband, your family can call in and get information on you that they should know, that also sometimes stops somebody from getting help.

And again, it can be lifesaving in some cases, I'm convinced. And in other cases, it stops the individual from getting help.

The classic example being the commander of a unit who insists on knowing if any of his or her soldiers or Marines go to see the psychiatrist or mental health for depression or for problems. Why? Because the commander wants to be a good commander and wants to engage, and wants to make sure he knows that that individual, that he and the NCOs are taking care of them.

The problem is, when we do surveys and we ask Marines and soldiers, "Will you

still go raise your hand and get help in our system if your CO knows you're going to get help," many of them say, "I will not. I will not." So, this is the challenge that we wrestle with in this.

The Army's Comprehensive Soldier Fitness Program, as you know, the way it works is you sit down at a computer terminal, you take a survey, and that survey, then, tells you, based on the answer to your question, how much stress you are under and how serious your condition is.

That survey can result in the computer telling you, you are in extreme danger; you need to get help immediately. Here are numbers you can call.

The commanders of the Army have said to the people who run that program, "As soon as the computer lights up to that degree, it should automatically light up on my computer, me, the commander, to let me know I have a soldier in extremis and in distress.

The Army has said, "We're not going to do that. We're not going to do that because we're worried that our soldiers will not answer the questions accurately or honestly if they think their whole chain of command is going to know their mental status."

So, again, reducing stigma is the answer. But I bring that background in because there's no question that families are in anguish when they feel like they have been left out of the loop on somebody who is struggling.

CO-CHAIR CROCKETT-JONES: I think I want to add my voice to that, in that we have seen where spouses, caregivers, and parents have felt at a loss to know how to respond to someone who them know is struggling. And we have heard Behavioral Health Services saying, "We could provide education. We could provide assistance, general information on how to live with someone who is going through these issues."

But connecting those people frequently doesn't happen, out of concern for HIPAA.

And there needs to be some sort of -- the Services need to find some way to make that access happen without HIPAA being the obstacle to education in general. So, if there is anyone who wants to second the motion to vote as is, I'm for it. I'm for it, too, but I'm not supposed to second it.

DR. PHILLIPS: I just might add personal experience. This is my personal opinion. Thirty-five years of medical practice, I think the HIPAA rules have done more harm than good overall, just my personal opinion related to my dealings with patients and families and caregivers over the years.

Sure, there are plenty of instances where harm can be done by providing too much information for people who really don't deserve it. But when you consider the balance between the good and bad, what can be done to prevent a suicide or prevent some

injury versus the downside, I think the HIPAA rules -- and I'm much in favor of this activity for the military sector.

LTCOL WONG: Sir, thank you for your comments regarding the Army. I also wanted to weigh-in just for the record that, on the Marine Corps side, we have allowed commanders access to that type of information. On the Reserve side, we have PEHA, which has a very similar program to what the Army does. And then, when it does rise to a certain level, actually, local commanders are advised.

And the issue that our local commanders are seeing on the Reserve side is their concern is not sharing the information across from the VA when they have drilling Reservists that potentially may have homicidal or suicidal ideations, unless that state has a requirement to report.

And, of course, HIPAA does have some guidelines. I mean, I believe it shouldn't be an open book where, all of a

sudden, they just release information. There should be a registry. When people request for that information, I mean, there is a process for recording the personnel that requested it and who they release it to. And that may become cumbersome for the hospitals or the caregivers, et cetera, but it is a requirement.

So, we do take the duty to try to protect as much health information as possible. But some of it I think would provide more help than it would harm, especially when we are talking about transitional assistance, caregivers, to provide the right type of assistance or knowledge of what maybe are the stressors for that recovering Service member.

DR. PHILLIPS: I just might say that, I just want to mention there is another aspect to this whole issue, which may not be directly related to the task at hand. But if you could collect all the information that is

out there and deidentify the personal parts of it, it would help so much in research and activities to find ways to help these folks.

CO-CHAIR NATHAN: Yes, those are great comments. The challenge, of course, is that once you have seen one individual who is failing, you have sort of seen one individual who is failing because they all have different parameters.

A big difference between active duty -- this was a retiree or medically-boarded individual who had suffered. The Human Factors Board is what the Marine Corps is doing. And COs are certainly alerted to anybody whose fitness is potentially affected or mission capability is potentially affected. They are not alerted to somebody who just says, "I'm depressed and I need to see the doc."

And so, I agree, it is a two-edge sword. I also agree with Dr. Phillips in that HIPAA has handcuffed us more than it has

liberated us from patient care.

So, any further discussion? Otherwise, we have a motion to bring this to a vote.

TSGT EUDY: I'll make a second.

CO-CHAIR NATHAN: Okay. So, the motion on the floor is to accept the language which says, "To optimize the family and significant other contribution to warrior's recovery, facilitate their participation in socialization throughout the continuum of care, management, and transition, HIPAA rules that potentially constrain family involvement should be mitigated."

All those in favor of supporting that as a recommendation, please raise your hands.

All those opposed?

The recommendation carries.

CO-CHAIR CROCKETT-JONES: Okay.

CO-CHAIR NATHAN: We can keep plowing, if you want.

CO-CHAIR CROCKETT-JONES: Yes, I think we should keep plowing.

So, the next recommendation for discussion addresses the transfer of Service members to Veterans Affairs upon separation. This recommendation states, "Pre-DD214, facilitate the transfer of each Service member to the Veterans Affairs by automatically enrolling him or her, scheduling an initial appointment, providing information on how to fully utilize the VA benefit."

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

MR. REHBEIN: So moved, Madam Chairman.

DR. PHILLIPS: Second.

CO-CHAIR CROCKETT-JONES: Would anyone like to open a discussion on this?

LTCOL WONG: I know we have said this a few times, but less is more. I think this is a good item that could be captured under Best Practices as the TRS has changed or

former TAPs has changed, where they do have VA and DAV personnel at all the new combined TR, Transitional Readiness, seminars.

They do start pre-enrollment to the VA. They go through, for those personnel that see the VA reps, they start from the top of their head all the way down to their toes, and mark all their items. And then, they can start establishing appointments for them prior to leaving military service now, if it is within six months.

So, I think probably prior, when we were formulating this recommendation, it probably wasn't a Best Practice, but it is now enacted, at least on the Marine Corps side. I don't know if the other Services have adopted it, but the Marine Corps has been doing it since February of last year.

MS. MALEBRANCHE: Is that in Separation Health Assessment?

LTCOL WONG: Yes. Yes, ma'am.

MS. MALEBRANCHE: Because the

Admiral and I were just also thinking about that. I think there is that place.

And the way that we have this worded about the automatic enrollment is a little bit awkward because we have talked about this before in the VA. We have thought it was a good idea, but people have to actually do a -- we want them to actively enroll. So, what they do is they register. Because we have people that are active duty, then, I mean, when they are in the Guard and Reserves, are activated and, then, they are civilians.

And sometimes it impacts on other things and they need to know. So, for example, if they have other insurance through their spouse, and whatnot, they may not want to do this because it might invalidate some other benefit.

So, depending on whether or not we do adopt this, but if we do, we need to change that enrollment to register. And then, they

choose at the time they want to come in.

The Separation Health Assessment is now taking effect, but I don't know how prevalent or mandatory it is throughout all the different areas. And I believe there might even be some pending legislation for some of the issues based on a lot of the current.

So, I know the Marine Corps has always been first in putting a lot of things into place, but I don't know about the other Services.

LTCOL WONG: Yes, ma'am. And in addition, as part of the checkout or separation process, a Service member is given now a CD of their health record and three hard copies. One is mailed off to the VA immediately. The Service member is not responsible for that; the command actually is. And then, they are given one for their own personal record to take the VA when they begin their appointments, and then, one is for them

to keep.

DR. STONE: Go ahead, Ron.

MR. DRACH: I'm not sure if this recommendation could possibly have -- I think it could possibly have an unintended consequence of clogging up the VA system, to the point where I'm getting out; you schedule me. You put me through the whole process. You schedule me and say, "You have an appointment next Thursday." And I'm not going. I don't want to go. I don't need to go, so forth and so on.

So now, I'm on the schedule and taking up time from somebody else who could and would and does want to go to see the doctor, for whatever reason. So, are we going to have an unintended consequences of clogging the system by setting up these appointments in advance, when they really don't want to have an appointment?

Then, you have a bigger issue that I think, and it affects everybody, whether

they are wounded, ill, and injured, or not, and I don't know how well it's being documented or not, or being provided, information is being provided. It is that every Service member, once he or she gets out, has five years to go and get treatment at the VA at anytime, not anytime, but scheduled, obviously. But they are entitled to get free care at the VA for any condition, whether it has been recognized as Service-connected or not. A lot of the particularly wounded warriors that I have talked to know nothing about it.

MS. DAILEY: I might need to correct the record on that, ladies and gentlemen. It is you have five years of healthcare if you deployed. Okay? I, as an individual, never deployed, would be queued up in their system for care. I would not have automatic care. You have to have deployed in the current conflict to have automatically enabled yourself for five years.

The rest of us are queued and evaluated for income. They are good about bringing us in. I don't know that we are getting kicked out. But the law only covers the deployed individuals.

DR. STONE: I think you will get in these days for a while.

CO-CHAIR NATHAN: General Stone, I want to hear from you in just a second. But I just want to address, just bring this back in the context. Because, as I recall, the genesis of this was the concern that there was a gap and that we were having folks fall between the cracks as they left active duty, did not appreciate or understand what their VA benefits were, and were not enrolling in the VA system through, as you said, either their own sort of apathy or I'll do it later, or whatever. We weren't seeing a good continuity of care (a) because they weren't either agile with the program, facile with the program, or they didn't understand the benefits of what

they could do to utilize the program. So, that is the context that this is in.

And now, Rich, interested in your thoughts.

DR. STONE: No, this is exactly where my comments are. We create an artificial transition point here that should not exist in a system of delivery.

And part of that system of delivery is I can receive care for decades in the DoD system, but, then, I have to actually register. And the process of registration I mentioned at the last meeting for myself, as a recent retiree, has been brutal and taken hours and has been fraught with a lot of frustration and difficulty, just to register.

This must become a system. And I think what this recommendation attempts to force is this system approach to our beneficiaries who have gotten care for decades through the military system and now are part of the VA system. And we begin to erase the

lines.

The fact that there needs to be a separate registration at all seems ludicrous to me. And I understand that there is; I'm working my way through it. But I would strongly support this in order to begin to force the resolution of this line of transition that, frankly, should not exist.

MR. REHBEIN: My only comment would be what Dr. Stone is going through really violates the definition of "warm handoff," because that's what we talk about with our Recovering Warriors and Service members, is the need for a "warm handoff".

And to put Service members, as they leave the Service, through that kind of process, particularly for those that aren't of the stable mental health that Dr. Stone is, is really -- I'm trusting; I'm trusting.

CO-CHAIR NATHAN: I mean, that's a leap of faith, if I ever heard one, yes.

(Laughter.)

MR. REHBEIN: But there are those that, if they have to try to navigate that process on their own, will throw up their hands and walk away. And they're the ones that need it the most.

CO-CHAIR CROCKETT-JONES: Yes, if you read down on the Findings, this recommendation was made to pressure an IT solution, a technology solution, that would streamline basically a DEERS-to-VA enrollment process, not enrollment, registration process. So that the only work that would have to be done would be enrollment.

You know, that there would be -- it seems ridiculous to me that there couldn't be a filtered system that took DEERS enrolled and everyone who is in the DEERS system, filter out those who don't meet the criteria for registration, and put everyone else in. And then, only an enrollment process would have to be completed when benefits were needed.

CO-CHAIR NATHAN: So, Suzanne, would better wording of this recommendation be that a system should be in place that automatically populates the VA database with members being discharged?

MS. MALEBRANCHE: I was going to actually -- Suzanne's is right about the IT solution, but you know where it works best, Admiral? It works best in North Chicago, where the recruits come in. Those folks are put into a system, and then, they already have a VA record starting.

And I'm not exactly sure of all the behind-the-scenes sort of thing with IT, but I do know in North Chicago with the recruits, they put them in the system and they have that ability now. And they register in VA when they come in. But it is an IT thing.

So, that group has started their 20-year career or their forever VA record, and it needs to be connected to the IT piece of this.

DR. PHILLIPS: I have a comment and a suggestion. I retired from the military in 1993, and I still haven't registered for the VA because I am an inpatient surgeon and I can't deal with what Rich Stone was saying.

But when I turned 65, I got my Medicare card in the mail. I mean, it was automatic. I didn't have to really do a lot.

Having said that, we were talking, Mr. Rehbein and I were talking before the meeting. If you look at D13, it's another recommendation. It's a recommendation to automatically allow folks who are eligible for CHAMPUS, VA, and DoD to be eligible for Medicare.

Perhaps would we consider -- and I'm not sure what the Robert's Rule of Order would do -- consider combining some form of this recommendation with that further recommendation that is the last one, D13, to make the whole thing sort of an automatic IT process for our Services.

CO-CHAIR CROCKETT-JONES: It's sort of an IT solution for streamlining healthcare access? I think that they are very similar concepts of access and having agencies identify their potential beneficiaries automatically without requiring an outreach.

If we can find language for both of those, I can see that. I can see that --

CO-CHAIR NATHAN: So, let me summarize what we are or are not talking about then. So, what I hear the general group talking about is, by example, I leave the Service and I walk into the VA. I'm automatically on their database. That happens now in North Chicago by design.

But we're suggesting that needs to happen by an IT solution. So that, when I leave the Service, when I walk out of the Service and I go to the VA, and I give them my name and my Social, they say, "We have you on our system."

The eligibility criteria, Denise,

may or may not be allowing me carte blanche care, but we have you on our system. We know who you are. We have your mailing address. We have your telephone, or at least the last one that was in the DoD.

What I haven't heard anybody talk about now is the other issue in this, which is scheduling appointments. Do you still wish that to be a critical element of this, that somebody gets an appointment before they leave the Service? Or are you content with, as long as the VA knows who you are the minute you walk in, or you can call them on the phone and they have you on their records already, to schedule you an appointment?

CSM DEJONG: I know during the discussion of this, we had talked a system of opting out, to put the burden on those that don't want the care from the VA to opt out, and not everybody is opted-in.

I agree with the statements about clogging the system with appointments because

there are many that aren't going to make it. We know we have a waiting list now. We know we have kind of a crisis right now.

If we can somehow formulate this recommendation into like what North Chicago is doing where everybody automatically is opted into the system, and then, the burden is on the Service member that does not want the care to opt out?

CO-CHAIR CROCKETT-JONES: I also would say caution with the appointments. It is where to make those appointments. We have members who leave from a location that is not at all geographically the same as where they want that first appointment.

So, I think the appointment becomes tricky. And I think that we love to see the warm handoff, but I'm not sure that it is setting up the appointment that will facilitate it any better. I think that all the consequences that we have talked about are in an initial problem. But registration

shouldn't have to be part of this difficulty.

MS. MALEBRANCHE: Yes, and I agree with you. I think the scheduling of the appointment should not be an automatic thing. It should be a conscious decision. Because, like you said, there is a crisis now with this.

But part of the things we heard from people, too, is they were scheduled appointments at times that they didn't choose to have that appointment and couldn't make it. And it became difficult. And then, they are looked at as non-compliant.

CO-CHAIR NATHAN: So, we're going to line-through "Schedule initial appointment." Does anybody have any problem with that? Rather than take a formal vote, if somebody has an issue, I'll be happy to keep discussing it.

(No response.)

Now we're looking for verbiage that talks about linking the VA database with

the DoD. The next line, "A system should be in place that automatically populates the VA database with transitioning members." Is that suitable?

MR. DRACH: Do we want to qualify that by saying "wounded, ill, and injured"? I mean, that implies or infers all transitioning Service members.

CO-CHAIR NATHAN: I think you want all.

CO-CHAIR CROCKETT-JONES: I think it should be all, not just wounded, ill, and injured. Because if it is done early and is all, then anyone who becomes wounded, ill, or injured or who deploys will be registered if they want to access the benefits.

MR. DRACH: Then, maybe we should add the word "all" because, given who we are --

CO-CHAIR NATHAN: Yes, that's fine. Absolutely.

TSGT EUDY: Are we not talking

about the concept of the integrated electronic healthcare record at that point? We're just not using the direct --

CO-CHAIR NATHAN: Right, but that's, you know --

CO-CHAIR CROCKETT-JONES: Actually, no, because that amount of information doesn't need to -- registration does not require your health record. It requires personnel records.

CO-CHAIR NATHAN: Right. But you're right. When the EHR comes into being, you will be able to see each -- that will be an automatic population -- because you will be able to see each other's. The problem is that's about $15 to $20 billion away, and your grandchildren will enjoy that. It is going to be a while in coming.

The other bullet in there is providing information on how to fully utilize the VA benefit. The genesis of that came from the belief that a lot of people don't

understand their VA benefits.

By design, TAP classes and those kinds of things are supposed to familiarize people, and the Services have now put an additional burden on themselves to get people through, all rates and ranks, through a TAP class. So, that is being emphasized.

Do we want to pursue that as well?

MR. REHBEIN: Sir, I think in keeping with the meaning of the rest of the recommendation, I would narrow those last words. I would replace "benefit" with "medical system" because that's really what we're talking about in this recommendation, is healthcare. We're not talking about claims. We're not talking about education. We're not --

CO-CHAIR CROCKETT-JONES: No, in order to do the coke rehab, they have to be registered.

MS. MALEBRANCHE: And I think, too, when we talk to families as we have gone

through --

MR. REHBEIN: But I don't want this recommendation to imply that we should be providing information on how to fully utilize the entire VA system of benefits as part of this recommendation.

I think the important part to me is getting them into the medical system, getting them into the VA healthcare system. And I don't want to see any barriers put in front of that because they are saying, they think we are saying we want a full, detailed briefing on the entire VA.

CO-CHAIR CROCKETT-JONES: Well, I have to say that I think that the improved TAP actually might be -- this section might best be put into, codified under the Best Practice, because I think that has been improved, and it is being marketed differently than it was when we first started talking about this.

MS. MALEBRANCHE: That was, I think, a previous recommendation. But when I

say that "fully utilize the VA benefits," and Sergeant Eudy was talking about the electronic health record, I was thinking it does kind of imply the STR, the Service Treatment Record, which does help you to get the benefits, and it does help family and caregivers. I mean, that all is a piece of this. I mean, it is all kind of interwoven. People might consider healthcare a benefit.

So, I am not exactly sure how we want to state that piece, but I agree with the Admiral; we probably need to somehow definitize that. And I'm not exactly sure that we have done what we are trying to do here.

LTCOL KEANE: I would like to make some comments.

So, who do we task this to? Who is going to start doing the 30,000 Marines that get out every year, inputting the data? DoD or VA?

MS. MALEBRANCHE: The data in

while they're --

LTCOL KEANE: Registering. What are we changing, to registering?

MS. MALEBRANCHE: That can be done either side.

LTCOL WONG: Well, I think we are doing that now. I mean, that's the issue.

MS. MALEBRANCHE: The issue, though, what we started to say, though, too, and what we were talking about, if it is done when they are coming into DoD, there shouldn't have to be a tasker of who has to do it because it's there. The actual transfer of that data, when it happens, I don't know how we would automatically do that.

DR. STONE: So, we worked on this in 2009-2010 as a Joint Committee when we were trying to look for uniform registration. And we actually failed based on whether we used Social Security Numbers or not.

At that time, the VA I don't think was using the Social Security Number as a

registration point and DoD was, or vice versa. There was some issue. But we could not overcome this process of registration based on patient identifier and the unique identifier codes for each department.

And so, there are IT solutions that are out there that could make this pretty simple, but it is going to require a really high-level decision on how we identify patients.

MR. DRACH: I would like to comment on Suzanne's comment about TAP. I think definitely the content has been improved. Hopefully, that has improved the delivery. I think the outcome is yet to be proven, whether it has been success or not. And I am not sure when we will know the success of the new TAP program.

But, if you look in our Finding, we indicate only about 55 percent of OEF/OIF/OND veterans utilize VA services. Now utilizing services is different than getting

them registered for the services.

So, will this recommendation improve that 55 percent utilization rate? My guess is no. Do we want to increase the utilization rate or do we want to just increase the number of veterans that are enrolled?

Now I think the VSOs would embrace this because the more veterans enrolled in the system, the more ammunition it gives them to argue for the retention of the system as it currently exists and not deviate from that by getting private sector to get treatment from the private sector. So, I am not sure what we want to accomplish by this other than getting the higher number of registrants.

I would like to go back just briefly to the appointment scheduling. Perhaps where we have at the first sentence, information on how to fully utilize the VA benefit, including assistance in scheduling your first appointment, or something like

that. So, it gets kind of to the opt-in/opt-out. Do you want us to make an appointment for you? Some people may want it, and some people may not. I think that will mitigate to some extent the clogging of the system.

LTCOL KEANE: Mr. Drach, when you brought that up, that sentence, I look at it differently. "Only about 55 percent of OEF/OIF/OND veterans utilize VA services." I would recommend deleting "only". I look at that as a plus. Fifty-five percent of veterans, you know, I don't know why we have "only" in there. That kind of steers the reader to think that that is a bad thing.

I think 55 percent -- not everybody is broken -- 55 percent seems like a pretty good amount that is utilizing the VA. You know, we don't want everyone to go, "I have a hangnail. I need to get that looked at." No, if you have your own healthcare, you don't need to go to the VA for every single thing. So, I thought that 55 percent was

actually a pretty good number, and then, we have "only" in there.

DR. PHILLIPS: If I might comment, I sort of researched that. It is about 50 percent or so, but they move back and forth. So, sometimes the same individual might use the private sector and sometimes they might use the VA.

MS. MALEBRANCHE: The VA, I mean, we do have unique identifiers, and it has been going up, steadily going up as far as enrollment. But I think Colonel Keane is correct, most of the people that are coming out are fairly young, healthy, and active-duty folks.

But, for scheduling first appointments, we have a liaison program. So, for th wounded warriors, and they have got 43 liaisons assigned at different facilities, they do help those folks with that first appointment. So, the insistence for first appointments for those that are not able to do

so themselves or coming out of a severe injury or illness, that's being done.

For the others, that is something that, again, everybody has made some good comments here, to include Ms. Crockett-Jones, on where they get out is not necessarily where they are going to be seen. And they sometimes don't know where they are going to end up being. So, to make appointments and not know that, that is certainly -- you know, there is this crisis right now.

There is also some legislation, by the way -- I don't know the status of it, and it shouldn't affect our recommendation -- of allowing veterans to have their choice of a number of options, to include outside and fee-basis care. So, that might change the picture or the landscape in the future.

DR. STONE: At the risk of gumming this whole thing up, I wander if Steve did not introduce to us a while ago the solution to this. Medicare gets its information from

someplace. My bet is it is tax returns or at least contributions; that allows the registration and your ongoing updates of where you sit in the system.

I wonder if this should not be directed either in the findings or in some portion as a similar system should be used for automatic registration.

MR. DRACH: Well, yes, the 50-55 percent is the glass half full, the glass half empty. But that 55 percent could represent 100 percent of those who want or need VA healthcare.

CO-CHAIR NATHAN: Yes, I agree with that. The way it works in the VA is potentially everybody who has served has eligibility in the VA, eligibility of varying degrees, whether it is Service connection or space available or those kinds of things. Potentially, everybody who has at least a general to honorable discharge from the Service can potentially be seen at the VA.

So, I think everybody could and should be populated on their database, so it doesn't require them to have to take action to get on their database.

There will certainly be thousands and thousands of people whose names are on the VA rolls who never cross the threshold of VA or try to. As far as who does it, Colonel, if this is a recommendation, and DoD and Congress get this and concur, where we may get an answer back is in the current genre of the VA re-engineering their access standards, they may come back and say, "We're looking at this in order to improve access."

But if they concur, then this is going to be onus put on DoD and the VA to figure out a patch, an IT patch, that allows that, whether it is drawn from Social Security Numbers or drawn from somewhere else. Following Medicare rolls is, I guarantee you, for a 23-year-old kid in America, you're not on the Medicare list.

So, I guess at this point we need to decide where we want to hone this down. I think everybody -- so, just summarizing -- I think everybody buys off on the fact that we need to automatically populate a VA database. How we do that, we have been talking about maybe that's probably beyond our scope. That's something we think the government should do.

What I have heard is we should not worry about trying to secure initial appointments for people because of a variety of reasons. What I have heard is, by and large, you all feel that providing information on how to fully utilize the VA benefits, including assistance in getting a benefit, is important. True? Providing information on how to fully -- or is that supplanted by we have got an increase in TAP; let's wait and see if TAP answers the mail with the renewed effort of the Services to provide retirement planning for members?

CAPT SANDERS: One other point, sir. Somebody earlier spoke about the Chicago experiment where they populate them initially at the earliest-possible point. Is that a concern, also, having them populated into the system at the earliest-possible point as opposed to the latter opportunity on their way out the door?

CO-CHAIR NATHAN: Well, but, see, that is such a unique environment at North Chicago because that is a true joint VA/DoD healthcare facility. And you are seen by, you walk in the door and you are seen by both VA and DoD employees.

By the way, they both have different data systems still, but they have put patches into place to let AHLTA talk to VISTA pretty easily, so that you can see what is happening. So, the VA ophthalmologist who sees you in that hospital can, then, tell the DoD or Navy optometrist what's going on.

But that is a unique environment.

That is why, when they come in there, they are automatically put into a database. They are really only put into our database or each other's, but the two talk to each other.

We are looking to see if we can extrapolate what is going on in North Chicago to the rest of the enterprise. Maybe, maybe not. It has cost us over $100 million to just get the two systems to talk to each other at North Chicago. So, there is more to be seen on that. But that is sort of a unique center.

So, is there anything else somebody would want to add besides what we have there?

LTCOL WONG: Again, sir, I want to reiterate, I still think this is a spot where we can capture this in the Best Practices. And I don't know if a lot of these things aren't already being done.

I mean, I am sorry to hear that Dr. Stone had a very difficult time enrolling, and I have heard horror stories as well from

other veterans.

I just worked with a Navy commander. About a month ago, he had called to try to get registered because he had an injury that occurred on active duty. He was trying to get physical therapy, called; no one called him back. Called. Would go through the phone tree and it would disconnect on him. He was totally disenchanted.

I brought him to a focus group at the VA. An OEF/OIF Coordinator was there, sat him down at the computer, had him enrolled within 30 minutes. He didn't even have to have his DD214 because, once they punched him in, it was automatically there.

So, I don't know if that is already happening with how we have been sending across medical records now upon separation, et cetera. So, I don't think -- the staff can do the homework to find out if that is already in place now with the new MARADMINS that the Marine Corps is doing and

part of this TRS that's getting the VA in there or not.

But I am all for an IT solution to make sure it is automatic --

CO-CHAIR NATHAN: So, Colonel, just to bring this to a point, am I hearing you say you just don't think --

LTCOL WONG: It may not be cross all Services.

CO-CHAIR NATHAN: So, you would suggest that that is not a problem that really needs to be dealt with at this time?

LTCOL WONG: Yes, sir. It may be a problem on other Services. At least on the Marine Corps side, I see it as it is currently an automated process.

CO-CHAIR NATHAN: Well, this is talking about ease of getting into the VA system. And you're saying that you think the Marines have cracked the nut on that.

LTCOL WONG: They have gone partway there, sir.

CO-CHAIR NATHAN: Right.

LTCOL WONG: But I think there is still an issue with DEERS because, whenever an enlisted member re-enlists, extends their contract, they still have to go manually walk down to DEERS and change the date, so their dependents are covered. It is not an automated task.

Just like if a Service member dies, they still have to contact the Casualty Branch and provide a DD14 to provide that they have burial support.

CO-CHAIR NATHAN: I don't have -- and I don't know if anybody does -- have firsthand knowledge of whether these folks, whether the Marines are automatically populated on the VA rolls or not. I know that, from an EHR standpoint, from a medical database standpoint, many are not.

If you talk to Wounded Warrior Regiments around the world and you ask them about their care in the VA, they almost

universally say the same thing. The care is compassionate and it is thorough. Their great frustration lies, when they show up, the practitioner has no visibility on what happened to them in the DoD system and the practitioner has no labs or other reports. And that's why they have to bring their paper record or get their alter record printed out to do it. That is their common lament.

Now this doesn't really address that. This is addressing I leave the Service. I'm a Marine. I'm discharged. And I call the VA or I walk into a VA, and do you know who I am already?

And what I am hearing you say is you think that part is okay.

LTCOL WONG: I believe it is okay now. Was it four months ago? I don't think so.

CO-CHAIR NATHAN: So, you have heard somebody say that this may be superfluous, this recommendation?

For those of you who think it isn't, is there anything else you would add to it?

MR. REHBEIN: Sir, keeping in mind the fact that this is our last meeting, and that we recognize there are those knowledge gaps regarding what the Marines doing -- is that coming systemwide -- and evaluation of the new TAP process, if we had a meeting scheduled into fall to receive more information, then I would tend to agree with Colonel Wong.

CO-CHAIR NATHAN: Okay.

MR. REHBEIN: But we don't. And so, I think those things could be recognized in the Findings, that we understand there are initial steps being made to accomplish these purposes, but we don't yet know the degree of success, what barriers there might be. And so, we would like to restate these as issues of importance to the Task Force.

CO-CHAIR NATHAN: Right. So, your

point being --

MR. REHBEIN: That these initial efforts continue.

CO-CHAIR NATHAN: Right. Your point being that this probably is still worthy of attention because we just don't know for sure and don't have a chance to follow up.

Karen, your comments?

MS. MALEBRANCHE: You're right, this is a two-part piece. And I think the first part about registering, I think that is important. In any managed-care system you want to know your population or your potential population. It is important to know, whether they use it or not.

The second piece of this, about the providing information about how to utilize the VA, I'm talking about -- was it last year or the year before we had put a recommendation in about -- was it last year?

CO-CHAIR CROCKETT-JONES: A marketing recommendation.

MS. MALEBRANCHE: Yes, about when you first are going into a system of care or a system, one of the things that is helpful, and that I had suggested, I think, last year -- I want to say it's 35; I'm not sure. But we talked about continuously through the life cycle of people, commanders, Service members, and the like, educating them.

Like when you come into basic training you are told you're going to do this, this, and this. And obviously, that is the very beginning.

But you now are going to be eligible for VA benefits. You probably need to know some things. The commander doesn't know about them.

The first time that we usually hear from people in VA is when people are getting ready to retire. "Tell me about my benefits." But they don't know.

I mean, in my own life when I am going in to look at insurance and all those

other things, I'm kind of shopping around and looking and educating myself all along the way. And if you look to leadership, like to the sergeant majors or those different places, I think that we still, as the VA, owe that information about understanding what is in the VA for you or not. It is like the GI bill. I mean, that has changed over time. So, continuous.

But I still think at these pre-command courses, command courses, and the like, there needs to be a piece of understanding your VA benefit, which, like I said, we did it before. And it looks to me like this is kind of combining those two. But we did make that recommendation before, and I don't remember how that all -- I'm trying to remember how that was done in the end. I don't know.

MS. DAILEY: So, yes, DoD says, "We're doing all that." And so, you made the recommendation. And the GPS program, which is

the new TAP, is doing a lot of that now, the life cycle of Service members.

So, yes, they are increasing the knowledge base across the DoD for VA benefits. There are attempts to do that. There are programs to do that. There are incentives to do that in the GPS program, which is the new TAP, which we described in the Findings, because it supports, basically, it supports the recommendation.

CO-CHAIR NATHAN: So, Karen, you would or would not support the line in there that says, "and providing information on how to fully utilize the VA benefit"?

MS. MALEBRANCHE: Well, the Colonel was just telling me it was in the 2012 recommendation. So, we have done that already. So, if we are going to say that, if it is not working or if people aren't getting it, we would have to say it another way because it is basically the same as what we had said, "providing the information," back in

2012.

So, we are connecting it to this other piece, which I don't know --

CO-CHAIR NATHAN: Okay. So, should we just limit this recommendation? And I know some people may vote against this recommendation as a recommendation at all. But, for those who are considering it, should we just limit it, then, to facilitate the transfer of each Service member to the VA by automatically registering him/her in a system that automatically populates the VA database with all transitioning Service members?

CO-CHAIR CROCKETT-JONES: I want to throw out one more item for those who are on the fence about this. This could be included in a Best Practice at North Chicago by saying that an early IT solution for data mining -- we could basically say that that eliminates registration obstacles later. I believe the obstacle that we want to address has been relieved there, and we could point to

that.

CO-CHAIR NATHAN: In our Best Practices, right.

CO-CHAIR CROCKETT-JONES: In our Best Practices --

CO-CHAIR NATHAN: Right.

CO-CHAIR CROCKETT-JONES: -- when it comes just to the concept --

CO-CHAIR NATHAN: Yes.

CO-CHAIR CROCKETT-JONES: -- of registration.

MS. DAILEY: We have already had in previous reports North Chicago as a Best Practice.

CO-CHAIR CROCKETT-JONES: I know you've had North Chicago in general as a Best Practice, but did we specifically talk about the registration? Okay.

MS. DAILEY: It's pretty thorough.

CO-CHAIR CROCKETT-JONES: Okay.

CO-CHAIR NATHAN: Well, we can double-check on that.

CO-CHAIR CROCKETT-JONES: Okay.

CO-CHAIR NATHAN: But I agree, if it is not in there as a Best Practice for registration, we should probably include it in this report.

CO-CHAIR CROCKETT-JONES: We need to specify --

CO-CHAIR NATHAN: Right.

CO-CHAIR CROCKETT-JONES: -- that that is still a concern.

CO-CHAIR NATHAN: Okay. So, any further discussion on that?

What we have so far, or what we have at this point, barring further discussion, if there is any, is: "Facilitate the transfer of each Service member to the VA by automatically registering him/her in a system that automatically populates the VA database with all transitioning Service members."

DR. PHILLIPS: I just want to bring up one more time, do we want to possibly

combine that with D13, which talks about better access? Because better access, automatic --

CO-CHAIR NATHAN: Dr. Phillips, I looked at D13. My thoughts would be -- and, please, people, chime-in one way or the other -- when I was reading it last night, it occurred to me this may be one that -- this is just my two cents -- this may be one that we may not want to broach because the VA is very busy at this time looking at their own way to obtain access.

In other words, D13 says, "In order to expand access to care for Service members and veterans, provide an option to use Medicare, TRICARE, or CHAMPUS VA." I think all those things are currently actively on the table with the VA.

I think, again, before the VA system, before we had this fracture in the delta in access locally and centrally and how they measure it, I think this would have been

very germane, very germane. But now, I think there are committees meeting and there are Senators meeting and there are hearings meeting, trying to decide what are they going to do to access people in the VA.

You know, the initial emergency measure was provide civilian care for those. And then, now we have had questions from Congress as to, can you accommodate veterans in your system, in DoD? We have had questions, can DoD nurses volunteer in VA systems? So, we are learning all about the Title 10/Title 38 seams.

So, I was going to keep powder dry until we got to 12 -- or 13 -- but that is my concern with that, is that it is already -- and there's no reason we can't talk about 13 now before --

CO-CHAIR CROCKETT-JONES: Well, I think we have to move that. There's a Robert's Rules issue.

CO-CHAIR NATHAN: Right.

CO-CHAIR CROCKETT-JONES: But I think --

CO-CHAIR NATHAN: But I am giving my two cents as to why I wouldn't --

CO-CHAIR CROCKETT-JONES: Combine them --

CO-CHAIR NATHAN: -- combine the two.

CO-CHAIR NATHAN: -- at this time. But the floor is open for anybody who feels that -- and really what Dr. Phillips is saying is, do you feel that D -- which one was it?

CO-CHAIR CROCKETT-JONES: Thirteen?

CO-CHAIR NATHAN: No, I'm sorry, the one we're on, D9. Do you feel that D9 needs verbiage in there, in addition to what we have already, that talks about not only facilitate transfer of each Service member to the VA by automatically registering, but augmenting access by additional systems, to include Medicare, TRICARE, or CHAMPUS?

MR. DRACH: I prefer, in all due respect to Dr. Phillips, to let D13 stand on its own and deal with it separately.

MS. MALEBRANCHE: I think so, too, only in that this one talks about getting into the VA, and the other one talks about outside. So, I guess options for people is what's being looked at now congressionally as well. And there are some combinations. As the Admiral said, we are looking at more sharing agreements and DoD things. But that is accessing healthcare, and this one I thought was a little bit even broader by putting them in the system.

Because when we say "registering in the system," we just talk about, even though we're saying "VA", I think we're talking VHA, not necessarily VBA.

DR. PHILLIPS: I am basically fine with that. My thought was a little different, that if we do accept some form of D13, that the registration would just be automatic for

all aspects of access.

CO-CHAIR NATHAN: No, it is a very valid point you bring up, Dr. Phillips. And, you know, I tease people in a sense. I mean, I am a huge fan of the VA, had a lot of my training in the VA, and I'm just a huge fan of the VA and also believe that the VA has had a very, very difficult mission where they have just had a tsunami of veterans coming out the last 12 years that have sort of rolled up on their shores, and they are trying to dig out from it. And that's where part of the problem lies right now.

But it is a cumbersome process to get into and to negotiate. And as Dr. Stone has found out, and when I go to grade schools to talk about careers in medicine to grade-schoolers and what it is like to be a doctor, I tell them, "If any of you are thinking you're going to go into the VA system, start enrolling now" because it just takes a long time.

(Laughter.)

So, we have before us this. Do I have any motions to bring to a vote or to vote on D9?

LTCOL KEANE: Sir, I still would like to make a comment before we do make a vote to --

CO-CHAIR NATHAN: Okay. What's the comment?

LTCOL KEANE: The minimalist comment. As we look at this one and the following recommendations, I feel each recommendation is like a silver bullet. And it is a no-brainer to me, burn down IDES, and that may be a different tier, like the highest tier, or I have three that in my mind are equivalent.

These other ones are tiers below. If we had a year or more to follow, maybe we could follow up on this.

My own personal thing, the VA we know today is probably going to be a little

bit different than three to five years from now. There are going to be some major changes to task; ask the VA to do this in the middle of their turmoil over how going to define it.

I think it's going to be, "Yes, sure, we can't do that. Noted. We can't do that at this point."

I just throw out the minimalist thing, and I am going to make that comment for the following ones and take the 50,000-foot you're in the airplane and you look down. Okay, what's the most important? Oh, that objective there: burn down IDES. That objective there: we need members at the WCP. That's the level of the silver bullet that I feel the recommendations --

CO-CHAIR NATHAN: So, and correct me if I'm wrong, what I hear Colonel Keane saying is the fewer bullets we have, the more impact -- or the fewer recommendations we have, the more impact each one carries. And his comment on this particular one, I think,

and some of the ones to follow, is that these probably are not going to carry the day or result in a lot of dramatic concern or interest, and we want to keep those very few that we think we want to stick in somebody's eye to a minimum.

So, he would say, I think your persuasion in that would be by those people who vote not to adopt this as a recommendation.

LTCOL KEANE: Yes, sir. And if I could capture what you just said as ditto, I'll just say, "Ditto."

(Laughter.)

CO-CHAIR NATHAN: Okay. Any other comments? Or a motion to bring this to a vote?

MR. REHBEIN: I'm going to disagree with Colonel Keane for a moment because, from my view, this recommendation does fit the 50,000-foot category because there are so many people out there slipping

through that crack, that chasm that exists between DoD and VA for healthcare.

CO-CHAIR NATHAN: Right.

MR. REHBEIN: And I don't know of anything we can do to close that canyon.

CO-CHAIR NATHAN: Right.

MR. REHBEIN: I think it fits that 50,000-foot category.

CAPT SANDERS: I would just note in the comments in the Findings the statement is 55 percent of OEF, OIF, and OND veterans utilize VA services. Is that a good number or a bad number? I think that is probably a bad number.

MS. MALEBRANCHE: It has been increasing, like I said, over the years. I think most of the people coming out, you know, excluding the ones that we are mostly concerned with, they probably don't need, and they come in later. It is like we are getting more Vietnam vets than we ever got in mental health now, as the stigma issue starts to

decrease for mental health. That is a good thing.

But I would agree with Mr. Rehbein. I think this is a huge thing. We have talked and thought about it some time. And before, we called it "automatic enrollment," and Colonel Keane says, well, the VA has got a huge workload now.

But I don't know that the VA necessarily is the one that is going to be doing this. If you are registering them before they get out, there's no reason. If the systems were connected, that we would have to, then it wouldn't be in the system beforehand.

So, just some thoughts. But I think it is good to have the population in there.

And the part of Dr. Phillips' piece that I really liked, when he talked about the Medicare, it is like, if we were using Social Security, because we have used

the last four/first initial for unique identifiers, if that was automatically done, because everybody that is working has got a Social Security. If we use that system as a basis, that would be lovely. I do not know how to do that connection or even how to verbalize that connection from the Services, you know, when you go into active duty and, then, you come to the VA. But that is how Medicare gets us. And wouldn't that be great?

CO-CHAIR NATHAN: Very good.

So, we have heard pros and cons for whether it should stay a recommendation. Do I have a motion?

MR. REHBEIN: So moved.

CO-CHAIR NATHAN: A second?

MR. DRACH: Second.

CO-CHAIR NATHAN: Okay. So, a vote in the affirmative would be to install as a recommendation D9: "Pre-DD214, facilitate the transfer of each Service member to the VA by automatically registering him or her in a

system that automatically populates the VA database with all transitioning Service members."

All of those in favor of adopting this as a recommendation, please raise your hand.

All those opposed?

Okay, the recommendation carries.

You realize they just removed your whole data entry from the VA system when they found out how you voted?

(Laughter.)

Okay. No, I mean, I appreciate the very robust discussion on this, and I think it helps frame the issue.

MS. DAILEY: A little bit of a break?

CO-CHAIR CROCKETT-JONES: Yes, we need a break. Let's take a 10-minute break, a 15-minute break.

(Whereupon, the foregoing matter went off the record at 9:34 a.m. and went back

on the record at 9:54 a.m.)

MS. DAILEY: Ladies and gentlemen, can I bring your attention to D9 again?

We have "automatically" in there twice. "Facilitate transfer of each Service member to the VA by automatically registering him or her in a system that automatically populates the VA database with all transitioning Service members."

Without a vote, I mean, are you at all interested? We would just pull out that second "automatically". Okay. All right, it's gone. Thank you.

DR. PHILLIPS: Would it be better to pull the first one out? I'm sorry to do this.

I read it again. Pull the second one out.

CO-CHAIR NATHAN: We will now discuss a recommendation regarding vocational and employment programs. This recommendation states, "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 Recovering Warrior population and family members."

So, identifying DoD and Service-level vocational and employment programs and systematically assessing as a whole whether they satisfy the needs of the Recovering Warrior population and family members.

We're open for discussion if somebody so moves it at this time.

LTCOL WONG: I make a motion to open this for discussion.

TSGT EUDY: I second.

CO-CHAIR NATHAN: Okay, we're open to ideas or concerns or issues.

TSGT EUDY: I think the premise for this, when we talked to populations of warriors and providers of these services, is always hearing, "Oh, everything's fine. Everything's great. We're at high success

rates." But not being able to get any quantitative data, and what we did was very minimal.

So, I think that is where we saw this overarching need for a recommendation like this, to get some concrete data for one, and to know that these programs were being effectively utilized with all that is being put into them.

LTCOL WONG: Yes. I mean, a Six Sigma guy, I am a metrics guy. In our last briefings that we received we had lots of overarching big blue arrow stuff, but no metrics to it, just like our previous transitional or CAPS stuff. You know, they say, "Oh, we provide resume writing and federal resume writing courses."

And you ask them, "Well, how successful and how many people are getting GS jobs from this or how many are getting civilian?" "Oh, well, we didn't keep that metric."

But, in addition, if you look back at our past recommendations, in 2011 there were 15; 2012, numbers 16 and 35; 2013, number 10. We continue to ask for these type of things, you know, educate, push out this information. We haven't asked for the metric.

I think there is just a resistance from the groups to provide that metric because probably it is not a great number. I mean, I have been to some locations where the resume-writing profile is missing, can gain some expertise from the civilian population or from HR people because they will show them how to write resumes from 1970.

But I think we are pounding the sword against a rock in this recommendation, and it's --

CO-CHAIR NATHAN: So, Colonel, what I hear you saying is you're not a huge fan of maintaining this as a recommendation?

LTCOL WONG: We have addressed this several times already in the past, of

pushing out the education, which I think we are doing a better job at it now. But I think that, if we are going to push this forward, we need to put the word "metric" in here or provide how satisfying the needs is collect metrics to ensure satisfaction of the program.

CO-CHAIR NATHAN: So, you would either amplify or replace "systematically assess" with "determination of metrics"?

LTCOL WONG: Yes, sir.

CO-CHAIR NATHAN: Okay. Other comments?

DR. STONE: You know, I think in the Findings below this, the actual Bureau of Labor Statistics is what is the key here. There are hundreds and hundreds of employment programs, but, yet, unemployment is really a national disgrace amongst this population.

And I'm not sure that by doing a systematic assessment you get to really what the key is. And the key is, just like we discussed yesterday, that this is a population

who should be the preferential hire, should be the preferential hire for employers.

You can come into Maryland or Virginia in any quarter and find huge employment advocacy organizations at the universities where they will bring veterans in, but rarely do they actually match jobs to the applicant.

And so, these statistics in the 21 percent -- I know when we were down in Florida a few years ago the National Guard BCT had an over 30 percent unemployment rate more than six months after return.

So, to me, this is a national disgrace. And I am not sure that this recommendation at all gets at the sentiment that I possess for this one.

MR. DRACH: In my original comment, I said, should we add something to the extent about develop new vocational employment programs? If the existing programs aren't adequate, fix them or perhaps develop

new ones.

Yes, there is a whole lot of issues surrounding the unemployment problem. I mean, it is not one single thing.

One of the things that I hear constantly from employers is it is the resume; veterans don't know how to write a civilian resume; they don't know how to translate their military skills into civilian skills.

The other problem I hear constantly from employers -- and I'm involved with a couple of employer groups -- we can't find them. There is no centralized location to find qualified veterans.

Others say, "Veterans don't possess the skills that I'm looking for." And that's not unique to veterans. There's a lot of issues going on in terms of not meeting the skills that employers are looking for.

A couple of years ago there was an article in The Washington Post where the head of the D.C. Employment Security System said,

and I'm paraphrasing -- I don't remember the exact data -- but she had something like 60,000 people looking for employment and she had 72,000 jobs. What's wrong with this picture? I've got more jobs than people. Well, the people weren't qualified for the jobs that she had. So, that is a situation that is not unique to veterans. It's across the board.

CO-CHAIR NATHAN: Uh-hum.

MR. DRACH: I think one of the problems is that we need to be able to prepare -- and I know there has been some discussion about the life cycle, that we should be preparing Service members to get out of the Service when they get ready to get out of the Service, and get their act together, so to speak, with their resumes, making sure that they delineate all of the training that they've had.

There's a document called the VMET, the Veteran's Military Experience and

Training, that they are supposed to complete before they get out. I know it was around post-Vietnam and, then, it kind of went away. And now, I understand it is back out there.

At a minimum, it helps to give the counselor an opportunity to look at all the experience and training that the Service member has had, which will help them assist the veteran Service member developing their resume.

So, you know, conceptually, I like the idea of this recommendation. I just don't know what the needs are. I don't think we have a good handle on all of the needs. We have some anecdotal information. We have what we have. It is very, very frustrating because I have been doing this for 40-some years.

When you get down to the Finding, I do have a concern about the Bureau of Labor Statistics and 9 percent of all Gulf War II veterans, and 21 percent of Gulf War II who are 18 to 24. Those numbers are Gulf War Era.

People use these numbers very loosely and cite them as indicating for those that actually served in theater. It's not for those who served in theater. It is for anybody in that era. So, anybody that served post-9/11, whether it was Afghanistan, Iraq, or Washington, D.C., and they never stepped foot out of Washington, D.C., they are included in that unemployment data.

CO-CHAIR CROCKETT-JONES: I just want to throw out a concern, and I don't necessarily think that this -- while it is on this topic, I don't believe that this recommendation actually hits it.

I think that there is a leadership issue here. We have heard the sentiment, even from those involved in voc rehab at DoD WCP level, that solving unemployment problems, finding jobs, transitioning to jobs is not the mission of the U.S. military. It's not in the job title. And this is from those who are tasked with the assignment to develop programs

to do this.

So, we have a very schizophrenic approach to this issue. And there is not a clear concept from leadership that this is the job that the U.S. military should be doing.

And I think that we are not going to get any resolution on making those programs effective or making those programs well metric to meet needs when there is high-level sentiment that those programs should not even exist.

And I find it disheartened to hear this. I also understand the sentiment. This is a very different mission. I am not sure what the solution is, but I don't think that this recommendation addresses that core. And I certainly don't think, as long as that disparity exists, as long as those two very disparate voices are held with equal strength at the highest levels, this will not be resolved.

DR. STONE: So, I would like to

actually see this amended somewhat. And let me sort of throw this out. I think there are two pieces.

No. 1, is the employee appropriately prepared for their next job? Do they have the right tools in a resume? Are we matching them to employers?

But the second piece that is not here is the incentivization of the employer to reach out, maybe beyond what they do for the average employee, in order to hire that person.

And therefore, I would like to see us add a section that says that DoD should advocate for incentives for future employers. And that, clearly, the only way to incentivize is not with DoD budget dollars, but with IRS dollars. So, with general revenue dollars.

And so, I would like to see DoD take the position of advocating incentivization of future employment of this population.

MS. MALEBRANCHE: That's a good point. I was thinking, too, because, you know, at VA they do veterans' preference for hiring and you get points for that when they're going through the system.

But just a comment from the staff at the VA on this. They thought, when we were looking at this as assessment, that one of the things that we might look at, at how the employment programs in DoD are integrating and synchronizing with the VA programs.

Because when we went on our visits and a lot of these focus groups, and you asked about voc rehab, they were pointing to the Voc Rehab VA Counselor that was assigned there when they started putting many, many of those folks out there. And they can start working with Service members prior to leaving. And they don't just look at like just the VA job. They look at the entire sector. And if they are not eligible, for whatever reason, perhaps for some VR&E, they could steer them into the

post-9/11 GI bill to get them prepared for that. So, that is part of that training.

So, anyway, just evaluating all the programs, types of services, coordination between them might help address some of that larger question that General Stone was mentioning about providing some adequate and appropriate services. But I agree, it is a leadership issue. But places where we have put those folks, they are being very well-utilized.

CAPT SANDERS: This is not a new problem. At least 10 years ago, the HASC was doing things that were making the Services put in place criteria that made military jobs match up with civilian jobs. So that, when you went to cross over the line, your work experience and your certifications matched the civilian world.

I'm not sure if that fits into this box, but I think there is at least a tangential relationship where we need to

advocate not only the vocational employment programs, but the certification programs matched as well, and that they are all lining up together.

I know that push was made through Congress because I was at the hearing when it happened, and I worked on the bill after it was done. I don't know where it is now because I am not in that business anymore.

But if we are looking for or recognizing that two things at leadership are not working, there's at least a third prong that was trying to do something at one time.

MS. DAILEY: I do think that is the genesis of this question, in that there are a lot of programs out there. There are the certification programs. There are the matching of the skills, the VMET. There are employment programs. OWF is not an employment program. E2I, the Services have programs where they are linking up people.

There is a sense it is generating

conversation, and you are morphing into something else which is wonderful. The intent here was to get their arms around DoD's programs, and it does blend well with one; get their arms around DoD's employment programs. See how effective they are and change them to increase their effectiveness.

CO-CHAIR CROCKETT-JONES: Okay. I just want to point out that WCP has a person tasked with that job. I mean, he is only really supposed to cover E2I and OWF.

MS. DAILEY: Correct, and then, this expands that role in the Warrior Care Policy Office to assess the rest of the programs. They are going to have to do an inventory of what is in the Air Force and what's in the Army, and the certification programs that are going on, and just try to bring them together and figure out what is working.

MR. DRACH: I am going to address the general comments about incentivizing

employers. Right now, the tax incentives that have been around for many, many years are expired, and Congress is fiddling around, talking about extending them.

One of the populations that is eligible for tax credits are disabled veterans, grossly underutilized, mainly because employers tell me that "The Tax Code is so complicated, it costs me more money to pay my accountant to do the paperwork than it is the tax credit that I get."

It can be up to, for disabled veterans, it can be up to $9800 on the first year wages, which is, you know, not insignificant. It is insignificant to General Motors. It is insignificant to Boeing. You know, $9800, they pay more for screws for the jets than that.

So, mom-and-pop employers, certainly it is an incentive to them. But the mom-and-pop employers don't know about it, and the mom-and-pop employers' accountants aren't

sophisticated enough to work through all the tax angles on it.

So, you know, that incentive has been there for years; hasn't really made any kind of a significant dent in it.

The flip side of incentives is requirements. And March 24th, new regulations went into effect that require federal contractors of $100,000 or more to take affirmative action, so employ certain categories of veterans, which includes all recently-separated and disabled veterans, wounded, ill, and injured, or those who have a Service medal.

I'm covered because I have a Service medal from 1967. So, employers are required to take affirmative action to hire me, but not me personally, obviously, but as a category.

None of these have worked. And if I had the solution, I would have put myself out of a job 40 years ago. There is no single

solution, and I think there's a combination of things.

Both DoD and the National Governors Association are doing something I think is very, very positive, and they are doing pilots on, and we heard about this when we did the site visit at WCP, from DoD's perspective, they are doing pilots on licensing and credentialing. And that has been a big issue.

You know, we have heard the President cite EMTs. You have got combat medics who have literally saved lives on the battlefield and come home and can't get a job as an EMT because that experience is not recognized.

Truck drivers, people driving big trucks and tanks and everything else over in Iraq and Afghanistan, they can't get a CDL. They have to go through the whole process starting all over again.

So, some of what they are looking

at, I'm not sure what the status of the DoD pilot is, but the NGA pilot -- and there are some similarities in MOSes that they are looking at. There are some similarities, but I think the NGA report is due in September, and we will have recommendations. So, what that will lead to remains to be seen.

So, there is a lot of stuff that is going on. How tangible the results are going to be is anybody's guess. So, I just don't know.

CO-CHAIR NATHAN: Right. So, you adequately point out that there's a lot of green shoots coming up everywhere, trying different things. Somewhere through all this we need to find the pony, which is a recommendation.

So, what I have heard is that, No. 1, we don't have an adequate assessment of how effective the programs are. No. 2, we have heard from Ms. Crockett-Jones that there is a disparity of effort or interest on the

Services as to who is responsible for managing these programs and getting veterans jobs, be it from the DoD or from the private sector.

We have heard, Ron enumerated a number of specific programs that are happening to create jobs. Talked about the White House desire, the President's desire to create civilian equivalencies in the military.

So, at the end of the day, you need to decide if you should have a recommendation to this, and if you do, what are you really looking for? To simply say there needs to be a better voc rehab employment program is world hunger. Everybody will go, "We concur."

To tell them exactly how to do it is probably too tactical. So, what do you all want out of this recommendation?

MS. DAILEY: And keep in mind, we do have in the back -- and correct me if I am right or wrong, staff -- in the Best Practices we have highlighted tools that the SOCOM

utilized to match up skills and automated learning, intuitive software that they are programming and that they are utilizing to match up real skills with job interests and job availability.

And also in the back, we have the training program out at Fort Lewis, which is a pilot for 18 months before ETS. Individuals go into that program, and then, they come out of it certified and hired by the skill or the trade that trained them for the last 18 months.

So, we have highlighted some Best Practices in the employment area. So, yes, if we match, how we want to match or if you even want to match a recommendation, you know, we're game. We have got a lot of data.

CO-CHAIR NATHAN: Match this recommendation in what terms, Denise?

MS. DAILEY: Well, match or create a recommendation that captures your intent. If we don't have it here, which is to assess

their current programs and determine effectiveness and move forward from there, that is not capturing your intent.

I do have a lot of data in the Findings and in the Best Practices that will support some of the themes I have seen you talk.

DR. STONE: Before we tackle the question, sir, who should be the accountable agent here?

MS. DAILEY: This is Warrior Care Policy Office's responsibility, and the Services are also responsible. But it would come out of the Warrior Care Policy Office, a unified Service effort.

DR. STONE: So, if Warrior Care Policy, then, whatever we write should be directed to WCP?

MS. DAILEY: Correct.

DR. STONE: To keep this out of the tactical, principle No. 1 is match skill sets to employer, and No. 2, to make sure that

you are doing everything to make that an advantageous hire. You don't have to tell them how to do it, but, you know, this falls under the same thing as the monetary policy of trying to get the sand out of the gears, and where you are trying to manage advantageous borrowing of money.

CO-CHAIR NATHAN: Well, on that theme, Rich, let me ask Ms. Dailey, true or false then, the WCP does have a report or a metric that they can share that talks about those Recovering Warriors, those people who are formally documented or classified as Recovering Warriors and what percentage of them are getting jobs?

MS. DAILEY: No, sir, they are monitoring what is called the E2I Program --

CO-CHAIR NATHAN: Right.

MS. DAILEY: -- and the OWF Program.

CO-CHAIR NATHAN: Right.

MS. DAILEY: And they have got

some metrics for those programs alone.

CO-CHAIR NATHAN: Because I am getting a sense of the Task Force here that that is one thing we would like, is a better visibility on the overall landscape of the entire Recovering Warrior population and how they are doing as far as getting either vocational rehab or jobs.

We have examples of where it is working very well here and there with some programming, but we don't have a composite view or comprehensive view on how well we are doing getting jobs.

So, one intent of the recommendation would be a comprehensive report -- and I realize it sounds like world hunger -- but a comprehensive report that gives us a dashboard on how well Recovering Warriors are doing in the job market.

What we know is we say, objectively, like Rich, well, here's the sophisticated answer: "It's bad." Okay? But

we need something a little more defined. Because how do you manage something you don't measure.

And then, to your point, General Stone, what are we going to recommend we do about it, right? Which is not telling exactly how to do it, but recommending, if you want to say that again, how to start facilitating.

MS. DAILEY: His two terms were match skill to employers and take steps to make veterans --

CO-CHAIR NATHAN: Advantageous hires.

I mean, very briefly, an example of that, the EMT that you spoke of, Ron, the EMT is -- so, we now, when we train our Corpsmen, we now add additional training to make them EMT certification eligible. (A) It's the right thing to do, and (B) our boss is the President, and what interests our boss fascinates us.

(Laughter.)

So, that is a green shoot that is happening, but that is not a program that is being applied across the mirror.

So, comments on that?

MS. DAILEY: Also, the civilian personnel offices and OSD, DCPS has also been tasked with the hiring of the veteran. So, there is some diffusion in OSD about who is managing this. So, this could also go over to the Civilian Personnel Policy Office. It all falls under P&R.

CO-CHAIR NATHAN: Right. I think the metric part of it can be directed. We can direct the WCP. The match skill sets to employers and take steps to make veterans advantageous hires, is that P&R?

MS. DAILEY: Yes, it would be. And probably, I think now they have divided it out into and shifted it over to the Civilian Personnel Office.

MR. DRACH: I think in the match skill sets to employers, I think we should add

employers' needs or employers' employment vacancies, something that focuses on employment.

MS. DAILEY: Would you like us to try to take a crack at a new recommendation? Give us a couple of minutes and we will give you another draft of a recommendation.

CO-CHAIR CROCKETT-JONES: Yes, I think that is good. Let's take a few minutes.

MS. DAILEY: Okay, good.

CO-CHAIR NATHAN: Five minutes, folks.

(Whereupon, the foregoing matter went off the record at 10:25 a.m. and went back on the record at 10:35 a.m.)

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CO-CHAIR NATHAN: Okay, we're working on D10 now. And I would like to thank the folks for taking our ideas and distilling them down to the following. So, as Rod Serling used to say, "Submitted for your approval is" D10.

"DoD should take affirmative steps to ensure DoD employment programs are meeting expectations. These include: creating a dashboard, reporting Recovering Warrior employment metrics, allowing ongoing monitoring and visibility of how well Recovering Warriors are doing in the job market. Next is matching skill sets to employers' needs. Next is taking steps to make veterans advantageous hires. And finally, synchronizing the DoD, VA, and Department of Labor employment programs."

CO-CHAIR CROCKETT-JONES: Can we just add a word in there? "DoD should take affirmative steps to ensure DoD and Services' employment programs...." I mean, that is one of the things we want them to do, is get their arms around what the individual Services are doing as well.

CO-CHAIR NATHAN: Okay. Anybody else? Issues? Concerns? Happy to glad?

MS. DAILEY: I do think we have

some concerns, which is at the last bullet. It is synchronizing. You are really asking DoD to reach across the DD214 and to assess the employment of veterans, which is kind of why I focused it internal to DoD programs. But the fourth bullet there is intended to pull that information from VA and DoD -- excuse me -- DOL.

CO-CHAIR CROCKETT-JONES: Well, I think that is one of the issues, is that DoD needs data post-DD214 to know how effective programs are. And VA and DOL have that information.

So, really, it is about communicating between those three agencies. If they can't talk to VA and DOL about this in the conversation about successful hiring, obstacles to employment, and where those folks stand, their assessment will only be about -- I mean, how will they know whether people are getting hired?

DR. STONE: Denise, your point was

that this should not be a DoD lead here?

MS. DAILEY: We can only make recommendations to DoD. I am just saying that they don't have this data, what happens after, unless they pull it from DOL.

And you are refining it down to Recovering Warriors. I mean, we know what the general population is. But DOL is not gathering deployed unemployment rates, and they are certainly not gathering deployment rates of what we would categorize as the Recovering Warrior. I mean, there is no code for someone who left the military after disability evaluation. There is no IRS code.

CAPT SANDERS: Can we ask DoD to ask these agencies to capture the data for us because it is important data, as part of the recommendation?

MS. DAILEY: Yes, you can. I mean, it is an interagency issue to create these unique populations for tracking. But I think, ultimately, it would fall on DOL.

Mr. Drach, are you tracking here?

MR. DRACH: Well, DOL, basically, has two sets of data that shed some light on employment for veterans. One is the BLS data that is listed in the findings. That comes out -- well, the data on veterans is not published monthly, but it is available monthly. I get it sent to me because of my connections at BLS. But it is not available to the public on a monthly basis.

Part of the problem is the sample size and the survey that is done by the Census Bureau through the Current Population Survey, the sample size is so small and the data are just not real, real reliable. BLS wants people to use the annualized data, which makes it much easier or makes it much more accurate.

The 18-to-24, which is the big hot-button issue, there are only 60 veterans in the population that is surveyed. So, one or two veterans goes in or out of the labor force, gets a job, doesn't get a job. It

spikes the unemployment for that particular population back and forth.

The other data that DOL collects is through the Employment Security System, the state workforce agencies, most commonly referred to as the unemployment offices. The problem with those data, it tracks only veterans that register with that system. And that is one of the goals of the old TAP and the current GPS system, is to drive these transitioning Service members to the local job service, register there, and get employment assistance through there.

DOL tracks on a quarterly basis, and it is about two quarters delayed, as I recall. But it is fairly current. But what it tracks is the number of veterans that register, the number of veterans that receive different types of services, including the number that are placed in jobs, and including those that are retained in jobs 180 days post-employment.

So, neither set is really, I mean, it gives you a picture, a snapshot in time, but it is not all-inclusive. So, if the current population veterans, including Wounded Warriors, are not going to the Employment Security System -- oh, and then, they can be identified as recently separated, which is within the last four years. So, there are some subcategories of veterans in that monthly or that quarterly data where they track the services that are being provided.

The BLS data just tracks the number that are in the labor force, on the labor force, employed or unemployed. And then, annually, they come out with a much more robust study that is a supplement that is done in August of every year. And it is a supplement, and it really drills down to subpopulations, disabled veterans, women veterans, minority veterans, age categories, male/female. It is very, very robust.

But, again, you still have the

same problem because the survey is so small, but it is what it is and it is there.

CO-CHAIR CROCKETT-JONES: So, here's my question for you, Ron: based on your experience with the Department of Labor, if there was a coordinated effort for communication between the Department of Defense folks who are working the employment and transition issues and the Department of Labor folks who are gathering data, do you think that better data could be gathered with more integrity? Do you think that there is some way for those folks to communicate to improve the way things are happening? Will that help?

CAPT SANDERS: Could I ask even more simply, is there some way to just directly take a two-step ask, for us to go to the Department of Defense and ask them to go off to the people who are collecting the data to collect relevant data for measuring the purposes that we need to get information on?

MR. DRACH: Well, I guess part of is, what additional data do we want to be included. When you look at the BLS data, it costs money. There's an agreed-upon set of questions between the Department of Labor, Bureau of Labor Statistics, and the Census Bureau that says we're going to ask "X" number of questions. If you want to add a question, it's going to cost "X" number of -- pretty significant; I forget what it is -- "X" number of dollars per question.

If you delete a question and add a question, it's a wash. There's no cost involved. So, cost is an issue there.

The same thing applies to the data that is collected quarterly or reported quarterly. It is collected monthly, but it is reported quarterly. It is kind of the same thing.

Because the Department of Labor is asking the states to provide the data, and the states are saying, "Hey, we only have so much

money to do this also, and we'll give you nine data points, and that's all we're going to give you, unless you give us more money." And even then, they don't want to do it because of the cumbersome process of collecting the data that is wanted.

One of the concerns -- and I don't know what is going on now, so I can't speak to what DOL VETS, Veterans Employment and Training Service, is doing to work with WCP or anybody over at DoD.

When I was there, my boss, the Assistant Secretary, attended all the JEC meetings because Dr. Chu and Gordon Mansfield, then the Deputy Sec at VA, invited him to come and participate. He was not an official member of the JEC, but he went to the meetings.

We had a staff person. The JEC has a Veterans Benefits Committee and a Health Committee. The Department of Labor had a representative on each of those two JEC

Subcommittees. I don't know if they still do or not.

From the last I heard, there's very, very little, if any, interaction between DOL vets and Department of Defense. I know that there has been -- I have heard criticism from some people that I know at WCP who say, "What's wrong with vets? They don't answer emails. They don't call. They won't answer our phone calls."

To get back to what General Stone said earlier about leadership, you know, here the problem was some of the leadership. And I don't mean to be critical of the leadership there now, because I just don't know what is going on.

And I haven't heard the complaint about communication for quite a while, but I don't know what they are doing. Now an OIF veteran who used to work for John Campbell at WCP has just been hired as the Special Assistant to Keith Kelly, the Assistant

Secretary of Labor. So, Brian has a lot of experience working kind of both sides. So, I am hoping that Brian will bring some new emphasis to coordinating/cooperating with DoD.

And again, I am qualifying what I am saying because I don't know. They might be meeting with DoD every week. I just don't know what the current status is, but I doubt very seriously that they are doing very much with them.

You know, it is just very frustrating. DoD set up E2I. They set all the stuff that they have set up over the years, in part, because I think they were dissatisfied with the speed within which DOL was moving and, also, within the quality of services that DOL, through the states, was providing.

The average salary of somebody, a veteran that gets a job through the State Employment Security System, the state workforce agency, whatever you want to call

it, is around $17,000 a year. Seventeen thousand dollars a year in Ground Hog, Idaho is probably not too bad. In Washington, D.C., $17,000 is not very adequate.

Other programs, VA Voc Rehab, the last I looked, their average starting wage is around $36,000. So, where am I going to go? You know, am I going to go to the local job service for $17,000 a year or am I going to go to VA Voc Rehab for $36,000 a year? Now these are averages, obviously.

Part of the problem is the types of jobs that employers register or list with the state workforce agencies, they are generally low-wage, entry-level, no-career-ladder, high-turnover, difficult-to-fill, low-skilled. So, a lot of veterans just don't go there, you know. So, I think that is important.

And you look at several large corporations have started. Look at Monster. Monster does work with veterans. They have a

special effort for veterans.

Some employers, some of the federal contractors we know set up special programs to do their own recruiting, hiring, and including OIF/OEF veterans with TBI and PTSD. There's a couple of very successful programs.

Like I said, if I had the answer, I would have put myself out of work 40 years ago.

CO-CHAIR CROCKETT-JONES: So, here's my question for you, Ron. That final bullet, if it was communicating between the agencies on employment issues, would that be significant and should be left in or is that pipedreaming or is that not going to improve? Will that not demonstrate improvement?

MR. DRACH: You know, I like the idea of leaving it in. Is it going to have any impact? Who knows?

You still have three stovepipes. DoD is going to do their thing because they

are not happy with VA; they are not happy with DOL. DOL is going to do their thing because they are restricted by legislation, or whatever. VA is going to do their thing because they don't like DOL.

CO-CHAIR NATHAN: That's true. If this catches anybody's attention, it is going to catch Congress' attention. The DoD, the various agencies are not going to be the ones who direct this or who, I think, energize themselves to try to find cross-pollination. This would be something that Congress would look at and say, "Wow, you guys, you have tapped into a vein here. Good idea. Let's figure out how we can get these services to coordinate among each other," or these agencies to coordinate.

So, Ron feels that this bullet is worthwhile.

CO-CHAIR CROCKETT-JONES: Yes, I think we might want to talk about communicating. I think that if we say

"synchronizing unemployment programs," it is as if we're --

CO-CHAIR NATHAN: Specializing their employment programs.

CO-CHAIR CROCKETT-JONES: Something. They should be talking to each other, so that they aren't repetitive, aren't at cross-purposes, aren't unaware of each other.

I would think that they should be communicating. I am not sure that we can --

CO-CHAIR NATHAN: Cross-referencing?

CO-CHAIR CROCKETT-JONES: Cross-referencing, something like that.

MR. DRACH: Well, there's an Advisory Committee that is set by law, the Advisory Committee on Veterans Employment Training and Employer Outreach, which DoD serves on.

CO-CHAIR CROCKETT-JONES: Is DOL on that as well?

MR. DRACH: I'm sorry?

CO-CHAIR CROCKETT-JONES: Is Department of Labor on that as well?

MR. DRACH: Oh, it is, I'm sorry, it is a Department of Labor Advisory Committee, and it is housed in the Veterans Employment and Training Service. And right now, it is being chaired by -- oh, I forget his name. Anyway, it is made up of a couple of VSOs, veteran service organizations, the National Governors Association. Anyway, DoD is on it; VA is on it.

DoD has been very -- I have been to the last three or four meetings -- DoD is very there. I mean, they have a lot of input. VA also has a lot of input.

You know, so to that extent, they are talking. Now the DoD representative I don't think is from WCP. I'm not sure what office he is with.

So, should there be more, you know, something more robust than that? You

know, it is like so many advisory committees. They make recommendations in their annual report to Congress and to the Secretary, whether it is VA, DOL, or other advisory committees that I am aware of.

And it gets back to leadership. You know, even though the law requires the report to go to the Secretary, at best, the Secretary will get briefed by the Chief of Staff. And "Oh, I like that idea." "I don't like that idea."

And usually, the response to the task force or the committees is drafted by the people that the recommendation is focused on. So, they have got to make an excuse of why they don't like the recommendation.

So, I don't think we should just ignore it. I think, as the Admiral said, it might get the attention of Congress. The Armed Services Committee aren't going to care. They don't care about employment.

CO-CHAIR NATHAN: The Veterans

Committee will.

MR. DRACH: The Veterans Employment and Training Service exists.

CO-CHAIR NATHAN: The VA Committee may.

MR. DRACH: The VA Committee.

CO-CHAIR NATHAN: So, we are heading into our second hour on this one. At some point, we need to fish or cut bait. As the Rolling Stones say, "You don't always get what you want," but sometimes you get what you need. You will have to decide if this is good enough for need.

CAPT SANDERS: Just one comment, sir.

CO-CHAIR NATHAN: Of course.

CAPT SANDERS: Based on that last level of communication, do we want to be more overt in trying to catch Congress' attention and less covert in our response that is going to DoD?

CO-CHAIR NATHAN: I don't know.

You can ask Ms. Dailey if she is comfortable with putting in "Congress should direct...." or "Congress should...."

CO-CHAIR CROCKETT-JONES: They could be put under the agency task, you know, asking for a response, right?

CO-CHAIR NATHAN: Congress should ensure...."? I mean, if you want to be aggressive about it, "Congress should ensure there is better coordination or cross-referencing or" --

DR. STONE: I think this is in the final bullet. And where you are going right now, it makes me feel a lot more comfortable. Better communication to me doesn't say anything at all. And so, "Congress should ensure integration of effort."

CO-CHAIR NATHAN: It works for me.

DR. STONE: That would make me feel a lot more comfortable and be a lot more direct of where we would like to see this go. And with that change, I'm comfortable.

CO-CHAIR NATHAN: Okay. So, do we have a motion to vote for this recommendation or not?

CAPT SANDERS: So moved.

TSGT EUDY: Second it.

CO-CHAIR NATHAN: So, the motion before us is to vote as to whether or not to accept the following as Recommendation D10:

"DoD should take affirmative steps to ensure DoD's and the Services' employment programs are meeting expectations. These include: creating a dashboard, reporting Recovering Warrior employment metrics, allowing ongoing monitoring and visibility of how well Recovering Warriors are doing in the job market. Next, matching veteran skill sets to employers' needs. Next, taking steps to make veterans advantageous hires. Finally, Congress should ensure integration of effort among DoD, VA, and Department of Labor employment programs."

MR. REHBEIN: I'm sorry, sir, but

we start out with the recommendation saying that DoD should take affirmative steps, and then, one of the steps is that Congress should do something. That strikes me as strange language.

CO-CHAIR NATHAN: Yes, it's a good point. Good point.

MR. REHBEIN: And I don't know if it should say "Congress and DoD" or I don't know exactly how to word that, but --

CO-CHAIR NATHAN: Do you want to put the whole thing under the aegis of Congress and start off the whole thing with "Congress should ensure affirmative steps...."?

CO-CHAIR CROCKETT-JONES: I think that, actually, the first iteration of "take affirmative steps," and then, the bullets should be specified. That would make more sense to me. Congress doesn't need to create a dashboard.

CO-CHAIR NATHAN: Okay. So, just

start with "Take affirmative steps"? "Take affirmative steps"? Okay. Does that work for you, Dave? Okay.

So now, the motion before us is as reads.

So, all those in favor of accepting --

LTCOL KEANE: One comment, sir?

CO-CHAIR NATHAN: Please.

LTCOL KEANE: "Creating a dashboard, reporting Recovering Warrior employment metrics, allowing ongoing monitoring and visibility of how well they are doing in the job market" I believe is an impossible task.

We at the Warrior Regiment, when I was there -- things may have changed -- had a good grasp on whether or not the Recovering Warrior as he transitioned had a job or not. What we don't have a perfect hold on is as they transition and they don't do well with that job. They are unemployed six months

later. They have transitioned to another job. I don't know how you would do that.

CO-CHAIR NATHAN: I don't know how you do it tactically, either. You know, in medicine we have what is called a Tumor Registry Board for people who suffer cancer. And if you develop a cancer, you are put in the Tumor Registry Board, and we follow up with you and we survey you and we mail to you to see how you are doing and where you are going.

We do it for two reasons. One, to keep track of you. And two, we want to know how well treatments and therapies are going in various cancers.

I see something similar to that in the Recovering Warrior population where, as they leave the Service, we pulse them and see where they are, see what is happening to them, to see if we are making headway.

And it is no small task, by the way, but I don't know otherwise how you would

do it.

LTCOL WONG: Well, we do spend a lot of manhours with our Call Center to do followups. If the Recovering Warrior rises to the level of an FRC or as the Lead Coordinator Program gains more traction, I think they will be able to start doing it. But, really, for all Services, it has to be a comprehensive CRP that is we have asked for many times.

CO-CHAIR NATHAN: Good points. So, here's how I see it. We have a motion before us. If you like the verbiage, vote for it. If you don't like the verbiage, don't vote for it. If this is voted down, then we will entertain motions to resurrect it in a different format.

So, all those in favor of accepting -- this is what, D11? Ten, D10. It should be 11. All those in favor of accepting D10 as written, please signify by raising your hand.

All those opposed?

Okay, the recommendation carries.

You guys not only are not going to be registered in the VA system, you are not going to get jobs, either.

(Laughter.)

Okay. That's democracy at work. I very much appreciate that.

CO-CHAIR CROCKETT-JONES: All right. So now, we are going to look at D11.

Our next recommendation addresses recruitment standards. This recommendation states:

"Consider existing recruitment standards to ensure quality future accessions."

I invite you, I invite someone to move to adopt this recommendation for discussion.

CAPT SANDERS: I so move.

CO-CHAIR CROCKETT-JONES: Does anyone have anything to say for or against this recommendation?

DR. STONE: Wasn't this part of last year's NDAA? Didn't last year's NDAA include recruitment standards?

DR. PHILLIPS: I think it did. I originally brought this up based on the issues related to the standards during the surge. But I will just throw this out for advice. I know recruitment standards have changed now. And certainly only one of four folks I think trying to be inducted are inducted.

The intent was to, at least my intent was to at least set some standards for future induction when surge is necessary, but I don't know that this will have any impact.

Obviously, just kind of off the record or a personal opinion is that, if we need a surge, I would rather see a draft than just taking people who don't do well, either don't graduate high school or don't do well on their Armed Forces testing, and so forth.

CO-CHAIR NATHAN: So, we could make the 11, "Reinstitute the draft."

(Laughter.)

DR. PHILLIPS: Personally, that's what I would --

DR. STONE: There is a flurry of activity behind you, sir.

So, it was my understanding that somewhere buried in NDAA last year was a change in screening for recruitment standards for all Services. And before we go anyplace with this, I think we probably should know whether that, in fact, does exist or not exist.

We have discussed in past years the failure going back to World War II in order to effectively screen for mental health problems, and the efforts that were made during the draft of World War II as we expanded to a 10-million force, 10-million-person force in uniform, and how ineffective it was to screen out for behavioral health issues.

CO-CHAIR NATHAN: Yes, a great

point.

My bias on this is -- and I am just one voice -- but my bias on this is that DoD is going to come back and tell us, "We are already doing this."

I can tell you in our Service, and I think in the Marines, we are scrutinizing very hard now who comes in, under what aegis. We have had a couple of Congressmen, or at least Members of Congress, contact us and say they want us to start screening people with predictive tests for who is going to have mental and emotional health problems down the road.

We have told them no such thing exists. I mean, you know, you could swing a crystal over somebody's head, or whatever, or give them a Ouija board, but we don't have anything and we are not going to get into the business of looking at somebody and saying, "Even though you've been fine, we predict that you are going to go off the reservation."

So, I know that we are immersed in this in the Service, in my Service, looking very hard at who we should and shouldn't be recruiting, recognizing, as you said, Dr. Phillips, that I think we have a burning platform on our hands in the military, in that only one out of four to one out of five individuals between the ages of 18 and 25 are actually eligible to join the Service because of obesity, disciplinary issues, physical fitness problems, education. So, that is a challenge.

So, my take would be -- and again, I am just one voice -- but my take would be this will make the minimalist happy in the group. But this is something that I think would dilute the other recommendations.

CSM DEJONG: I concur. I know on the Army side, which was a large portion of the surge, I think the lessons have been learned. It is quite costly, what we are involved in now. We are in a position that we

can't tell whether it was preexisting or non-preexisting.

But, if you look at the standards that are out there now, if you look at the changes in the standards, I believe that this is already taking place.

DR. PHILLIPS: Yes, I agree. You know, having been the one, I think, that brought this up initially.

I am just wondering if there is some way somewhere that we can insert in Findings or related to lessons learned that, during surge, folks, remember that when you go above the 4 percent level, that you end up paying the penalty of taking people who are really not qualified in the long-run. I don't know how we would do that. That is just a suggestion. But I agree, this should not be a primary recommendation.

CO-CHAIR NATHAN: And I think your point is a very, very good one. I would only add that I think most of the Services now, Dr.

Phillips, would say "Amen" to that and agree with you, that they recognize, especially the Army which has been involved for 12 years now in a very large personnel requirement.

I think if you went to the Army and said, "You know, once you get past where you take the people who you want to take and you have to take those that you have to take, you're in trouble," I think the Army would say, "Amen. Drink a beer to that."

We are trying to figure out how to mitigate that now. And unfortunately, without a draft, I don't know that you can. But, on the other hand, there have been tremendous advantages of having an all-volunteer force. It is just, when you take an all-volunteer force to war for 12 years, you run into some issues.

Okay. Any motions or more discussion?

CSM DEJONG: I make a motion to strike this from the recommendations.

CO-CHAIR NATHAN: Well, you make a motion to vote on it, and we can either vote it up or down.

CSM DEJONG: I make a motion to vote on it.

CO-CHAIR NATHAN: Okay. And seconds?

TSGT EUDY: Second.

CO-CHAIR NATHAN: Okay. So, a vote in the affirmative would be to adopt D11 as a recommendation, which is: "Consider existing recruitment standards to ensure quality of future accessions."

A vote in the negative would be to drop this from consideration.

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

All those opposed to adopting this as a recommendation, please raise your hands.

Okay. Thank you. Unusual, but the noes are above the ayes.

Are you okay with plowing ahead to --

CSM DEJONG: This one is going to be a long one.

CO-CHAIR NATHAN: -- 12? So, how soon --

MS. DAILEY: David, did you have something you wanted to say?

MR. REHBEIN: Oh, no, no.

MS. DAILEY: Okay. All right. I'm happy for you all to press ahead in appropriate discussion. Two o'clock, I've got to have you here, even if you finish early. Dr. Guice is coming over to do presentations and to send you off with a kiss on the cheek. So, I need you here at 2:00, regardless of how fast or how slow you go.

CO-CHAIR NATHAN: All right. Well, we will go ahead and start on 12, and we will see how we do. We may or may not, you know, we may break for lunch before that.

This recommendation for discussion

addresses the health insurance for Reserve component Service members. This recommendation states that you require health insurance as a condition of employment in the Reserve component.

Is there a motion to adopt this for discussion?

MR. REHBEIN: So moved.

TSGT EUDY: Second.

CO-CHAIR NATHAN: So, discussion on that recommendation?

LTCOL KEANE: I have a comment. And I may be missing something, but doesn't the Affordable Care Act require people have insurance?

LTCOL WONG: Yes.

DR. STONE: It certainly does, but because these are part-time employees, and therefore, serve under 30 hours, there is not a requirement for the Affordable Care Act to be implemented for this.

MS. DAILEY: Reserve Affairs also

wanted to provide us input on this. So, if you go to Tab I or J -- or did we put it in the lefthand side? It is in I. And I sent it out to you. I sent it out to you also to read over the weekend. So, "I"; it is not in my "I", but my package is early. Yes, okay. So, my package was early. So, I didn't get all the good stuff.

But it is a fairly-robust response, which is a little along the party lines, but I think it does have merit for your -- when we initially discussed this, I thought that we had said that we wanted everyone in the Reserve component to be eligible to purchase TRICARE Prime Remote. Or TRICARE Reserve Select, is that the one. That's right, TRICARE Reserve Select.

LTCOL WONG: Every drilling Reservist, not IRR members or IMA members, only if they are drilling. You have to be able to do the point threshold, correct.

MS. DAILEY: So, then, drilling

Reservist is eligible to buy TRICARE Reserve Select. That is a correct statement.

CO-CHAIR CROCKETT-JONES: So, just looking at what they said, if this was said, that they were required to have -- okay, I just have to process this.

LTCOL WONG: Right. If you read the comment from them, I don't think we are looking to remove the LOD process in our recommendation. And to bring back the statement from earlier that we read today, there were some inconsistencies, at least from the JACMAN and LOD process, that there is a presumption for Reserve component members to be under the line of duty and not under misconduct.

And I don't think an investigation is required for every injury. It is up to the local commander to do that preliminary investigation and determine if it involves misconduct or should not be covered by the military. Then, it goes up to a formal

investigation and signed off by the general.

But the earlier statement was saying that everyone should have an LODI, and that definitely would bog-up the entire system and general officers would have to sign off on every single injury. And I think that was --

CO-CHAIR CROCKETT-JONES: Well, I think that this was, our alternate fix was to say that, if everyone had health insurance, that their immediate needs while the resolution of LOD issues happened, they would at least have access to care.

And I am a little confused by the response.

LTCOL WONG: As I am. I think a better, if we rephrase this, is that every Reserve component member can be under line of duty, regardless of Service. You know, there is a presumption for Service connection.

DR. STONE: So, this has nothing to do with line of duty any more than it does, Ted, with active duty. If you are injured

this weekend repairing your house, nobody is going to question whether you have access to healthcare or not. LOD has nothing to do with this.

This has to do with the fact that Reserve component members are exercising their preparation mission even when they are not in duty status. So, if call out in PT and fall off the curb and break an ankle, they have been training for their service and their readiness, and they need health insurance.

Now most of this has to do with access problems. When there is a question, and when we get into this, we can have tremendous delays in healthcare and at great risk to the Service member.

So, Congress has a very generous program here that has been developed and accepted extraordinarily. TRICARE Reserve Select is some of the most retained health insurance in America and has well over 100,000 active members at this point.

In spite of that, we still have a significant portion of young Service members who have chosen to not participate, even though the rate of charge is around $50 a month, including pharmaceutical coverage.

This is a condition of employment, is as simple as you can make it to say you're going into a high-risk job; you've got to have some way to be cared for, so that we don't have a mess that places in you and your family at risk.

CO-CHAIR CROCKETT-JONES: Yes. When I look at this, the response, I think that they have taken, that they aren't necessarily understanding the point and purpose or the meaning of this. And so, perhaps we can word it better and say that it is required as a condition of employment in the Reserve component, if you do not have other health insurance, that you will enroll in TRICARE Reserve Select. That might be the way we want to put this.

You know, their concern is that there would be this sudden great cost to the Services if we say we will provide it, but we didn't say that. And their concern is that, you know, everyone has to acquire this before they can be considered for employment, but that is not really what we are saying, either.

So, for those who already have healthcare through another access point, a spouse or a job, they would have health insurance, and there is no difficulty in status. But if they don't have any other health insurance, Reserve component should then have to take, if they have nothing else, TRICARE Reserve Select. It is a reasonable cost to them, and it is part of their employment.

CO-CHAIR NATHAN: So, if I can summarize what I have heard, General Stone, what you're saying is, listen, this makes sense because if you are in between duty statuses and you have an illness or an injury

befall you, that materially affects your readiness; it affects your ability to activate, and you need to have expedient and competent care for mission-readiness and for total force.

The Reserve people come back and say, "If you do this, it is going to adversely affect our recruiting because people may not want to join the Reserves if they have to spend money on healthcare viz those extra few CDs a month." Because, as you pointed out, for 50 bucks a month, you can get TRICARE Reserve and be covered.

They further go on in the information here to talk about, if you are trying to imply that, once you join the Reserve component, there would be free healthcare provided by the Service, similar to the active component, then be more clear on that.

I don't think we are implying that at all. So, it comes down to the yin and the

yang now, the yin being, do you believe that, regardless of what the source is -- regardless of what the source is -- do you believe that a Reservist, to maintain Reserve status, should have to carry or be insured for health, regardless of what the source is? And if you do, then you have sort of answered this.

The question, then, becomes, who should provide it and where should it come from, but that is the crux of this. Do you believe that a Reservist, to maintain their Reserve status, should have underlying health insurance, either through TRICARE Reserve, Kaiser, whatever? That's how I see it.

DR. STONE: That is correct.

CO-CHAIR NATHAN: So, other comments?

DR. STONE: So, I don't think we have to tell them what type of insurance to take. I think there are options that are given. I think that the writer, in the response from the Reserve component, frankly,

got it wrong.

This is fairly simplistic to say, at the point that you raise your hand and are joined, you are now eligible for health insurance if you can't find it in some other manner. But there is not a commander in the Reserve components that is not dealing with nightmares in access to healthcare and readiness.

LTCOL WONG: To include that, I mean, you are required as a Reservist to keep your teeth clean and, you know, get your annual exams, but, I mean, local commanders struggle every single year with their readiness numbers just for dental care, because people are not Class 1 or Class 2.

CSM DEJONG: If we went back to the Reserve component over the last 12 years of war, and we actually added up the amount of expenditures on becoming medically- and dentally-ready to deploy through the Service members, we would see that this would be a

huge benefit, both fiscally -- and that was our biggest nightmares, as command teams, of getting Reserve components ready, was medically-ready and dentally-ready to deploy. Training was the easy part. It was the personal readiness portion that caused us our nightmares.

I know -- well, let's finish up with that part first, and then, we will go into the LOD portion.

CAPT SANDERS: I asked earlier, and Denise answered my question about whether or not there had been any exploration of the civilian government employee healthcare system and whether or not that was -- insurance system; excuse me -- whether that was a viable thing to add to the list of options that Reservists could access by virtue of their Reserve status. And I guess it was researched and looked at at one of the offsites that I didn't attend. At that particular offsite they didn't see it as the best way forward.

I don't know fully why they didn't see it as the best way forward, but they didn't.

DR. STONE: Frankly, because of the way TRICARE Reserve Select is structured, it is at lower cost than the federal employee healthcare system.

Admiral Chris Hunter really, when she was the Deputy Director of TRICARE, really began this program and spearheaded TRICARE Reserve Select and the discussions with Congress on it. She now is head of the federal employee healthcare system and has been a great partner as we have developed this over the years and moved forward.

But it would actually be at cost disadvantage to go under the federal employee system of healthcare.

CO-CHAIR NATHAN: And again, that's sort of deciding how you're going to meet the requirement.

DR. STONE: As an option.

CO-CHAIR NATHAN: As an option.

No, no, as an option, but this isn't dealing with that. D12 simply is saying, to me, it is a binary question; it is a yes or a no. Do you believe, does the Task Force believe that health insurance should be a condition to be in the Reserves? How you get it and where you get it can be the subject of another recommendation or in the Findings or left Task Force part deux, but that is what this is.

Now was there something else that somebody wanted to augment this with LOD? Discussions?

CSM DEJONG: I know in the discussion, when this came up, one of those is that -- and General Stone had just mentioned it -- if I'm on active duty and I'm running, it is automatically assumed that I am running for -- I'm covered.

CO-CHAIR NATHAN: Right.

CSM DEJONG: After I take off this uniform and I'm in the civilian sector as a Reservist, I am running -- the burden, there

is no proof; there is no burden of proof; there is no argument on whether I am going to be covered or not. I won't be covered.

So, the second part of this recommendation was to somehow equalize the assumption that some injuries and/or illnesses are automatically in LOD versus trying to put the burden of proof on the individual to get it covered.

I don't know if we will ever come to an agreement on this because it is very difficult. But, in lack of that being able to be solved anytime soon, the existence of health insurance would at least cover that individual's immediate needs until it can be determined whether it is in the line of duty or whether it is not.

CO-CHAIR NATHAN: Right. I agree. I think that is a can of worms, the LOD.

I am playing in a softball game and I am rounding third and I break my ankle. Well, playing in a softball game is a form of

fitness. It is a form of exercise. It should be a good thing that the Service sees me playing sports.

On the other hand, you know, I was having a couple of beers and it was one of those games where every time you would get a hit, you've got to drink a beer and, then, run around the game. So, some people would say, "That's not line of duty. That's just pure recreation."

So, that is a can of worms, but I think here the eye on the prize is, do you believe health insurance is required to be in the Reserve component?

CO-CHAIR CROCKETT-JONES: Yes, that could be just even in the findings, a note that TRICARE Reserve Select is an affordable option. If no other healthcare options exist, that TRICARE Reserve Select would be available once someone joined the Reserves.

LTCOL WONG: This would definitely

remove barriers to care. I mean, it is the magic timing a lot of times. I mean, when we look at suicide ideation, suicide attempts on the Reserve force, I think we are averaging, I think, 1.2 suicide ideations a day on the Reserve force on the Marine Corps.

And if the Marine comes during drill weekend and, then, has the ideation, he is covered under LOD. If he does it Thursday in preparation -- you know, he is fearing to go for reprisal order, and then, comes in and reports, "Oh, last Thursday I was thinking about killing myself," well, now you are not covered. And we can send you to the ER or refer you to PEHA, but LOD is not going to pay for it.

And now, we are creating a barrier to care for someone that we have already invested in and potentially not providing that healthcare viz, if under a condition of employment or a condition of participation in the Reserve they do have some type of

healthcare, possibly some of the issues may be that their deductible level doesn't cover it or their insurance doesn't cover it, that type of care. That is another can of worms that we have. But at least it will remove at least that one barrier.

CO-CHAIR NATHAN: Exactly. In other words, what we know for a fact is, if you are driving to the store to pick up some milk and you end up going through the windshield, that is not in the line of duty. That is clear-cut, and you are going to need some coverage for that. Otherwise, now you are laid up and you can't get the care you need. You can't activate.

You are anxious over activating this weekend, for whatever reason, and you have an ideation of self-harm or self-harm. Put 100 people in a room; 50 of them are going to say that is line of duty; 50 of them are going to say that's not. And so, the possibility exists that you won't get covered

for that.

So, this removes all those possibilities. I think that this doesn't address how you are going to -- we happen to know in the Findings, as Suzanne said, we can put, all else fails, you have TRICARE Reserve, which for the price of a couple of movies a month you can afford. But this doesn't address that. This just simply addresses, do we believe you should have something, whether we provide it or not or somebody provides it, or whatever, but you should have health insurance to be in the Reserves.

DR. STONE: Nor does this preclude the Services from providing additional financial support in order to diffuse the cost for the lowest-ranking Service member. When we examined this with both the head of the National Guard, the Army National Guard, as well as the Chief of the Army Reserve, where most of these young uninsured individuals reside, there was a willingness to at least

discuss the use of some operational funds to diffuse for E3 and below the cost.

So, this doesn't tell them how to get the tactical work done. It does make a statement on the fact that we believe it is absolutely necessary to resolve this.

The fact that we continue to deal with late-arising health issues well beyond the transition points of Service, when you're coming off of active duty as a Reserve component Service member, I think also creates a broader safety net. So, it is readiness. It is safety net, and it is the right thing to do for these Service members. There will be pushback on dollars here, but it is the right thing to do for the Service member.

CSM DEJONG: To clarify the language in the Findings of the LODs, we have not heard over the last four years that someone is not getting cared for when they had an injury in the line of duty. What we are hearing over the last four years is that, as

Dr. Stone has just said, my PTSD symptoms came eight months after I came home. And now, we have to go back -- and a lot of it was in the Air Guard and other places -- now I have to go back and prove, the burden of proof is on me to prove that these hidden injuries have come in the time.

And then, their complaints and their ask for help was, "I need something to cover me in this time," which a lot of times INCAP funds was using, which we can go back to that argument, which we won't. But this is, again, a safety net, and I think it needs to be just a little bit clarified in the Findings, but also pushed very heavily.

DR. PHILLIPS: I would agree by voting yes, it makes a statement that you all have said. I mean, there are requirements to be a Reservist. You have to be physically fit. You have to be medically stable, on and on and on. I think this is just another one of the requirements that I think are very

positive.

CO-CHAIR NATHAN: Okay. Do we have a call for the motion?

MS. DAILEY: Sir, I'm sorry, we might need to extend this discussion a little bit, so that my staff and I understand.

So, they come into the Reserve component. They have got mom and dad's insurance still. And so, they are able to be. And if they fall off the curb running, mom and dad's insurance has got them covered. But if they are injured while in the drilling status -- a truck runs over their foot, for example -- they aren't going to use mom and dad's insurance. They are going to create the line of duty and they are going to go through getting orders. And they are going to access a military treatment facility or be put on the network?

DR. STONE: Well, Denise, I think that answer to that is we are not going down that road. Today many Service-related

problems are handled by private health insurance from an individual's employers, and there is never a question about it. I don't think we have to go down that road because you are going to get into a complexity that is very difficult.

MS. DAILEY: Okay. That makes my Findings very short.

DR. STONE: Exactly.

MS. DAILEY: I mean, it has got one paragraph in here --

DR. STONE: This is a very simple recommendation. But if, in fact, you begin to go down that road of when is LOD appropriate, when is access to MTF appropriate, then you begin to fall into duty status that really creates how Defense Health Program dollars can be spent. Because there is in law, you have to be in a designated duty status to have access to Defense Health Program dollars.

So, this is different. And so, I would keep this as simple and as broad as

possible. Simply, if you take the position of condition of employment, then the rest can be figured out later.

CO-CHAIR NATHAN: I agree, they are separate issues. Denise, the issue you are articulating is --

MS. DAILEY: I am trying to write Findings to support it.

CO-CHAIR NATHAN: Well --

MS. DAILEY: Then, I'm fine with one -- the only paragraph that fits is page 40, the second paragraph. "Requiring Reservists to have health insurance and access to care they need under any circumstances." That is the only one that doesn't have a line of duty in it or doesn't tie it to line of duty.

LTCOL WONG: Right. Because, I mean, as Dr. Stone lamented regarding the situation you are providing, many rights they sign away were for the LOD, because they are going to take it on their own public health

insurance because it is easier. So, I mean, I think that removes that --

CO-CHAIR CROCKETT-JONES: I think that you can make clear that this covers the gap while waiting for an LOD status to be determined. But how they choose to pursue their care, whether they choose to just keep it within the insurance that they have, that we are saying they have to have, or whether they choose to pursue the line of duty and do that, that is their -- then, this only creates that choice. We are not saying that they have to do one or the other.

CO-CHAIR NATHAN: But I understand Denise's point because we are putting the cart a little bit before the horse.

CAPT SANDERS: That's it, sir. We are putting the cart before the horse.

CO-CHAIR NATHAN: And so, what you may have to do -- and this is not palatable to you, I know -- but you may have to go out and build the cart again after we have already got

the horse.

I think there is a consensus -- well, I don't, but I am hearing generally a consensus that, from a mission-readiness standpoint, if your findings were to be that you canvassed 10 commanders of Reserve units and said, "Would it be helpful to you if your Reservists had access to healthcare through a financially-expedient means," usually insurance, to dental care and/or medical care, I think your findings would be an overwhelming yes.

We didn't go down that path because there was LOD involved in it. And so, people started talking about LOD and what's LOD and what's not LOD. And where the conversation has centered here is on the actual verbiage of the recommendation, which is a Reservist will have health insurance.

And so, LOD complicates it, but the complication is where we become sort of mired down is when you have health insurance,

and now, you are trying to decide what insurance you use when you are injured, which is mom and dad's BlueCross BlueShield or TRICARE because you were injured on the job or preparing for the job.

That is a separate issue. That is sort of where your Findings come and go, is arguing over that decision.

CO-CHAIR CROCKETT-JONES: I don't think anyone is concerned that the Findings -- I think most of us would say we are comfortable with the Findings.

CO-CHAIR NATHAN: Right. All I am saying is, if you aren't comfortable with the Findings, then I don't have a problem with you going out after the fact and bolstering it. But, again, I don't think you have to.

CAPT SANDERS: I'm not going to agree with that. I'm not comfortable with the Findings because the cart-before-the-horse part is, as you pointed out, sir, is evident. You are telling folks, as a condition of

employment, they must have insurance, but we are backing that up with saying, "Well, you know, when you get onboard, then you can get this TRICARE insurance which is really cheap. So, you will be okay."

CO-CHAIR NATHAN: No, no. We're just saying we believe there is a mechanism that they can utilize.

CAPT SANDERS: But that's the mechanism we are falling back on. We are falling back on the fact that they can get this TRICARE insurance which will make them okay. And they can use a lot of other things to make them okay later on, but the condition of employment is to come to the door --

CO-CHAIR NATHAN: Right.

CAPT SANDERS: -- with insurance.

CO-CHAIR CROCKETT-JONES: However, it is just the condition of employment doesn't mean condition of being employed.

DR. STONE: So, when I raise my hand and take my oath, I'm not quite yet an

employee because I haven't started serving yet. At some point, I am going to ship. When I ship for my basic training, I am on active duty. I have health insurance, right? I don't start serving before I go to some sort of training. I am not at risk before I go to some sort of training which includes an active-duty stint.

On the back-end of my basic and my AIT, I am going to come off of active duty. And at that point, I have to do something in order to assure that I have insurance.

CAPT SANDERS: Okay. So, I want to join the Reserves. I don't have insurance. Can I join or can I not?

CO-CHAIR CROCKETT-JONES: You can apply.

CO-CHAIR NATHAN: You can apply.

CO-CHAIR CROCKETT-JONES: You don't just join. They don't just take everybody.

CAPT SANDERS: Okay. I was a

Reservist. I didn't have to have insurance before I was a Reservist, before I go on active duty. Today do I have to have insurance to go on as a Reservist before I go to boot camp?

DR. PHILLIPS: For example, I apply to be a Reservist and I meet every qualification except you don't have insurance.

CO-CHAIR CROCKETT-JONES: So, your application has been accepted. Now you must get insurance in order to start your service --

DR. PHILLIPS: But I have no money; I can't get insurance.

CO-CHAIR CROCKETT-JONES: -- and your employment.

DR. PHILLIPS: I have no money; I can't get insurance.

CO-CHAIR CROCKETT-JONES: Employment doesn't start until after the application has been accepted. So, you apply, and now, we have accepted your application.

Now, yes, now you must get insurance.

DR. PHILLIPS: But am I eligible for TRICARE?

CO-CHAIR CROCKETT-JONES: Yes, you can; your application has been accepted. You're eligible.

DR. PHILLIPS: So, it's not like you can't --

CO-CHAIR CROCKETT-JONES: Yes, unless -- with few exceptions.

DR. PHILLIPS: I can take the oath and get insurance?

CO-CHAIR NATHAN: Well, there may be nuances to it. I think we are trying to pole vault over mouse droppings.

(Laughter.)

You know, the nuance may be that you are required within 60 days of acceptance into the Reserves to engage health insurance. The spirit of this is just to create, as I see it, the spirit of this is to create an environment where, more often than not, the

Reserve individual has some sort of health coverage when they are not on active duty. That is the spirit --

CAPT SANDERS: I think the nuance, sir, in those mouse droppings is a big deal. And I think that nuance needs to be reflected in what Denise is trying to figure out in her Findings. And if we vault over that, I think we have made a mistake.

DR. PHILLIPS: Yes, I agree 100 percent with the spirit of it. I just don't want someone else to misinterpret the fact that, my God, you don't have insurance; you are not eligible. Don't even bother to apply for the Reserves. So, it is just a language -- well, it is something in the Findings that we have to massage.

LTCOL WONG: Maybe it is participation in a Reserve component unit, is the right wording for it.

MS. DAILEY: To continue service --

LTCOL WONG: Or continued service.

MS. DAILEY: -- as a Reserve component member --

LTCOL WONG: Or upon transfer to a Reserve unit, a Reserve component unit.

MS. DAILEY: Health insurance is required.

MR. DRACH: I would like to bring up something on the LOD. Most, if not all, private insurers have or had a war risk clause. So, if you have an LOD issue that has not been determined, and the Service says, "Not LOD," or they haven't made an official determination, and the private insurer says, "Uh-uh, this was caused by the military. We're not going to cover it under the war risk provision," is that an issue? Is that a concern?

CO-CHAIR CROCKETT-JONES: You know what? I think that it might be a small one. But I think, in general, if you have insurance and you present yourself to receive care, you

are treated, and then, the matters of payment and coverage are then -- you have a timeframe that is significant to resolve that. And you would be in the same process of resolving whether this was an LOD, and there would be time to get those issues resolved.

I think if you don't have insurance, for some injuries you would just have to fork over the money, which they might not have. And therefore, they might not seek treatment at all.

DR. STONE: So, if I am placed in combat, I am in a duty status on active duty, there are no Reservists not on orders that are deployed to combat. And when they are placed on orders, they are automatically placed into the active-duty healthcare system.

And by the same token, we worked bunches of these over the years as part of my Reserve component work. And I will tell you, never did I have a health insurer refuse to grant access to healthcare when someone was

insured. And then, they resolved it afterwards of sort of who was liable for the bill. And that was really virtually invisible to the Service member.

CO-CHAIR NATHAN: So, Captain Sanders, what is your recommendation on this?

CAPT SANDERS: I just have two scenarios that keep coming back to me. I had a Reservist who left his Reserve time to go home, to come back on active duty, and drowned in between. It was not covered by any of his insurance policies because he was not in a line-of-duty status because he was in between the two Reserve blocks. And unfortunately, he didn't have adequate information for himself and his family. It was life insurance, not health insurance, because he was dead.

CO-CHAIR NATHAN: Right.

CAPT SANDERS: The second scenario is I was a Reservist as well, and I came from civilian life to Reserve life. When I went to boot camp at Great Lakes, I went in an active-

duty status and I had insurance.

Would I have been able to do that if this requirement was in place? Would I have been able to come from civilian life without insurance to boot camp? According to the comments, yes, this is not an issue; it is a nuance issue. I'm not so sure.

CO-CHAIR NATHAN: The Reserve response agrees with you. The Reserve response says, "Hey, this is going to adverse in the Reserves because people are going to balk and say, "I don't want to do that." Okay?

So, I look at that as a legitimate -- a legitimate -- con to this, a con. You had decide if that is outweighed by the fact that enough people will get insurance by requiring it that the mission readiness that is improved and the issues for the commander being able to get their people up-to-speed and activated outweighs the few people, if there are few, that will not come into the Reserves.

So, that's how I see it.

CO-CHAIR CROCKETT-JONES: So, if the language is, Lieutenant Colonel Wong had said, upon transfer to your first, to a Reserve unit. That would give folks the time between their training and their first unit to acquire that health insurance.

LTCOL WONG: And there are some gray areas. I mean, maybe it is that they don't have it, that it is provided to them. I don't know if that is the wording we want to, because there are those gray-area Marines like, when you finish boot camp and you go back to your Reserve center and you check in, I have this one case that we have exactly.

The Marine went to boot camp, went to his MOS school, checked out, drove back to his Reserve unit, checked in, checked out. Now he is on Reserve duty. "Hey, do you want to track your Reserve slip?" "No, I'm good. I don't need it." Drove to his parents house. Got in a car wreck. Not covered because he is

now offboard because he is checked out of his unit.

His parents covered him initially under their healthcare. Then, they capped out and they couldn't provide any other healthcare.

CO-CHAIR CROCKETT-JONES: Well, I think that the answer to this is --

CO-CHAIR NATHAN: And he went to the Marine Court, and he said, hey, he was kind of in the line of duty. If he would have gotten into an accident two hours earlier, because he got in the accident at 2:00 in the morning, because his orders expired at midnight, even though he had checked in and checked out of the unit. Because it was that two-hour gap, he is no longer covered.

CO-CHAIR CROCKETT-JONES: Well, and we already know that there is in the Services a willingness for those E3s and below to get help with that. I mean, this has already been a topic. We just heard General

Stone talking about that.

So, I think that if we slide it to report to, you know, by the time you report to your unit, then folks will have had time to receive a paycheck and start paying for TRS, even if they have no other means.

LTCOL WONG: Like SGLI, it is automatically taken out. I mean, so they would have to opt-out. So, I don't have a problem with saying, if they don't have it, it is provided to them. Now, if it is offset cost or not, like commanders want to do with their own funds, I think that gets to the sausage-making, but you make it as an automatic enrollment.

CO-CHAIR CROCKETT-JONES: I think that, yes --

CAPT SANDERS: I'm more comfortable with that, and I am sure that Denise can craft the Findings to reflect our discussion that fits into this box.

MS. DAILEY: Well, my

recommendation was, if you want to make a requirement, the language should be, if you don't have health insurance when you come into the Reserve, and then, you are required to have TRS. Why are we not making TRS mandatory? Why are you not making a recommendation to make TRS mandatory --

CO-CHAIR CROCKETT-JONES: I would --

MS. DAILEY: -- or other --

CO-CHAIR CROCKETT-JONES: Or other.

CO-CHAIR NATHAN: Or other.

CO-CHAIR CROCKETT-JONES: I think that that a legitimate language.

CO-CHAIR NATHAN: And I know you're not wild about the nuances, but at the end of the day -- see, because as a medical guy, and I'll put my biases right out there, it frustrates me that people will spend $50 a month on Call of Duty 3, but not on healthcare insurance. And it is what is eating us alive

in this country. We don't have the problem in the military, active components, but it is eating us alive because we are paying a hefty price for the uninsured.

And then, they, themselves, are becoming bankrupt and destitute if they don't have insurance and have to go through a payment plan and everything else.

I think we are better than that in the military, and I think we should expect better than that from our personnel who, one of the conditions of employment in the Reserves is that you stay fit; you are not allowed, in theory, you are not allowed to gain 100 pounds in between active-duty status and, then, lose it all. You're supposed to be fit at all times.

And I believe one of those things that is incumbent upon you is to have access or capability to fund incidental illnesses or injuries that occur to you when you are not on active duty.

The good news is we make an affordable thing available to you. I think your point is great one, that we need to define it, so that, no, Mr. Jones, you do not have to have, as you walk into the recruiting office, you do not to have health insurance that day. But if we accept you into our program, if we make you a Reservist in the United States military, you will be expected to have health coverage that covers you for things that are not related to active-duty service or activation. And here's the good news: TRS is available to you at that point.

So, that is my bent on it, and I am very happy with rearranging the wording to make sure that it reflects that. You transfer to a first Reserve unit. Is that the case or to a Reserve unit?

LTCOL WONG: Their Reserve unit I think would be fine. I don't think we have to put "first".

CO-CHAIR NATHAN: So, you can

remove "first" I think and just the Colonel said "transfer to their Reserve unit" or "to a Reserve unit". "To a Reserve unit."

CAPT SANDERS: "A Reserve unit," so you can catch folks who are re-upping and doing other things along the way.

CO-CHAIR NATHAN: So, Denise, now that we have that worded like that, how are you comfortable with your Findings?

MS. DAILEY: Yes, I'm good with it. I am going to pull most of that line-of-duty stuff out of there, okay? Because it seems to confuse the issue.

DR. STONE: So, I'm uncomfortable with including TRS as a designated insurance. And the reason I am is some policies TRICARE has that, if you miss your payment, you are not eligible to re-enroll for a year.

And so, the idea was to keep this as broad as possible and say, "You're going to figure out how to get health insurance if you want to be a participant in this program."

And it goes back, sir, to your comments of this is just part of what we expect of our individuals.

CAPT SANDERS: Well, rather than run away from that as a particular source, because it sounds to me like --

DR. STONE: You should not perceive any running.

CAPT SANDERS: Well, whether they move away from that as a particular source, as opposed to running from it, why don't we just identify that as an issue, and there are other issues that need to be addressed with this process?

DR. STONE: So, the main thing is we begin to get into the nuances of how to administratively do something that the Department ought to be able to figure out how to implement.

CAPT SANDERS: Well, one of the things I keep hearing, as we hang our hat on this, is that this particular insurance is

such a boondoggle for the kids to get, and it is the best way to go. And now, we are stepping back from that.

And the conversation all the way through has been, at least from my understanding, that this is such a good thing and such an easy way to go, that we should not have a problem with this. We should not worry about this as an issue because we can all get there with this TRICARE Select. And now, we want to step away from that. That is problematic.

DR. STONE: I don't think there is ever a step away from it because it was not in the original recommendation. It was simply a condition fo employment that you had health insurance, and then, you allow the Department to figure it out.

CO-CHAIR NATHAN: Rich, what about, instead of saying "automatically enrolled in TRS, unless they have other private health insurance," what about "enroll

them in TRS or other private health insurance."?

DR. STONE: And so, one of the problems we have had with TRS is if there is a problem in payment and a delay in payment, there was an administrative policy that --

CO-CHAIR NATHAN: Right, but they are going to have their eyes open.

DR. STONE: Okay.

CO-CHAIR NATHAN: In other words, if you say TRS or other private health insurance, then, basically -- and again, this is a nuance, which drives Captain Sanders crazy, but the devil is in the details. And part of the details would be that part of your counseling, as you join the Reserves, is here you must have health insurance; here are your options. One of them is TRS. Be advised, if you decide to subscribe to TRS, here's what happens to you; if you don't make your payment, they're going to bounce you for a year. Remember, if they bounce you for a

year, you're going to have to run over and get other health insurance because you are not allowed to stay in Reserve status if you don't have health insurance.

MS. DAILEY: Automatic enrollment means it is being pulled out of your pay. You don't have a choice. You are not cutting a check. You have designated a --

DR. STONE: You know, TRS does not work that way. TRS has a third way of pay. Yes, it is check, money order, Visa, Mastercard. It does not come out of the Defense Accounting System.

LTCOL KEANE: I would like to throw a wrench into this.

CO-CHAIR NATHAN: Why am I shocked?

LTCOL KEANE: So, you've got a Reserve Marine or a Reservist who hates driving 100 miles. You know what? I know how to get out of the Reserves. I'll stop having a health insurance; I'm required to have it.

So, I cut it out. Now I'm out of the Reserves. I think it's un-American to require them to have it.

(Laughter.)

CO-CHAIR CROCKETT-JONES: Well, isn't that the same guy who now he has lower back pain. So, he is not part of readiness, but he can stay in the Reserves? Isn't that a potential on all these levels for people to abuse systems that are in place that effectively are positive in a large way?

But, right now, a guy gets to stay in the Reserves and maybe he doesn't have to deploy because he never got his dental done, and we don't say, because he didn't have dental insurance, and now, basically, somebody has got to pay for him to -- do you see what I'm saying? There's always going to be layers for potential abuse for people who don't want to do their duty, even though they signed up and they're taking the money.

I don't think that we can use

potential abuse of something as a consideration for whether this is the right or the wrong thing to do. You might still say it is the wrong thing to do, but --

CO-CHAIR NATHAN: It comes down to supply and demand, right? I mean, it really does, because we temper incentive programs and restrictions based on how hard it is to get in or stay in.

You could equate this to a family care plan to a single parent, right, or to dual military? We require them to have a family care plan, and they simply refuse to have one. And they say, "No, this is how I'll either get out of the Service as an active component or a Reserve component. I refuse to do a family are plan."

And we say, "Well, then you've got to leave because we require that. Because we may deploy you at a moment's notice, and we need to know, we need to be comfortable that you have somebody to look after your kid."

I see the same thing here. You know, you may get injured or ill in between an incidental finding. We require you to be able to get healthy and take care of yourself. And if you need physical therapy to strengthen your orthopedic injury again, so that we can get you back to duty sooner than possible, but it is not on us to buy that for you. It is on you to buy that for you. Here's the good news: We make it affordable for you. That's how I see it.

So, I understand that you are echoing the sentiments of the Reserve community which is saying, "Hey, this may be ideal for you to keep the most fit fighting force and ready force, but it is going to negatively impact our ability to either recruit or maintain Reservists."

And my answer is, "I believe that. I believe that." The question in my mind is, is the fit-and-ready force going to outweigh the negative people I'm recruiting? So,

that's how I look at it.

TSGT EUDY: Denise, regarding the Findings, from our visits to JFHQs, talks with the National Guard Bureau, CBWTUs, to help set the tone of the Findings, I know we had plenty of conversations regarding surgeons or commanders dealing with Service members in those situations. So, perhaps some of the language from that can be used to increase the subsidy in that paragraph. But I know we had plenty of visits. I remember being on several with both Karen and Dave on that one.

MS. DAILEY: The Colonel, the National Guard will validate the fact their biggest problem is the young National Guardsman with no insurance, no family, and their injuries and accessing care for them. So, yes, we will go in that direction. You're right.

CSM DEJONG: And I would like to keep the first paragraph on page 40 into the Findings, which does highlight the problems of

long-term injuries, the PTSD injuries that we have heard so much about over the last four years of being hard to prove, and then, put the spin on that as to at least they can get care for their illnesses or their conditions while that is being proved into LOD status.

CO-CHAIR CROCKETT-JONES: And here is another fine point: "automatically enroll them" could be replaced with, semicolon, "either NTR or other private health insurance," and we would have not specified.

CO-CHAIR NATHAN: General Stone is not here, so he is not allowed to vote against it.

CO-CHAIR CROCKETT-JONES: I have his proxy.

CO-CHAIR NATHAN: Oh, yes. Everybody has a proxy.

CO-CHAIR CROCKETT-JONES: I'm sorry, General Stone gave me his proxy.

CO-CHAIR NATHAN: Now you can't all have his proxy, I think, unless this is a

Chicago election.

(Laughter.)

Okay.

Any more discussion?

LTCOL WONG: And if this is accepted, we have already discussed that in the Findings it will set the tone for this is to increase unit readiness; it is an additional requirement like family care plans.

CO-CHAIR NATHAN: This is what Tech Sergeant Eudy and the Command Sergeant were talking about, which is there are things scattered throughout that we can use to distill Findings that would support this.

LTCOL WONG: And then, this does not replace the LOD process as well.

CO-CHAIR NATHAN: No, it does not replace the LOD process.

CO-CHAIR CROCKETT-JONES: Exactly.

CO-CHAIR NATHAN: No.

At the risk of somebody saying "yes," is there any further discussion on

this?

(No response.)

So, do I have a motion to take this to a vote?

CO-CHAIR CROCKETT-JONES: Do we have enough people?

CSM DEJONG: I would refer to three members; I don't think we have a quorum.

CO-CHAIR NATHAN: Oh, we have three members out?

MS. DAILEY: Staff, go find my three members, please, if they want to be in on this vote.

If you would like to vote, you have your Designated Federal Officer's authority to go forward with a vote.

CO-CHAIR NATHAN: I'm worried about offending Captain Sanders' sensibilities as an attorney. We will wait another minute and see.

MS. DAILEY: The other word we might want to put in there is, "as a condition

of continued employment".

CO-CHAIR CROCKETT-JONES: Yes, yes.

MS. DAILEY: "Continued employment"?

CSM DEJONG: That's fine with me. Do you want to put "initial and/or continued employment"?

CO-CHAIR CROCKETT-JONES: Not "initial".

MS. DAILEY: Yes, not "initial". There's too much opposition to "initial".

CO-CHAIR CROCKETT-JONES: Okay. So, the language that we have gotten to is, "Upon Reservist's transfer to a Reserve unit, require health insurance, TRS or other private health insurance, as a condition of continued employment in the RC."

Does anyone move to vote on this recommendation?

CO-CHAIR NATHAN: I think we had one, right? Didn't you?

CSM DEJONG: So moved.

CO-CHAIR NATHAN: Yes, and we had a move. A second?

MR. REHBEIN: Second.

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

All those who abstain? Or, I'm mean, that's right; I forgot. All those who say no?

MS. DAILEY: I need my yeses up again.

Okay, thank you.

CO-CHAIR CROCKETT-JONES: All right, the recommendation will be included. I think that we are at our lunchtime.

MR. DRACH: Yes, one o'clock.

CO-CHAIR CROCKETT-JONES: We will be back here at one o'clock.

Thank you.

(Whereupon, the proceedings went off the record at 12:07 p.m. and resumed at 1:08 p.m.)

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

1:08 p.m.

CO-CHAIR NATHAN: Okay, welcome back.

This recommendation for discussion addresses health insurance for the Reserve component Service members. This recommendation states as follows:

Whoops, I'm on the old one, deja vu all over again, Ground Hog Day. Ground Hog Day.

MS. DAILEY: Go to three o'clock.

CO-CHAIR NATHAN: The last recommendation for discussion covers expanding the access to care. The recommendation states that, "In order to expand access to care for Service members and for veterans, provide an option to use Medicare, TRICARE, or CHAMPUS VA.

At this time I invite members to move to adopt this for discussion.

DR. PHILLIPS: So moved.

MR. DRACH: Second.

CO-CHAIR NATHAN: Up for discussion is the proposed recommendation that deals with expanding access to Service members and veterans, providing an option for them to use to Medicare, TRICARE, or CHAMPUS VA.

Does anybody want to discuss the genesis for this or what we believe the basis is after looking at the Findings?

DR. PHILLIPS: I can start off, and I think I was sort of instrumental in moving this along.

This is based on my own personal experience, but mostly based on what we have seen in our travels and interviews. The access, not the quality -- the quality of care is excellent. The access to care has been difficult for Service members, either in a DoD facility, which is not as difficult as perhaps some of the VA facilities, basically because of distance to many of the VA facilities.

Just trying to think through a

simple solution perhaps is too simple. Since it is the same pool of money, tax dollars, that support DoD, TRICARE, VA, why not let those folks that are eligible, the Service members that are DD214, or even perhaps that are still in the ranks, those that are eligible for VA/CHAMPUS VA, TRICARE, DoD care have the option to be eligible for Medicare?

And I can go into some of the more reasons. Folks waiting a long time to get a hernia repaired, out of work, because the waiting list is three to six months, and issues like that.

CO-CHAIR CROCKETT-JONES: I have a question. I know that Medicare enrollment happens at a certain rating. When my husband was medically retired, he became eligible for at least part of Medicare. And I am wondering how that figure in. Who is and who isn't enrolled in Medicare now in this process? So that I understand where we stand.

MR. DRACH: Well, in order for

somebody under age 65 to get Medicare, he or she must be on SSDI or SSI for two years. After the two-year waiting period, then they're eligible for Medicare.

DR. PHILLIPS: Yes, you know, I wanted to keep it simple.

CO-CHAIR CROCKETT-JONES: I just wondered, you know, who we already had on that, but now I see, it is because of the SSDI that went over two years in the process of his medical retirement and the process of IDES.

DR. PHILLIPS: So, that's how he met the --

CO-CHAIR CROCKETT-JONES: That's how he met the criteria. Okay, I understand now.

DR. PHILLIPS: Again, not to be too redundant, if you served and you're eligible for VA or TRICARE or DoD, for as long or short a period that you're eligible for, in order to make it easy, you automatically are eligible for Medicare.

I know you can go and get approval, but you have to make an appointment. You have to see somebody. They have to say, okay, you're approved or not approved, as opposed to just being eligible.

CO-CHAIR NATHAN: So, Dr. Phillips, I guess playing the devil's advocate, I would ask you, do you think that this has sort of become overcome by events, given that now there is a tremendous internal and external effort going on to try to find what VA -- we can talk about DoD, the military facilities in a minute in healthcare -- but the VA system, and, Karen, I would be interested in your comments on this.

You know, we are talking about expanding access to care. And it would seem to me that that has sort of exploded now in the VA system at least, as they now look for what the way ahead is going to be. And I think most people who know anything about it recognize that 95 percent, if not higher, of

the VA hospitals are dedicated, hard-working, doing great work every day.

There was a small percentage of those that had an integrity issue where they were gundecking and sort of fiddling with the stats to look better than they did in the local area. And that sort of brought the house down.

But that's my question: do you think that this is still something that we need to light up in our report, given that it is kind of lit up already, given the current events?

DR. PHILLIPS: Well, I do, and I think, obviously, what you are saying is correct. I think that is part of it.

Personal experience, I practice cardiac surgery in Des Moines, Iowa. I was voluntary Chief of Thoracic Surgery at the VA Hospital, which was a wonderful hospital down the street. Every week I would sit at cardiac conference and recommend surgery for a small

group of patients, who were, then, shipped off to either Texas or Milwaukee to another VA facility that did surgery.

And families would come to me and say, "Well, there are three other programs in town. Why do we have to fly off to somewhere else?" And the response would be, "Well, it's part of the VA budget."

And so, after a year or two of this, we started accepting -- I mean there was a contract -- we started accepting patients.

I mean, that is perhaps a small example, but it was access to care. And so, this is, again, an issue of access to care which happened recently, in addition to the people that live remotely from a VA hospital or a DoD facility.

So, again, it is not the quality of care at all. It just the access. So, trying to think of a simple solution based on my own personal experience, and budget-wise, it turned out, at least for my practice, it

didn't cost the VA any more to just have them done in town with a contract, as opposed to flying them off with a family member and staying somewhere for two or three weeks, or whatever.

And again, the same pot of money. I don't know what it costs per patient per year to have VA or DoD care. The numbers I looked at were around $10,000 to $15,000 per person. And, of course, I don't want to compare apples and oranges. Medicare costs per person on the Medicare rolls is about $6,000 a year. So, it is a little more, but the disease and the injuries are a little more.

I would just think, looking at a simple solution as a stop gap for what is going on right now, and as a long-term solution for people that don't have physically access to care, and as things change, people can at least have the option to go one of the three.

MS. MALEBRANCHE: You know, we are in the middle of this change, obviously, right now. But one of the things is all the VAs are TRICARE providers. I mean as a space-available sort of thing. So, that is already a given there.

The access issues, like the Admiral said, are in certain places and, also, because of the timelines of within 14 days, within this amount of time. There are some things right now at work. So, the recommendations, whatever we do might be superseded by some congressional action.

But the VA does have a number of options in the ways to do things, like you are mentioning, Dr. Phillips, because there are fee basis when it is unavailable, depending on the specialty. Also, we have a new, what they call, PC3 contract. I am trying to remember that acronym. I will have to look it up for you, Suzanne. But we have contracts with TriWest, and Health Net just won those

contracts. So that, in an area where there is not enough specialty care, that the facility can outsource that to those contracts.

And the other thing that we have that is not listed per se up here that has some bearing on this is Dr. Woodson and our Acting Under Secretary for Health did discuss the possibility of using sharing agreements and resource-sharing. So, where there is capacity at one, perhaps VA can use that, but it also depends on the specialties, because still being support of GME, which VA has always been, and working with the university hospitals to continue using various different sources.

One of the things you're suggesting -- I know in Augusta we had cardiothoracic agreements with the Medical College of Georgia, with Fort Gordon, and with the VA. And so, there was a three-way agreement.

So, we still have a lot of things

available to us to do exactly that, so you don't drive by three hospitals to have someone who needs the cardiothoracic surgery.

So, I am not sure in order to do this that we need to actually do this, because I think we already have it. I'm not sure, but I think we have this.

DR. PHILLIPS: Let me just add to it, and not in a disagreeable way. I was trying to make as seamless as possible, just automatic, as opposed to having to create a contract in an area that may not have a contract, be approved by perhaps a VA or a TRICARE doctor or administrator, waiting to get that appointment, to get permission, to get approval.

I said this before. I'm 74 years old, or I will be next week, and I can go to any VA hospital, any DoD facility, or any private hospital at will without having to fill out any paperwork or request anything. And why should I, at my age, have better

access to care than a 22-year-old that lost two legs or just served without any real injury, but is deserving of that? And that is the way I was looking at it.

CO-CHAIR NATHAN: So, from the DoD standpoint, as you know, it is a little different than the VA, in that in TRICARE, if we can't get you -- and I realize this is an imperfect system -- but, in theory, if we can't get you to care within the time parameters that we have promised you, especially if you are TRICARE Prime, if you enroll to us, which means 24 hours for an urgent issue, seven days for a routine issue, and 30 days for an elective issue, we buy you that care out in the community. Or you can elect, if you are a family member -- active duty must enroll to the MTF. If you are a family member or a retiree, you can enroll to TRICARE Extra or just basic TRICARE Standard, which allows you to pick and choose from among civilian providers. Ironically, often they

can't get you in any faster than we can.

So, I don't know that this is -- I think this was more critical to the VA than it was to us. We are undergoing a huge review now in the MHS, in the Military Health System, as a result of a couple of things, not the least of which was -- and I don't think this is any big secret.

So, the VA started having some issues, some high-profile issues. The Secretary of Defense was concerned, could my agency have similar issues? In other words, is it possible that what my local facilities are saying is not true and my central reporting agency is telling me that access is good and quality is good, but maybe it is not true at the local level because people are sort of hiding things?

That made SECDEF nervous because sort of would they be catching the "VA flu" in that regard? And again, I emphasize that, in my personal opinion, this was a very small,

small piece of the VA system. The overwhelming majority of it has tremendous integrity and dedication.

Then, the second thing that happened was a New York Times reporter decided to write a series of articles that are not very complimentary of military healthcare. This is apart from VA healthcare, military healthcare. That made the Secretary of Defense even more concerned and nervous.

And then, when the Army relieved its command element at Womack Army Hospital at Fort Bragg, the Secretary of Defense said, "Enough is enough. I don't know if we have real problems or not, but I'm not going to wait to find out," and has instituted a review, a very thorough one that is due by the end of August that is basically a FOD walk.

A FOD walk, for those who don't know, is where you walk down together in a line looking at an airfield for any foreign objects or debris to make sure nothing gets

picked up by a rotor blade or an intake. So, it is a very meticulous inch-by-inch look at the airfield to make sure there is nothing lying around.

We are at a FOD walk of the military health system, looking at, specifically, how do we measure standards of access, quality, and safety? So, this is why, from my perspective, I am looking at it saying, gosh, this is just what the doctor ordered probably six months ago. But now, the events that have transpired, both initially in the VA and now that the MHS, Military Health System, is getting swept up on the VA concerns as well as media concerns, as well as some high-profile hospital issues, we are sort of turning all this over.

We have brought external reviewers in from the outside to help us look at our own system in the Military Health System. We believe that our data is accurate. We believe what we are saying centrally is true. We

don't believe we have a gap from our facilities.

But that is why I bring up the fact that, just coincidentally or ironically or incidentally, however you choose to look at it, the VA and the MHS now are all in, if I can use that term, they are all in and looking at how we are providing access, whatever.

I understand your concept, which is, okay, got it; everybody is all in, but just makes it very easy. If we just say, "Hey, look, anybody who's eligible for the military healthcare or VA healthcare, find a Medicare provider, find a CHAMPUS provider."

I'm not confident in making that assessment yet or that recommendation until I see where the VA lands on their assessment of their access and what they think is best and where I see the Military Health System land on how its access is best. And what is the real challenge; what is the real truth?

So, that is my concern about this

one particular --

CO-CHAIR CROCKETT-JONES: I also wanted to point out to you, I know that, to your question, you're 74 and you have access -- almost -- and you have access to more choices than someone who is maybe a very seriously-injured 22-year-old vet. But you have also paid into Medicare for 50 years more than that vet has. So, Medicare is not something that you don't contribute to through the course of your employment.

I'm not saying that that's a reason to -- but, yes, it is a small amount, but over time those amounts build up. And I am not saying it is a reason to nix this. I am just saying that that is a consideration.

My concern right now is that I think Medicare can sometimes be confusing. Its benefits can be sometimes incomplete. There are different parts. Some require copayment. What is covered by what? It is a little more complicated, I think, and I am a

little concerned that there might be unintended consequences.

That is the one thing that, since we have started talking about this, that I haven't felt clear and comfortable about, is that I don't know enough about Medicare and benefits to know if there isn't some hidden minefields on veterans winding up using it, and then, not having the coverage they thought they had or not being able to, then -- you know, will Medicare become the secondary insurance? Will that affect their TRICARE benefits because now they have, you know, once they enroll -- I'm just worried that there are some regulatory minefields that I have not -- because I don't understand how they work.

DR. PHILLIPS: Obviously, there can be many issues associated with this. I think the number of people that would be accessing this would probably be small; therefore, a small budget.

And, of course, it is hard to

compare, not going to the VA, how much money they save by not seeing a particular patient and, then, going to a Medicare provider.

Just in my mind, and I'm not trying to disparage the military or VA healthcare system -- I think it is an excellent system. I go to Walter Reed routinely. I just don't see, when you balance everything, I don't see really a downside to recommending something like this, which will probably get turned down anyway. But I don't see a downside to recommending something like this even as a stop gap for what is going on right now, until everything is sorted out. It is going to take six months, a year, or longer to sort out the issues.

And the other aspect of it -- and I don't know how important this is -- whether it is real or perceived, the public has perceived this as a very negative event, what has happened in the VA and now with the Military Hospital Systems. And I don't really

agree with it, but that is the way it is written up and that is the way it is perceived.

And perhaps in some obtuse way this is an answer from our Committee to say, "Listen, we understand there's an issue. Let's do this. And when the system is fixed or improved, it can be taken away."

That's just my thoughts and my argument. I don't see a real downside to it, but --

DR. STONE: I'm feeling uncomfortable from the following point: we are a DoD committee. Therefore, our focus has been on Service members and, as Admiral Nathan has already pointed out, all of those Service members have access through TRICARE and can either choose MTF-based care or private access to care.

What this really is is about solving a problem within the VA. And I am feeling uncomfortable with us making that

recommendation. I happen to believe that part of the solution to the VA's problems are placing them under the same pressures that the military healthcare system is today, where it has to go out and earn your trust.

So, specifically, you are talking about a subset of veterans. And I am just thinking we are solving a problem that is beyond our charge and which already has tremendous attention of the American public, as well as the American Congress and leadership.

So, I am feeling pretty uncomfortable with this one as it is.

DR. PHILLIPS: Well, I know there is legislation with the thoughts about, if you live more than 40 miles from a VA hospital, you have other options, and so forth.

Well, whatever; I just wanted to express my opinion.

MS. MALEBRANCHE: Yes, I think it is similar, though, in VA. And you're all

right in that it is going to take a lot earned-back trust. But, in terms of the VA, when people are part of that system, they have the VA; they also have, many of them still have the MTF. They have TRICARE. Where the VA cannot provide the care, they have fee basis. And now, the VA Administrators, Directors, have access to another venue of this PC3 contract. They have the sharing agreements. They have agreements with universities.

We have had this issue of the appointments and the waiting times and those things. And the VA does not have the TRICARE for life. So, people often have a menu of options. But perhaps the group that we're talking about, the Recovering Warriors, or the younger ones, may not have Medicare. Some may if it has been over the two years with the Social Security piece.

So, I don't know that we can expand any more other than the whole issue of

the timing. Like if you need to have an appointment, those access times, those times are pretty critical for your specialty care, for routine care, those sorts of things, which is what the VA is looking at right now.

So, I don't know that it offers a lot more by saying they can do Medicare because, frankly, if the VA can't get a neuropsychiatrist in "Wherever, Montana," chances are there's not one there anyway. I mean, you know, you don't have all these places. And the VA has facilities in more rural places oftentimes than DoD.

So, there's a lot of nuances of this, and I am a little uncomfortable in it, but I am not sure that we can put out for the others. I mean, I don't know if it is expanding access or creating access.

DR. PHILLIPS: I'm getting the message.

(Laughter.)

Again, I just don't see a real

downside to doing it.

CO-CHAIR NATHAN: Well, let me, first of all, compliment your perception and your desire. You recognize that there are access problems. I think we are all agreed on that.

What I don't know is, is that the best answer, Medicare, TRICARE, CHAMPUS VA? I don't know if that is the best answer.

I agree with you, Steve. I think you have hit on something that needs a more creative solution. What I don't know is if there is something better than Medicare/TRICARE. And combining what Karen and Rich Stone said together, there are people at work in the VA right now who are talking to the Medicare people, who are talking to the federal employees' benefit unions, who are talking to Aetna and other private insurance companies, and are crafting solutions that are probably more erudite than we have access to. So, it is not really in our purview.

And then, secondly, there are second- and third-order effects that have to do with the way we fund our TRICARE plans and our TRICARE supplemental plans that are beyond the purview.

So, you have me as far as, if we wanted to make a recommendation -- and I think we have done this over the years, so I don't know if it is necessary -- but if you wanted to make a recommendation, we need to have more creative solutions for expanding access across the MHS and the VA and the veteran population. That is true. The Surgeons General are united in that our patients don't get the access they need, especially those who live outside our catchment areas, who live in what we call sort of the interstitial space or the white space. That is true.

What I just can't sign up for, me personally at this point, is saying that I am comfortable as just a Task Force member saying that the best thing to do is throw out to

Medicare, TRICARE, CHAMPUS VA, because I would love to hear Medicare stand in front of us or CHAMPUS VA stand in front of us and say, "Boy, would this help us. Thank you for doing it because this is what we need." Or would they stand in front of us and say, "And this is the last thing in the world we need, is to try to take care of your population."?

So, I just don't have enough data to tell you that that is the best solution. I agree wholeheartedly with you that there is a problem. I think it is being looked at. And whether it will be fixed or not I can't tell you. I just can't in confidence recommend that particular solution set because I don't have the data, the findings, or the experience talking to those people to see if that is what they think is best.

CAPT SANDERS: Without going into the solution or recommendation to the solution of the problem, is it incumbent upon as a body looking at these areas to recognize the

problem and to state the fact that we have recognized the problem someplace other than in a recommendation?

LTCOL WONG: It is a pernicious --

CO-CHAIR NATHAN: Well, we are technically a Recovering Warrior Task Force. So, do we believe that Recovering Warriors have, that subset of the military, the Recovering Warrior who is also a veteran or who becomes a veteran, has access problems? And I think we know, through certain dramatic anecdotal issues, that it does happen on occasion. We see people who can't get into mental health, who have PTS and dramatic things happen as a result. So, we know that.

But, if you believe, as a Task Force, that our Recovering Warriors -- and that includes the individual who, from the minute they are injured or ill to the continuum of care when they are transitioned to either the VA or private sector, isn't getting the access they need -- to answer your

question, we can decide if we still feel that needs a recommendation to call attention to that.

CAPT SANDERS: Or something less than a recommendation.

CO-CHAIR NATHAN: Or something.

CAPT SANDERS: And I would say your span of Recovering Warrior-ness in terms of the injury moment through the end of the cycle, I think any part of that cycle that we think is significant is something that we need to address, since they are a Recovering Warrior the whole time.

And if we see that as an issue, whether we decide to put an answer to it, I think we also have a role as an issue-spotter, and to lay those things out, in someone said in a pernicious way -- someone used another word a minute ago -- and lay that into the body of the document that goes forward.

And I am not quite sure how you would lay that out, Denise, but as a though

process, is that something that fits into the way we have done business?

MS. DAILEY: Well, yes, you have got several issues in the introduction, Chapter 2 -- is that correct? -- Chapter 1. You have several locations in Chapter 1 where we have said you need to continue to watch PTSD; you need to continue to watch your EHRs. We added yesterdays Centers of Excellence.

Now we have built quite a body, a knowledge of these three issues over the last four years. Yes, we could put it at that location. It would be a one-liner. I don't have a lot over the last three years about it, but, yes, we can put it in the introduction. We can put it in Chapter 1 and say, "Continue to monitor your access issues and consider Medicare possibly as an option." That is what it would consist of.

DR. PHILLIPS: Before we vote it down, I just want one final comment.

(Laughter.)

It is my surgeon's culture and personality that I want to fix it; I don't want to discuss it. You know, it's bleeding. Let's stop the bleeding and we will figure out how to fix it later on.

CO-CHAIR NATHAN: I appreciate that.

MR. REHBEIN: One comment for the staff, if they are going to put this the pernicious issues area. One of the groups of Recovering Warriors that has not been addressed here today is those of the Reserve component. The problem is not as big as it was, but many of those Reserve component people came back home to states where geographically access to the VA was difficult. And it was their only choice because they were sent home to go to the VA.

And so, that is a group that really needs to be kept in mind. It is not just waiting time for appointments. It is not just access to specialty care. It is the fact

that a 25-year-old National Guardsman has to take most of a day off work to go to the VA for a one-hour appointment. That makes it hard to continue employment.

And so, there is that group out there that I think we need to keep in mind as we do whatever we decide to do in Findings or pernicious issues. I think there is basis there for the need for continued attention to the problem.

MS. MALEBRANCHE: You know, actually, Mr. Rehbein, you reminded me of something, too. Just a sidebar for one second, a little tangential here. I do like Medicare as an option for those. I think that is at least another venue.

But one of the things that is being explored, and we haven't talked a lot about in this or put a suggestion in, but telemedicine for those rural areas is a huge, huge thing. And I think probably more ought to be putting it out. Because, for that hour

appointment, you can have a specialist, I mean far away, too far to travel, but not take so much of the Service member or the veteran's time by doing some of the telemedicine.

And we haven't done much as a committee for that. I know people are working it, just not working all that fast. But that is a huge area to consider.

DR. PHILLIPS: It works very well in certain areas like dermatology, and so forth. Behavioral health is a little different. But it is something that we do a lot at the NIH.

CO-CHAIR NATHAN: I think I speak for everybody when I say the most astonishing fact that has been brought up so far is that you're 73 years old.

(Laughter.)

Okay. Any further discussion on this recommendation, on this submission for a recommendation?

(No response.)

If not, I need a motion, if someone so desires to vote this up or down.

DR. PHILLIPS: So moved.

CAPT SANDERS: So moved to vote.

CO-CHAIR CROCKETT-JONES: Okay. Let me just say let's me clear in that "create" was not the language.

So now, I am ready for a second. Did someone second yet?

DR. PHILLIPS: If you move, I'll second.

CO-CHAIR NATHAN: Okay. So, there is a motion before us to adopt D13 and order a vote. In the affirmative means that you are adopting as a recommendation, in order to expand access to care for Service members/veterans, provide an option to use Medicare, TRICARE, CHAMPUS VA.

A vote in the negative means not to adopt this.

All those in favor of adopting this as a recommendation, please raise your

hand.

Keep them up. Keep them up.

(Laughter.)

All those opposed?

Those abstaining?

One abstention. One abstention, okay.

DR. PHILLIPS: Well, I feel like I'm talking to my wife.

(Laughter.)

CO-CHAIR NATHAN: No, but we actually listen to you. We listen to you.

(Laughter.)

CAPT SANDERS: A point of order, sir. At the next moment, I would like to ask the group to move this into a pernicious area of our report as a problem.

CO-CHAIR NATHAN: Okay. So, Captain Sanders is asking that this be put in part in our pernicious category.

MS. DAILEY: Yes, we will put in the pernicious issues section of the

introduction. We will align it along the lines of access to care possibly as an option to increase access, to be considered.

CAPT SANDERS: And you could even align it, if it feels appropriate, with the access to legal support in the long-distance scenario that we have going on now where that has also been identified as a problem. But it actually made it into a recommendation.

MS. DAILEY: Okay. Okay, good. Good.

CO-CHAIR CROCKETT-JONES: I think we have reached the end of our rest of the recommendations, but we have, I believe, a two o'clock --

MS. DAILEY: Yes. So, Dr. Guice has arrived.

CO-CHAIR CROCKETT-JONES: Okay. Shall we take a break first?

MS. DAILEY: A very brief break, yes.

CO-CHAIR CROCKETT-JONES: A brief

break. Ten minutes?

MS. DAILEY: Uh-hum. And we will bring Dr. Guice up for presentations of awards, ladies and gentlemen.

LTCOL WONG: And then, Denise, are we going to, similar to what we did yesterday, re-review all we voted?

MS. DAILEY: Yes, right after the ceremony. It might be a little anti-climatic. We will go back to our seats and we will just tie up some details.

(Whereupon, the foregoing matter went off the record at 1:46 p.m. and went back on the record at 1:58 p.m.)

DR. GUICE: All right. Well, first of all, I want to thank Denise for asking me to come do this.

I must admit, although there's some new faces at the table, I feel like this is a little bit of a coming-home for me. I was here when this thing started and had the privilege and the pleasure of going on a

couple of site visits and working on the first report. And then, life changed for me and I went over to the Department of Defense.

But I can tell you all that I think your work has been incredibly important. I think the contributions you have made over the years that this Task Force has been working have been sound, good recommendations for both the Departments and how we care for our Wounded Warriors.

I hope that you will be able to look back on the body of the work that you have done and be extraordinarily proud of the changes that have been made.

You also need to remember that, while not everything will get enacted the way you envisioned or implemented in the way that you thought it should be done, the fact that you spent the time and effort, the fact that you went out and you actually got data from people, talked to them on the ground, got to ground truth on a variety of issues, and then,

thoughtfully derived recommendations in a process that was collaborative and sharing, is really important. And I think you all should be extraordinarily proud of what you have done.

So, I personally would like to give you guys a round of applause, and you should give yourselves one, too.

(Applause.)

DR. PHILLIPS: And the staff, the extraordinary staff.

DR. GUICE: Oh, the staff are the reason you guys look good. They're the only reason you look good.

(Laughter.)

You can't do this kind of work without extraordinary backup and help and assistance. So, yes, the staff has been there for you, and that is just priceless, absolutely priceless.

So, I understand we have awards to give now. All right?

MR. McKELVIN: Good afternoon.

We begin with those receiving the Task Force Certificate of Appreciation. The Certificate of Appreciation citation reads as follows:

"For exceptionally meritorious service while serving with the Recovering Warrior Task Force.

"The Task Force member was instrumental to the Task Force as a subject matter expert on topics that impacted the future for wounded, ill, and injured Service members.

"Through the member's keen insight and experience, the Task Force member contributed to the Task Force's development of numerous recommendations to the Secretary of Defense.

"The member's dedication and outstanding work ethic reflects great credit upon himself and the Department of Defense.

As your name is announced, please

come towards the front, where Dr. Guice is standing, and receive your award.

The first award goes to Technical Sergeant Alex Eudy. He is receiving a Certificate of Appreciation for exceptionally meritorious service as United States Air Force and Special Operations Command Representative for the Recovering Warrior Task Force.

(Applause.)

Command Sergeant Major Steven DeJong will be receiving a Certificate of Appreciation for exceptionally meritorious service as the United States Army National Guard Representative for the Recovering Warrior Task Force.

(Applause.)

Lieutenant Colonel Sean Keane will be receiving a Certificate of Appreciation for exceptionally meritorious service as the United States Marine Corps Representative and the Reserve Component Representative for the Recovering Warrior Task Force.

(Applause.)

Lieutenant Colonel Theodore Wong will be receiving a Certificate of Appreciation for exceptionally meritorious service as the United States Marine Corps Representative for the Recovering Warrior Task Force.

(Applause.)

Captain Robert Sanders will be receiving a Certificate of Appreciation for exceptionally meritorious service as the United States Navy Representative for the Recovering Warrior Task Force.

(Applause.)

And Vice Admiral Matthew Nathan will be receiving a Certificate of Appreciation for exceptionally meritorious service as the Department of Defense Co-Chair for the Recovering Warrior Task Force.

(Applause.)

We will now present awards to those members receiving the Office of the

Secretary of Defense Award for Outstanding Achievement as well as the Office of the Secretary of Defense Award for Excellence.

The Office of the Secretary of Defense Award for Outstanding Achievement was established to recognize significant contributions to the mission of activities receiving operational support from the Washington Headquarters Service Directorate for Personnel and Security Customer Support Operating Office or the Organization of the Joint Chiefs of Staff.

The Office of the Secretary of Defense Award for Excellence was established to recognize career civilian employees assigned to the Washington Headquarters Service Directorate for Personnel and Security Customer Support Operating Office or the Organization of the Joint Chiefs of Staff, to have made significant contributions to the mission of activities.

The citation for each award reads

as follows:

"For meritorious service as a non-Department of Defense member for the Recovering Warrior Task Force.

"During their time on the Task Force, they provided significant contributions in various areas relating to wounded, ill, and injured Service members and families.

"Over 120 man-days were contributed to attend scheduled Task Force business meetings and installation visits to military and Department of Veteran Affairs facilities.

"Through the many installation visits, the members met with over 500 Service members and family members through focus groups held at CONUS and OCONUS military facilities.

"The members were also instrumental in the Task Force's development of four Annual Reports which encompassed numerous recommendations provided to the

Secretary of Defense regarding a number of recovering warrior policies and programs.

"These recommendations have had such an impact on the Department of Defense that 75 percent of the recommendations have been conferred with and/or taken action upon."

As your name is announced, please come towards the front and receive your award from Dr. Guice.

Ms. Suzanne Crockett-Jones will be receiving the Office of the Secretary of Defense Award for Outstanding Achievement for meritorious service as a non-Department of Defense Co-Chair for the Recovering Warrior Task Force.

(Applause.)

Mr. Ronald Drach will be receiving the Office of the Secretary of Defense Award for Outstanding Achievement for meritorious service as a non-Department of Defense member for the Recovering Warrior Task Force.

(Applause.)

Mr. David Rehbein will be receiving the Office of the Secretary of Defense Award for Outstanding Achievement for meritorious service as a non-Department of Defense member for the Recovering Warrior Task Force.

(Applause.)

Dr. Richard Stone will be receiving the Office of the Secretary of Defense Award for Outstanding Achievement for meritorious service as a non-Department of Defense member for the Recovering Warrior Task Force.

(Applause.)

Ms. Karen Malebranche will be receiving the Office of the Secretary of Defense Award for Excellence for meritorious service as a non-Department of Defense member for the Recovering Warrior Task Force.

(Applause.)

And last, Dr. Steven Phillips will be receiving the Office of the Secretary of

Defense Award for Excellence for meritorious service as a non-Department of Defense member for the Recovering Warrior Task Force.

(Applause.)

All right. This concludes the awards presentation portion of the business meeting.

Congratulations to the Task Force members for their awards.

And thank you, Dr. Guice, for making time to join us today.

DR. PHILLIPS: I would just like to applaud our Co-Chairs and everybody else. You guys were great.

(Applause.)

MS. DAILEY: Very good, ladies and gentlemen. Thank you very much for your vote and our set of recommendations.

I do want to pull up our last set of recommendations. I should have guided you. Did we have a chance to clean them up, so we could review them? Excellent.

So, we are going to go over what we have done today one last time and review those items. We will do what we did yesterday. We will send them out to our stakeholders.

We will start with where we left off, and then, we will go back.

The 9 July items. Okay, ma'am, can I get you to read these again. And you will see, we need to kind of get a feel. We don't want to do a lot of changing here. There might be some items that we will need to pluralize or something, but let's just review what we have accomplished.

CO-CHAIR CROCKETT-JONES: All right. D8, which is our seventh recommendation.

"To optimize the family and significant other contribution to warrior's recovery, facilitate the participation and socialization throughout the continuum of care, management, and transition. HIPAA rules

that potentially constrain family involvement should be mitigated."

D9, "Pre-DD214" --

MS. DAILEY: Hang on just a minute.

CO-CHAIR CROCKETT-JONES: Okay.

MS. DAILEY: And on that one, we are going to ask Warrior Care Policy Office to address this one. Okay.

CO-CHAIR CROCKETT-JONES: For D9, "Pre-DD214, facilitate the transfer of each Service member to the VA by automatically registering him or her in a system that populates the VA database with all transitioning Service members."

MS. DAILEY: Yes, this one, it falls under USD P&R. Probably it would end up in the Warrior Care Policy Office or DMDC, which is also an entity of the USD P&R.

Good.

CO-CHAIR CROCKETT-JONES: "Take affirmative steps to ensure DoD's and the

Services' employment programs are meeting expectation. These include: creating a dashboard, reporting RW employment metrics, allowing ongoing monitoring and visibility of how well RWs are doing in the job market. Matching skill sets to employers' needs. Taking steps to make veterans advantageous hires. And Congress should ensure integration of effort among DoD, VA, and DOL employment programs."

MS. DAILEY: Again, this one is going to fall under USD P&R, the Warrior Care Policy Office, and also probably the Office of Transition, the Office of Service Member Transition, Dr. Kelly's office.

Okay, we've got it, yes.

MS. MALEBRANCHE: Denise?

MS. DAILEY: Yes?

MS. MALEBRANCHE: I'm sorry. Just to go back one on the automatic registering --

MS. DAILEY: Right.

MS. MALEBRANCHE: -- would we not

also ask VA to respond to that?

MS. DAILEY: Okay. Yes, put VA in there also. Put it right after USD P&R. Okay.

CO-CHAIR CROCKETT-JONES: "Upon Reservist transfer to a Reserve unit, require health insurance, TRS, or other private health insurance as a condition of continued employment in the Reserve component.

MS. DAILEY: This would go to the ASD Reserve Affairs.

And that brings you to the last one. You have a total of 10 recommendations, ladies and gentlemen, that you will be going forward with. All right?

We had another one we wanted to do some tweaking on, which was Mr. Rehbein had concerns.

MR. REHBEIN: I just didn't want that to read like there was going to be just one policy.

MS. DAILEY: So, would you all,

without a vote, be comfortable with "these policies"?

CO-CHAIR CROCKETT-JONES: No, I think "such policy". I think Mr. Rehbein's word is actually the right one.

MS. DAILEY: Okay. Okay, good. Okay. All right.

CO-CHAIR CROCKETT-JONES: It says to respond Congressman Jack -- okay, I was just wondering if we needed DoD or VA to respond to that.

MS. DAILEY: Okay, very good. This is your embodied recommendations for this final year, 10 recommendations.

Okay, any questions?

(No response.)

We are going to email this out to you. We are going to email it out to the stakeholders.

All right, very good job.

All right, one last thing I want you all to touch, and I want to bring your

attention to, if you haven't already done it. I would like, everyone, let's turn to Tab E. Tab E is your Executive Summary and Chapter 1.

Now your Executive Summary is going to be modified to reflect your recommendations. It is non-controversial. It is just a listing of your recommendations.

We have introductory comments in the Executive Summary that encompass the last two years, kind of summarizes them very quickly. But, again, it is about these recommendations.

And if you haven't had a chance, you need to kind of read through this real quickly. But, again, it is very directed at doing a quick synopsis of the recommendations. It will be modified to reflect the 10 instead of the 13.

It guides you into Chapter 1, which is a more substantive chapter on the work that you have done this last year. It encompasses kind of a history. It talks about

your mission, your charter.

And then, I think the most controversial part is going to be page 6, where we really kind of task Congress to utilize this report and to utilize our recommendations over the last two years to monitor and to provide oversight to the Department of Defense. This is also where we have pernicious issues.

Page 7, where you see "Looking to the Future," we guide people to look at the Best Practices because we think we have encompassed in the Best Practices for you good partnerships, good models for the way forward, good templates for linking your recommendations and programs with the Department, with outside resources, with industry, with nonprofits.

And the theme here is, as we draw down, don't lose your connectivity with these services. They are out there. Reach out there to capitalize on them. Your "Looking to

the Future" section talks about reaching into society, reaching into the nonprofits, and integrating them better and utilizing them to pick up services that you, as a government agency, may not be able to deliver.

So, your introduction is a longer one than you have done in the past, and it has a number of components. It has your pernicious issues, and it also takes you into the future, a vision for the future.

Then, I do want to refer you to F, I believe. We have Best Practices at F.

Based on your guidance from the May meeting, we have captured a number of Best Practices that we came across this year. Most of them, again, are about bridging, linking your current DoD services to civilian, nonprofit, non-government resources that DoD can tap into as good models and good templates for continued care, continued services in the face of drawdowns.

And very, very quickly, we talked

about San Diego's model. We have talked about the University of Florida, the Augusta Warrior Project, San Antonio Health System, the National Abilities Center out at Utah, the Apprenticeship Program as your Recommendation -- what is it now, the employment? -- 9 or 10.

You know, this is one example of how you can prepare people for continued employment through a very good apprentice program which has been set up out at Lewis-McChord.

We saw a good program out at Hawaii for employing Service members in the VA.

And then, we also wanted to highlight the Marine Corps' efforts with their Reserve component as the last, not last but as the Best Practice on page 48.

So, your recommendations tie into a lot of these Best Practices as the next step, as the template that the DoD could go to to implement and to continue to deliver

services in the face of declining resources, declining budgets.

All right. I also want to draw your attention, then, to Tab G. We are going to capture in this report all the statuses of the recommendations of all the previous years. So, Tab G is updated to the best of our ability what we feel is the current status of recommendations.

The "Continue to Follow," there is some subjectivity here over the years, ladies and gentlemen, that we have had. "Continue to Follow" means that we really would like possibly Congress to continue to follow them. Obviously, we aren't going to be here.

The tenets still hold that these programs need to continue to get to the vision that the recommendation has laid out. Some we have said they have been met; some we just think that they haven't gotten there yet. And as Dr. Guice said, it may never seem to be in the vision that we had for the DoD to

implement, but it isn't there and you feel it needs to continue to be followed.

And we have done a percentage. I have to report this every year. What do we think is the percentage of completion? And, David, I heard you use the one, 75 percent, in your language.

David? Yes, okay.

On page 55 of Tab G, we do kind of wrap it up, where we thank Service members; we thank the Services.

LTCOL WONG: Denise, is there a difference between "Continue to Follow" and "Continue to Address"?

MS. DAILEY: David, did I have a nuance in there at one time, "Continue to Follow" and "Continue to Address"?

MR. McKELVIN: So, "Continue to Address" was supposed to be something that the Task Force would potentially make another recommendation for.

MS. DAILEY: Okay, yes. Yes.

"Continue to Address" means that we probably had a follow-on or a recommendation the next year that refined the recommendation or continued the recommendation. So, we continued to address it.

Okay, that is another one of your Annexes. And I would like, then, Tab H, ladies and gentlemen. We do have a timeline for what is going to be coming up.

In July, this report, the first voted draft is going to come back to me with all these changes on the 18th of July. And I will make any changes that are needed, and there will be any graphical changes, any typos, which I rarely see. So, it is kind of a quick turnaround.

And then, I will return it to the Research Team, and they are going to do the final editing on it. And you are going to get a pretty close to final document on the 29th of July.

Your feedback to me is going to be

due on the 5th of August. And any changes you make we will incorporate. I need to send it to Security. We are going to send it back to the desktop publisher on the 15th.

And then, we think we will have delivery of a final product on the 19th. And we are releasing on the 2nd. And somewhere between the 19th and the 2nd, we will outbrief DoD. We do not have the dates yet for outbriefing Congress.

All right?

CAPT SANDERS: On the outbrief, is that an event that members attend?

MS. DAILEY: Generally, because DoD is so fluid -- that is, they will make an appointment; they will cancel it; we will reschedule -- I am the only one who outbriefs DoD because I have that flexibility.

I take the two Chairs up to the Hill because that is more of, when they lock in a date, they lock it in.

So, we have been through Tab H.

We reviewed the final recommendations.

And I will turn it back over to the Co-Chairs for any closing comments.

CSM DEJONG: Ma'am, one quick question?

MS. DAILEY: Sure, sure.

CSM DEJONG: Do we need to do the signature page now?

MS. DAILEY: The signature page is complete. Please, the signature plate is complete.

CSM DEJONG: It never made it to this side of the table.

MS. DAILEY: Last year we were chasing it. It is done right there. David has got it. I think we did it in April, frankly. I think I stewarded some of my staff last year, so they got it out to you early this year.

MS. MALEBRANCHE: On this current set of recommendations where we have got

responsible agency, in the past we have seen where they have said they concurred or non-concurred. When does that come or do we ever hear? Or how does that work?

MS. DAILEY: Yes. Ninety days. So, on around 2 December, but it is really an internal Department of Defense requirement to respond to Congress. The bottom line is we have had the courtesy of having access to it over the last few years, but on the 2nd of December, when their first response to Congress is due, you will have sunset. You will have officially sunset.

So, you know, the answer is, theoretically, no, you will never see those responses. That is theoretically -- you know, I mean, I can probably reach into friends. I can call over to Drew at Warrior Care Policy Office, "Hey, give me a copy of that document," and/or the same thing on March the 3rd, when the Implementation Plan is due.

So, it is only after the 24th of

November, after you have sunsetted, it is only the good-buddy network that gains you access to that information.

CO-CHAIR NATHAN: I think, Denise, though, I think I speak for everybody that, since that information is not sequestered and is in the public domain, if we could get access to it or have somebody send it out to us, we would very much appreciate it.

MS. DAILEY: Okay. Good, good. We will keep that in mind.

LTCOL WONG: Will the website still be up and be able to populate through there or will that be shut down as well?

MS. DAILEY: It will not be shut down. I can freeze the website for a year. And when I say "freeze" it, I mean I can't post anything to it or I have got to find someone to post something to it, because the staff is gone. But what is on the website on the 29th of September will be the last postings.

CO-CHAIR CROCKETT-JONES: I just want to say, in closing, as we are finishing this work, this has been an amazing four years for me. I couldn't have imagined this group. I couldn't have created you out of whole cloth. I am just thoroughly amazed at the knowledge, expertise, the compassion, the cooperation, and the energy that everyone I have worked with has had.

I am so utterly impressed to have been here to see this happen and to have been included among it, and to have learned so much from each one of you. I cannot even find the right -- me, I can't find the right words to tell you how honored and impressed and proud I am of the work that was done and the people I have spent time with.

I am a bit brokenhearted that this is coming to a close, not even a bit. I am pretty much completely brokenhearted that this work is coming to a close. And I will never be able to express it all to you, and it goes

not just for the Task Force members, but also to the amazing staff.

And I can only say that most of you know where I live. And the only way that this broken heart will heal is if somebody comes out and visits me from time to time.

Thank you all very, very much.

CO-CHAIR NATHAN: I would echo all of that. I believe this nation owes everybody here two debts of gratitude, the first being just for the service that you have performed over the years in all the various capacities, be it in the federal or non-federal sector, be it as supporting spouses, be it as mentors and leaders, and those of you who have fought and suffered the wounds of war.

And the second debt is for what you have done collectively to make a difference. I recognize, I think we all recognize that this can be pretty tedious stuff, and a lot of it is fighting bureaucracy and a lot of it is wondering, if we fire

around into the void, does it really fall anywhere that makes a difference.

And I am convinced that, I certainly know that, from our site visits and meeting and focus groups, we have occasionally turned around a situation in one individual. That I know for a fact. But I also know that somewhere in this massive landslide of recommendations over the last few years, some of them take hold and have made a difference. And we don't get to see that, but somewhere there is a Service member or their spouse or their child who has a better life, who has a better outlook, who has a better chance because of the work you all have done. It is never going to be as many as we wish it would be, but it is going to be as many as we are grateful for.

And so, I thank you on behalf of those who aren't here to thank you. And I thank you on behalf of those that are doing well right now and whose life will deal them

a hard left turn, and they will have the wind knocked out of them. And maybe they will get up a little faster and feel a little better because of the work you all have done.

So, that goes to everybody in here who has had their hands on this, be it the people who have come to stand before us to give us their public opinions, to the amazing staff, and, Denise, you and your team, to my colleagues. And I am indebted to Suzanne and all of you for allowing me to make a difference.

I think, at the end of the day, all you can say is you tried to leave the place a little better than you found it. And I am convinced that you all have done that. And I have been very energized by the collective discourse on the issues that has allowed, I think, the best way forward, because everybody brought a different perspective and it opened my eyes to a lot of things.

And I guess I would just simply finish, Denise, by saying that we here, speaking for Suzanne and myself and the rest of the Task Force, we here want to applaud you and your staff for, indeed, making us look good and, indeed, making this almost seem effortless, both in the logistics of traveling as well as the final report.

So, thank you, Denise, and your staff very much.

(Applause.)

And with that, I think we are done.

MS. DAILEY: Would any of the members like to -- I know I don't want to drag this out, but if there is anything else any of the members would like to say, this is your chance.

LTCOL KEANE: Admiral, you opened with you echoed all of Ms. Crockett-Jones' comments. We went to her house. Could you please give us your address, so we could by

and visit you, too?

(Laughter.)

CO-CHAIR NATHAN: I didn't forget not to give you my address.

(Laughter.)

CAPT SANDERS: Just a quick comment. As a late-bloomer on the Task Force, thank you for the welcome and the engagement.

It was very, very, very rewarding to actually see this from a different perspective. Because, as the attorney for these individuals through the PEB process, I got to see one side of it, and this is a different piece.

MS. MALEBRANCHE: I would like to say also, just on behalf of the VA, because you know we're going through some awful times right now, but I want to assure you that we're working hard.

And it was an emotional piece for us, I think, to hear that. And in the midst of all this, it was a horrible thing to hear

for us, but I have to say the work on the Task Force and the issues that I have learned throughout the time have been amazing.

I carry a little special piece -- I am like Suzanne; I am a very emotional person. I wear everything right out. But I carry a little piece of every one of you from a different time, a different trip.

Denise, I have to say you and your staff have been amazing.

And if I ever get the chance to work with any of you again, I would hope that some of you would consider coming to the VA at some point in time to work, if not as a patient.

But I especially have enjoyed Suzanne's stories and I loved meeting her family. I think they were not surprised that we knew a little bit, a piece about every one of them.

But I take a little bit of each and every one of you, that you have added

something to my life. And I thank you.

DR. PHILLIPS: I want to say it has truly been a privilege. I mean, I feel like you were all combat buddies. I mean, this tough cardiac surgeon/paratrooper was actually brought to tears many times during some of these site visits.

I shared with Denise way back, and really almost quit because psychologically it was just getting to me. And then, I looked around at my colleagues and friends and said, you know, we really have to continue to do that.

I may not have been the best person to do it, but, with all of you, I think you made me the best person. So, thank you.

MR. REHBEIN: When I first came to this group, coming from the Midwest, not being involved in DoD for a long time, my learning curved looked more like the wall of a four-story building than it did any kind of an incline. Many of you put up with dumb

questions, sometimes maybe a not-so-quite-intelligent comment.

I have learned an awful lot from you. I will endeavor to tell this story back in the Midwest because there are parts of the country that don't understand the work that goes on out here. And so, I want to thank you for that, for allowing me the knowledge to help tell that story.

And I really want to say thank you to Denise and her staff because I have heard the frustration in her voice at us at times, and she has put that frustration down and continued to lead us and help us in what we have done. Denise, thank you.

CSM DEJONG: I can echo everything from everyone that is here. This is really one of the highlights of my career.

I did make the mistake one time of saying that the only place I haven't been assigned is the Pentagon or Washington, and that was almost done before the end of the

day, but I was able to fight that off.

I have learned a lot from all of you. I have got some truly good friendships out of this, and it is an honor and a privilege to do what we have done. I never would have imagined being selected or assigned to anything like this. And I thank you all. I wish you all the best in your future endeavors.

DR. STONE: Well, as one who served in both positions, both in uniform and out, Denise, thanks for having me back. It seems like a very short time ago you arrived in my cubicle in the Pentagon, or whatever building we were in, and told me, "Hey, we're going to do this." And then, it was six months later before we got approval to get moving.

And I am smiling because I am looking at our Recovering Warrior Task Force emblem here and thinking about the intense emotional arguments we had as we put that

thing together and what will we call ourselves.

(Laughter.)

Sir, you didn't have a chance to participate in that, but if you ask General Green, it was one of the points that he did lay his head on the table, not sure that we could go another inch.

But, look, we all worked hard at this, and we did some good stuff, and we made good friends.

However these are all used in the future, they are an enduring legacy to some really hard work in which we reached out to the beneficiaries that needed our help so much.

So, thanks very much for letting me be part of it.

MR. DRACH: Yews, I would just like to add my two cents and thank Denise and the staff.

I have been in Washington now for

45 years and been on a lot of task forces, commissions, and advisory committees. And I can say without any hesitation that the staff of this particular Task Force is second to done in terms of their responsiveness, their professionalism, their desire, their willingness to go the extra mile. It is not an eight-hour-a-day job for any of them.

And it actually started before the Task Force first met, when I first started talking with Denise. And Denise met me in the parking lot of the Pentagon for me to sign something for her for me to move forward on this. And that was before the Task Force had even started.

And I remember the first meeting and we had our ethics briefing, and so forth, and I got to meet a lot of the people here and thought, boy, this is going to take a long time. We have got four years to do this. And where did the four years go to?

And I have just enjoyed it

immensely, and I want to thank everybody for all the support and patience they have given to me. Thank you very much.

LTCOL KEANE: I, too, would like to thank Denise and her staff for all the hard work you did. But I also would like to publicly thank Denise and General Stone for thinking out of the box and allowing me to come in as a new persona, as the Marine Corps rep, as a Reserve rep. I have talked to you both personally, but publicly thank you very much for thinking out of the box to allow me to continue on and see this to the end.

TSGT EUDY: I would like to thank all of you for your mentorship. As many of you and those that have left the Task Force have taken off the uniform, and some of you will here in the future, or you may not be involved with something like this further on, thank you for your time and your patience with me. I am coming up on about the middle point of my career. So, I have plenty to look

forward to. But thank you for investing in me as a leader. And what I can take back on the Special Operations side and to the Air Force, I know that I will do my best.

And if any of you want to come back, maybe we will see each other in Afghanistan, sir, if you've got some time, or you, sir, or Sergeant Major, before they finally get to the Board.

But take care. Everyone take care. As you always know, my sense of humor is what gets me through. So, just keep laughing, keep enjoying things, and I am sure I will see you all again at some point.

MR. REHBEIN: I want to say one last thing because Alex brought it to mind, talking about some folks taking off the uniform. We have one member in the room that is about to put on the uniform and begin a career. And I think we all ought to say thank you to Heather for what she has done and what she is about to do through OCS and the United

States Marine Corps.

Heather, congratulations. Good luck. We look forward to seeing you.

(Applause.)

CO-CHAIR NATHAN: And we're through.

MS. DAILEY: Thank you again, ladies and gentlemen. Very well done. Very well done.

(Whereupon, at 2:42 p.m., the meeting was adjourned.)

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: 07-09-14

Place: Washington, DC

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