

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

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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.

1 Rieker.

2 MR. RIEKER: Good morning.

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

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

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

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

1 self-love realized.

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

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

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

1 therapy process.

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

6 Thank you for hearing my comments.

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

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

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

1 indicates like a push for more research?

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

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

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

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

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

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

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

17 DR. STONE: Paul, I appreciate
18 your coming.

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

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

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

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

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

1 Behavioral Health MEDCOM.

2 DR. STONE: Thank you.

3 CO-CHAIR CROCKETT-JONES: Thank
4 you.

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

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

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

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

15 MR. RIEKER: No.

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

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

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

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

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

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

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

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

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

19 Other comments, questions?

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

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

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

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

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

1 droves.

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

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

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

1 MR. RIEKER: Thank you.

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

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

7 CO-CHAIR NATHAN: Very good.
8 Thank you.

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

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

15 (Laughter.)

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

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

4 I invite the members to move to
5 adopt this recommendation for discussion.

6 Anybody move to discuss?

7 (Moved.)

8 Any seconds?

9 DR. PHILLIPS: Second.

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

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

16 CO-CHAIR NATHAN: Any further
17 discussion?

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

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

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

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

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

1 through the VA system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 liberated us from patient care.

2 So, any further discussion?

3 Otherwise, we have a motion to bring this to
4 a vote.

5 TSGT EUDY: I'll make a second.

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

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

18 All those opposed?

19 The recommendation carries.

20 CO-CHAIR CROCKETT-JONES: Okay.

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

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

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

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

14 MR. REHBEIN: So moved, Madam
15 Chairman.

16 DR. PHILLIPS: Second.

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

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

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

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

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

19 MS. MALEBRANCHE: Is that in
20 Separation Health Assessment?

21 LTCOL WONG: Yes. Yes, ma'am.

22 MS. MALEBRANCHE: Because the

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

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

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

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

1 choose at the time they want to come in.

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

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

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

1 to keep.

2 DR. STONE: Go ahead, Ron.

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

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

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

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

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

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

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

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

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

3 And now, Rich, interested in your
4 thoughts.

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

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

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

1 lines.

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

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

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

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

22 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 The eligibility criteria, Denise,

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

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

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

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

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

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

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

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

1 shouldn't have to be part of this difficulty.

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

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

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

20 (No response.)

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

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

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

9 CO-CHAIR NATHAN: I think you want
10 all.

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

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

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

22 TSGT EUDY: Are we not talking

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

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

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

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

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

1 understand their VA benefits.

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

8 Do we want to pursue that as well?

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

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

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

1 through --

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

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

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

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

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

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

16 LTCOL KEANE: I would like to make
17 some comments.

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

22 MS. MALEBRANCHE: The data in

1 while they're --

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

4 MS. MALEBRANCHE: That can be done
5 either side.

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

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

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

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

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

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

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

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

1 them registered for the services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 MR. DRACH: Well, yes, the 50-55
10 percent is the glass half full, the glass half
11 empty. But that 55 percent could represent
12 100 percent of those who want or need VA
13 healthcare.

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

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

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

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

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

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

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

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

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

22 But that is a unique environment.

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

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

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

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

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

1 other veterans.

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

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

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

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

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

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

8 LTCOL WONG: It may not be cross
9 all Services.

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

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

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

21 LTCOL WONG: They have gone
22 partway there, sir.

1 CO-CHAIR NATHAN: Right.

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

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

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

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

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

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

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

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

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

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

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

13 CO-CHAIR NATHAN: Okay.

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

22 CO-CHAIR NATHAN: Right. So, your

1 point being --

2 MR. REHBEIN: That these initial
3 efforts continue.

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

8 Karen, your comments?

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

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

21 CO-CHAIR CROCKETT-JONES: A
22 marketing recommendation.

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

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

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

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

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

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

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

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

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

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

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

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

1 2012.

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

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

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

1 that.

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

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

6 CO-CHAIR NATHAN: Right.

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

9 CO-CHAIR NATHAN: Yes.

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

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

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

19 MS. DAILEY: It's pretty thorough.

20 CO-CHAIR CROCKETT-JONES: Okay.

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

1 CO-CHAIR CROCKETT-JONES: Okay.

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

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

8 CO-CHAIR NATHAN: Right.

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

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

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

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

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

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

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

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

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

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

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

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

22 CO-CHAIR NATHAN: Right.

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

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

5 CO-CHAIR CROCKETT-JONES: Combine
6 them --

7 CO-CHAIR NATHAN: -- combine the
8 two.

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

13 CO-CHAIR CROCKETT-JONES:
14 Thirteen?

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

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

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

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

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

1 all aspects of access.

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

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

1 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

14 (Laughter.)

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

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

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

3 CO-CHAIR NATHAN: Right.

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

6 CO-CHAIR NATHAN: Right.

7 MR. REHBEIN: I think it fits that
8 50,000-foot category.

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

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

1 decrease for mental health. That is a good
2 thing.

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

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

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

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

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

11 CO-CHAIR NATHAN: Very good.

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

15 MR. REHBEIN: So moved.

16 CO-CHAIR NATHAN: A second?

17 MR. DRACH: Second.

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

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

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

7 All those opposed?

8 Okay, the recommendation carries.

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

12 (Laughter.)

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

16 MS. DAILEY: A little bit of a
17 break?

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

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

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

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

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

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

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

17 I read it again. Pull the second
18 one out.

19 CO-CHAIR NATHAN: We will now
20 discuss a recommendation regarding vocational
21 and employment programs. This recommendation
22 states, "Identify the major Department of

1 Defense and Service-level vocational and
2 employment programs and systematically assess
3 to what extent as a whole they satisfy the
4 needs of the Recovering Warrior population and
5 family members."

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

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

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

15 TSGT EUDY: I second.

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

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

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

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

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

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

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

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

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

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

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

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

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

10 LTCOL WONG: Yes, sir.

11 CO-CHAIR NATHAN: Okay. Other
12 comments?

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

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

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

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

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

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

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

1 new ones.

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

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

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

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

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

1 and I'm paraphrasing -- I don't remember the
2 exact data -- but she had something like
3 60,000 people looking for employment and she
4 had 72,000 jobs. What's wrong with this
5 picture? I've got more jobs than people.
6 Well, the people weren't qualified for the
7 jobs that she had. So, that is a situation
8 that is not unique to veterans. It's across
9 the board.

10 CO-CHAIR NATHAN: Uh-hum.

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

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

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

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

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

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

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

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

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

1 to do this.

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

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

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

22 DR. STONE: So, I would like to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 There is a sense it is generating

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So, some of what they are looking

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

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

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

18 So, what I have heard is that, No.
19 1, we don't have an adequate assessment of how
20 effective the programs are. No. 2, we have
21 heard from Ms. Crockett-Jones that there is a
22 disparity of effort or interest on the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 MS. DAILEY: Correct.

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

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

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

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

18 CO-CHAIR NATHAN: Right.

19 MS. DAILEY: -- and the OWF
20 Program.

21 CO-CHAIR NATHAN: Right.

22 MS. DAILEY: And they have got

1 some metrics for those programs alone.

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

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

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

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

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

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

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

12 CO-CHAIR NATHAN: Advantageous
13 hires.

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

22 (Laughter.)

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

4 So, comments on that?

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

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

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

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

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

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

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

10 MS. DAILEY: Okay, good.

11 CO-CHAIR NATHAN: Five minutes,
12 folks.

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

16 103559

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

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

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

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

22 MS. DAILEY: I do think we have

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

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

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

22 DR. STONE: Denise, your point was

1 that this should not be a DoD lead here?

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

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

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

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

1 Mr. Drach, are you tracking here?

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

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

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

1 spikes the unemployment for that particular
2 population back and forth.

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

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

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

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

22 But, again, you still have the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 it, is around \$17,000 a year. Seventeen
2 thousand dollars a year in Ground Hog, Idaho
3 is probably not too bad. In Washington, D.C.,
4 \$17,000 is not very adequate.

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

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

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

1 special effort for veterans.

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

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

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

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

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

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

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

18 So, Ron feels that this bullet is
19 worthwhile.

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

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

3 CO-CHAIR NATHAN: Specializing
4 their employment programs.

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

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

12 CO-CHAIR NATHAN: Cross-
13 referencing?

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

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

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

1 MR. DRACH: I'm sorry?

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

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

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

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

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

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

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

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

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

22 CO-CHAIR NATHAN: The Veterans

1 Committee will.

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

4 CO-CHAIR NATHAN: The VA Committee
5 may.

6 MR. DRACH: The VA Committee.

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

14 CAPT SANDERS: Just one comment,
15 sir.

16 CO-CHAIR NATHAN: Of course.

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

22 CO-CHAIR NATHAN: I don't know.

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

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

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

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

18 CO-CHAIR NATHAN: It works for me.

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

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

4 CAPT SANDERS: So moved.

5 TSGT EUDY: Second it.

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

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

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

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

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

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

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

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

22 CO-CHAIR NATHAN: Okay. So, just

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

4 So now, the motion before us is as
5 reads.

6 So, all those in favor of
7 accepting --

8 LTCOL KEANE: One comment, sir?

9 CO-CHAIR NATHAN: Please.

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

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

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

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

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

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

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

1 do it.

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

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

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

22 All those opposed?

1 Okay, the recommendation carries.

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

5 (Laughter.)

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

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

10 Our next recommendation addresses
11 recruitment standards. This recommendation
12 states:

13 "Consider existing recruitment
14 standards to ensure quality future
15 accessions."

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

19 CAPT SANDERS: I so move.

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

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

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

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

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

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

1 (Laughter.)

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

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

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

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

22 CO-CHAIR NATHAN: Yes, a great

1 point.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 Okay. Any motions or more
20 discussion?

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

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

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

6 CO-CHAIR NATHAN: Okay. And
7 seconds?

8 TSGT EUDY: Second.

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

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

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

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

21 Okay. Thank you. Unusual, but
22 the noes are above the eyes.

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

6 Is there a motion to adopt this
7 for discussion?

8 MR. REHBEIN: So moved.

9 TSGT EUDY: Second.

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

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

16 LTCOL WONG: Yes.

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

22 MS. DAILEY: Reserve Affairs also

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

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

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

22 MS. DAILEY: So, then, drilling

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

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

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

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

1 investigation and signed off by the general.

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

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

13 And I am a little confused by the
14 response.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 DR. STONE: That is correct.

16 CO-CHAIR NATHAN: So, other
17 comments?

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

1 got it wrong.

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

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

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

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

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

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

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

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

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

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

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

21 DR. STONE: As an option.

22 CO-CHAIR NATHAN: As an option.

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

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

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

19 CO-CHAIR NATHAN: Right.

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

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

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

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

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

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

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

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

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

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

22 LTCOL WONG: This would definitely

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

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

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

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

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

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

1 for that.

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

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

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

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

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

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

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

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

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

1 positive.

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

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

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

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

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

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

9 DR. STONE: Exactly.

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

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

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

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

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

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

9 CO-CHAIR NATHAN: Well --

10 MS. DAILEY: Then, I'm fine with
11 one -- the only paragraph that fits is page
12 40, the second paragraph. "Requiring
13 Reservists to have health insurance and access
14 to care they need under any circumstances."
15 That is the only one that doesn't have a line
16 of duty in it or doesn't tie it to line of
17 duty.

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

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

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

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

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

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

1 the horse.

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

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

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

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

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

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

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

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

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

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

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

16 CO-CHAIR NATHAN: Right.

17 CAPT SANDERS: -- with insurance.

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

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

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

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

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

16 CO-CHAIR CROCKETT-JONES: You can
17 apply.

18 CO-CHAIR NATHAN: You can apply.

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

22 CAPT SANDERS: Okay. I was a

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

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

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

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

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

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

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

1 Now, yes, now you must get insurance.

2 DR. PHILLIPS: But am I eligible
3 for TRICARE?

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

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

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

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

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

16 (Laughter.)

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

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

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

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

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

21 MS. DAILEY: To continue
22 service --

1 LTCOL WONG: Or continued service.

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

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

6 MS. DAILEY: Health insurance is
7 required.

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

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

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

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

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

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

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

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

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

18 CO-CHAIR NATHAN: Right.

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

1 duty status and I had insurance.

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

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

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

1 So, that's how I see it.

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

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

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

1 now offboard because he is checked out of his
2 unit.

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

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

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

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

1 Stone talking about that.

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

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

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

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

22 MS. DAILEY: Well, my

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

8 CO-CHAIR CROCKETT-JONES: I
9 would --

10 MS. DAILEY: -- or other --

11 CO-CHAIR CROCKETT-JONES: Or
12 other.

13 CO-CHAIR NATHAN: Or other.

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

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

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

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

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

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

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

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

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

22 CO-CHAIR NATHAN: So, you can

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

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

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

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

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

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

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

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

7 DR. STONE: You should not
8 perceive any running.

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

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

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

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

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

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

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

1 them in TRS or other private health
2 insurance."?

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

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

9 DR. STONE: Okay.

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

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

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

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

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

16 CO-CHAIR NATHAN: Why am I
17 shocked?

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

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

4 (Laughter.)

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

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

22 I don't think that we can use

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

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

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

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

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

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

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

1 that's how I look at it.

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

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

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

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

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

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

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

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

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

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

1 Chicago election.

2 (Laughter.)

3 Okay.

4 Any more discussion?

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

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

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

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

19 CO-CHAIR CROCKETT-JONES: Exactly.

20 CO-CHAIR NATHAN: No.

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

1 this?

2 (No response.)

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

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

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

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

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

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

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

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

1 of continued employment".

2 CO-CHAIR CROCKETT-JONES: Yes, yes.

3 MS. DAILEY: "Continued
4 employment"?

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

8 CO-CHAIR CROCKETT-JONES: Not
9 "initial".

10 MS. DAILEY: Yes, not "initial".
11 There's too much opposition to "initial".

12 CO-CHAIR CROCKETT-JONES: Okay.
13 So, the language that we have gotten to is,
14 "Upon Reservist's transfer to a Reserve unit,
15 require health insurance, TRS or other private
16 health insurance, as a condition of continued
17 employment in the RC."

18 Does anyone move to vote on this
19 recommendation?

20 CO-CHAIR NATHAN: I think we had
21 one, right? Didn't you?

22 CSM DEJONG: So moved.

1 CO-CHAIR NATHAN: Yes, and we had
2 a move. A second?

3 MR. REHBEIN: Second.

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

7 All those who abstain? Or, I'm
8 mean, that's right; I forgot. All those who
9 say no?

10 MS. DAILEY: I need my yeses up
11 again.

12 Okay, thank you.

13 CO-CHAIR CROCKETT-JONES: All
14 right, the recommendation will be included. I
15 think that we are at our lunchtime.

16 MR. DRACH: Yes, one o'clock.

17 CO-CHAIR CROCKETT-JONES: We will
18 be back here at one o'clock.

19 Thank you.

20 (Whereupon, the proceedings went
21 off the record at 12:07 p.m. and resumed at
22 1:08 p.m.)

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

2 1:08 p.m.

3 CO-CHAIR NATHAN: Okay, welcome
4 back.

5 This recommendation for discussion
6 addresses health insurance for the Reserve
7 component Service members. This
8 recommendation states as follows:

9 Whoops, I'm on the old one, deja
10 vu all over again, Ground Hog Day. Ground Hog
11 Day.

12 MS. DAILEY: Go to three o'clock.

13 CO-CHAIR NATHAN: The last
14 recommendation for discussion covers expanding
15 the access to care. The recommendation states
16 that, "In order to expand access to care for
17 Service members and for veterans, provide an
18 option to use Medicare, TRICARE, or CHAMPUS
19 VA.

20 At this time I invite members to
21 move to adopt this for discussion.

22 DR. PHILLIPS: So moved.

1 MR. DRACH: Second.

2 CO-CHAIR NATHAN: Up for
3 discussion is the proposed recommendation that
4 deals with expanding access to Service members
5 and veterans, providing an option for them to
6 use to Medicare, TRICARE, or CHAMPUS VA.

7 Does anybody want to discuss the
8 genesis for this or what we believe the basis
9 is after looking at the Findings?

10 DR. PHILLIPS: I can start off,
11 and I think I was sort of instrumental in
12 moving this along.

13 This is based on my own personal
14 experience, but mostly based on what we have
15 seen in our travels and interviews. The
16 access, not the quality -- the quality of care
17 is excellent. The access to care has been
18 difficult for Service members, either in a DoD
19 facility, which is not as difficult as perhaps
20 some of the VA facilities, basically because
21 of distance to many of the VA facilities.

22 Just trying to think through a

1 simple solution perhaps is too simple. Since
2 it is the same pool of money, tax dollars,
3 that support DoD, TRICARE, VA, why not let
4 those folks that are eligible, the Service
5 members that are DD214, or even perhaps that
6 are still in the ranks, those that are
7 eligible for VA/CHAMPUS VA, TRICARE, DoD care
8 have the option to be eligible for Medicare?

9 And I can go into some of the more
10 reasons. Folks waiting a long time to get a
11 hernia repaired, out of work, because the
12 waiting list is three to six months, and
13 issues like that.

14 CO-CHAIR CROCKETT-JONES: I have a
15 question. I know that Medicare enrollment
16 happens at a certain rating. When my husband
17 was medically retired, he became eligible for
18 at least part of Medicare. And I am wondering
19 how that figure in. Who is and who isn't
20 enrolled in Medicare now in this process? So
21 that I understand where we stand.

22 MR. DRACH: Well, in order for

1 somebody under age 65 to get Medicare, he or
2 she must be on SSDI or SSI for two years.
3 After the two-year waiting period, then
4 they're eligible for Medicare.

5 DR. PHILLIPS: Yes, you know, I
6 wanted to keep it simple.

7 CO-CHAIR CROCKETT-JONES: I just
8 wondered, you know, who we already had on
9 that, but now I see, it is because of the SSDI
10 that went over two years in the process of his
11 medical retirement and the process of IDES.

12 DR. PHILLIPS: So, that's how he
13 met the --

14 CO-CHAIR CROCKETT-JONES: That's
15 how he met the criteria. Okay, I understand
16 now.

17 DR. PHILLIPS: Again, not to be
18 too redundant, if you served and you're
19 eligible for VA or TRICARE or DoD, for as long
20 or short a period that you're eligible for, in
21 order to make it easy, you automatically are
22 eligible for Medicare.

1 I know you can go and get
2 approval, but you have to make an appointment.
3 You have to see somebody. They have to say,
4 okay, you're approved or not approved, as
5 opposed to just being eligible.

6 CO-CHAIR NATHAN: So, Dr.
7 Phillips, I guess playing the devil's
8 advocate, I would ask you, do you think that
9 this has sort of become overcome by events,
10 given that now there is a tremendous internal
11 and external effort going on to try to find
12 what VA -- we can talk about DoD, the military
13 facilities in a minute in healthcare -- but
14 the VA system, and, Karen, I would be
15 interested in your comments on this.

16 You know, we are talking about
17 expanding access to care. And it would seem
18 to me that that has sort of exploded now in
19 the VA system at least, as they now look for
20 what the way ahead is going to be. And I
21 think most people who know anything about it
22 recognize that 95 percent, if not higher, of

1 the VA hospitals are dedicated, hard-working,
2 doing great work every day.

3 There was a small percentage of
4 those that had an integrity issue where they
5 were gundecking and sort of fiddling with the
6 stats to look better than they did in the
7 local area. And that sort of brought the
8 house down.

9 But that's my question: do you
10 think that this is still something that we
11 need to light up in our report, given that it
12 is kind of lit up already, given the current
13 events?

14 DR. PHILLIPS: Well, I do, and I
15 think, obviously, what you are saying is
16 correct. I think that is part of it.

17 Personal experience, I practice
18 cardiac surgery in Des Moines, Iowa. I was
19 voluntary Chief of Thoracic Surgery at the VA
20 Hospital, which was a wonderful hospital down
21 the street. Every week I would sit at cardiac
22 conference and recommend surgery for a small

1 group of patients, who were, then, shipped off
2 to either Texas or Milwaukee to another VA
3 facility that did surgery.

4 And families would come to me and
5 say, "Well, there are three other programs in
6 town. Why do we have to fly off to somewhere
7 else?" And the response would be, "Well, it's
8 part of the VA budget."

9 And so, after a year or two of
10 this, we started accepting -- I mean there was
11 a contract -- we started accepting patients.

12 I mean, that is perhaps a small
13 example, but it was access to care. And so,
14 this is, again, an issue of access to care
15 which happened recently, in addition to the
16 people that live remotely from a VA hospital
17 or a DoD facility.

18 So, again, it is not the quality
19 of care at all. It just the access. So,
20 trying to think of a simple solution based on
21 my own personal experience, and budget-wise,
22 it turned out, at least for my practice, it

1 didn't cost the VA any more to just have them
2 done in town with a contract, as opposed to
3 flying them off with a family member and
4 staying somewhere for two or three weeks, or
5 whatever.

6 And again, the same pot of money.
7 I don't know what it costs per patient per
8 year to have VA or DoD care. The numbers I
9 looked at were around \$10,000 to \$15,000 per
10 person. And, of course, I don't want to
11 compare apples and oranges. Medicare costs
12 per person on the Medicare rolls is about
13 \$6,000 a year. So, it is a little more, but
14 the disease and the injuries are a little
15 more.

16 I would just think, looking at a
17 simple solution as a stop gap for what is
18 going on right now, and as a long-term
19 solution for people that don't have physically
20 access to care, and as things change, people
21 can at least have the option to go one of the
22 three.

1 MS. MALEBRANCHE: You know, we are
2 in the middle of this change, obviously, right
3 now. But one of the things is all the VAs are
4 TRICARE providers. I mean as a space-
5 available sort of thing. So, that is already
6 a given there.

7 The access issues, like the
8 Admiral said, are in certain places and, also,
9 because of the timelines of within 14 days,
10 within this amount of time. There are some
11 things right now at work. So, the
12 recommendations, whatever we do might be
13 superseded by some congressional action.

14 But the VA does have a number of
15 options in the ways to do things, like you are
16 mentioning, Dr. Phillips, because there are
17 fee basis when it is unavailable, depending on
18 the specialty. Also, we have a new, what they
19 call, PC3 contract. I am trying to remember
20 that acronym. I will have to look it up for
21 you, Suzanne. But we have contracts with
22 TriWest, and Health Net just won those

1 contracts. So that, in an area where there is
2 not enough specialty care, that the facility
3 can outsource that to those contracts.

4 And the other thing that we have
5 that is not listed per se up here that has
6 some bearing on this is Dr. Woodson and our
7 Acting Under Secretary for Health did discuss
8 the possibility of using sharing agreements
9 and resource-sharing. So, where there is
10 capacity at one, perhaps VA can use that, but
11 it also depends on the specialties, because
12 still being support of GME, which VA has
13 always been, and working with the university
14 hospitals to continue using various different
15 sources.

16 One of the things you're
17 suggesting -- I know in Augusta we had
18 cardiothoracic agreements with the Medical
19 College of Georgia, with Fort Gordon, and with
20 the VA. And so, there was a three-way
21 agreement.

22 So, we still have a lot of things

1 available to us to do exactly that, so you
2 don't drive by three hospitals to have someone
3 who needs the cardiothoracic surgery.

4 So, I am not sure in order to do
5 this that we need to actually do this, because
6 I think we already have it. I'm not sure, but
7 I think we have this.

8 DR. PHILLIPS: Let me just add to
9 it, and not in a disagreeable way. I was
10 trying to make as seamless as possible, just
11 automatic, as opposed to having to create a
12 contract in an area that may not have a
13 contract, be approved by perhaps a VA or a
14 TRICARE doctor or administrator, waiting to
15 get that appointment, to get permission, to
16 get approval.

17 I said this before. I'm 74 years
18 old, or I will be next week, and I can go to
19 any VA hospital, any DoD facility, or any
20 private hospital at will without having to
21 fill out any paperwork or request anything.
22 And why should I, at my age, have better

1 access to care than a 22-year-old that lost
2 two legs or just served without any real
3 injury, but is deserving of that? And that is
4 the way I was looking at it.

5 CO-CHAIR NATHAN: So, from the DoD
6 standpoint, as you know, it is a little
7 different than the VA, in that in TRICARE, if
8 we can't get you -- and I realize this is an
9 imperfect system -- but, in theory, if we
10 can't get you to care within the time
11 parameters that we have promised you,
12 especially if you are TRICARE Prime, if you
13 enroll to us, which means 24 hours for an
14 urgent issue, seven days for a routine issue,
15 and 30 days for an elective issue, we buy you
16 that care out in the community. Or you can
17 elect, if you are a family member -- active
18 duty must enroll to the MTF. If you are a
19 family member or a retiree, you can enroll to
20 TRICARE Extra or just basic TRICARE Standard,
21 which allows you to pick and choose from among
22 civilian providers. Ironically, often they

1 can't get you in any faster than we can.

2 So, I don't know that this is -- I
3 think this was more critical to the VA than it
4 was to us. We are undergoing a huge review
5 now in the MHS, in the Military Health System,
6 as a result of a couple of things, not the
7 least of which was -- and I don't think this
8 is any big secret.

9 So, the VA started having some
10 issues, some high-profile issues. The
11 Secretary of Defense was concerned, could my
12 agency have similar issues? In other words,
13 is it possible that what my local facilities
14 are saying is not true and my central
15 reporting agency is telling me that access is
16 good and quality is good, but maybe it is not
17 true at the local level because people are
18 sort of hiding things?

19 That made SECDEF nervous because
20 sort of would they be catching the "VA flu" in
21 that regard? And again, I emphasize that, in
22 my personal opinion, this was a very small,

1 small piece of the VA system. The
2 overwhelming majority of it has tremendous
3 integrity and dedication.

4 Then, the second thing that
5 happened was a New York Times reporter decided
6 to write a series of articles that are not
7 very complimentary of military healthcare.
8 This is apart from VA healthcare, military
9 healthcare. That made the Secretary of
10 Defense even more concerned and nervous.

11 And then, when the Army relieved
12 its command element at Womack Army Hospital at
13 Fort Bragg, the Secretary of Defense said,
14 "Enough is enough. I don't know if we have
15 real problems or not, but I'm not going to
16 wait to find out," and has instituted a
17 review, a very thorough one that is due by the
18 end of August that is basically a FOD walk.

19 A FOD walk, for those who don't
20 know, is where you walk down together in a
21 line looking at an airfield for any foreign
22 objects or debris to make sure nothing gets

1 picked up by a rotor blade or an intake. So,
2 it is a very meticulous inch-by-inch look at
3 the airfield to make sure there is nothing
4 lying around.

5 We are at a FOD walk of the
6 military health system, looking at,
7 specifically, how do we measure standards of
8 access, quality, and safety? So, this is why,
9 from my perspective, I am looking at it
10 saying, gosh, this is just what the doctor
11 ordered probably six months ago. But now, the
12 events that have transpired, both initially in
13 the VA and now that the MHS, Military Health
14 System, is getting swept up on the VA concerns
15 as well as media concerns, as well as some
16 high-profile hospital issues, we are sort of
17 turning all this over.

18 We have brought external reviewers
19 in from the outside to help us look at our own
20 system in the Military Health System. We
21 believe that our data is accurate. We believe
22 what we are saying centrally is true. We

1 don't believe we have a gap from our
2 facilities.

3 But that is why I bring up the
4 fact that, just coincidentally or ironically
5 or incidentally, however you choose to look at
6 it, the VA and the MHS now are all in, if I
7 can use that term, they are all in and looking
8 at how we are providing access, whatever.

9 I understand your concept, which
10 is, okay, got it; everybody is all in, but
11 just makes it very easy. If we just say,
12 "Hey, look, anybody who's eligible for the
13 military healthcare or VA healthcare, find a
14 Medicare provider, find a CHAMPUS provider."

15 I'm not confident in making that
16 assessment yet or that recommendation until I
17 see where the VA lands on their assessment of
18 their access and what they think is best and
19 where I see the Military Health System land on
20 how its access is best. And what is the real
21 challenge; what is the real truth?

22 So, that is my concern about this

1 one particular --

2 CO-CHAIR CROCKETT-JONES: I also
3 wanted to point out to you, I know that, to
4 your question, you're 74 and you have access
5 -- almost -- and you have access to more
6 choices than someone who is maybe a very
7 seriously-injured 22-year-old vet. But you
8 have also paid into Medicare for 50 years more
9 than that vet has. So, Medicare is not
10 something that you don't contribute to through
11 the course of your employment.

12 I'm not saying that that's a
13 reason to -- but, yes, it is a small amount,
14 but over time those amounts build up. And I
15 am not saying it is a reason to nix this. I
16 am just saying that that is a consideration.

17 My concern right now is that I
18 think Medicare can sometimes be confusing.
19 Its benefits can be sometimes incomplete.
20 There are different parts. Some require
21 copayment. What is covered by what? It is a
22 little more complicated, I think, and I am a

1 little concerned that there might be
2 unintended consequences.

3 That is the one thing that, since
4 we have started talking about this, that I
5 haven't felt clear and comfortable about, is
6 that I don't know enough about Medicare and
7 benefits to know if there isn't some hidden
8 minefields on veterans winding up using it,
9 and then, not having the coverage they thought
10 they had or not being able to, then -- you
11 know, will Medicare become the secondary
12 insurance? Will that affect their TRICARE
13 benefits because now they have, you know, once
14 they enroll -- I'm just worried that there are
15 some regulatory minefields that I have not --
16 because I don't understand how they work.

17 DR. PHILLIPS: Obviously, there
18 can be many issues associated with this. I
19 think the number of people that would be
20 accessing this would probably be small;
21 therefore, a small budget.

22 And, of course, it is hard to

1 compare, not going to the VA, how much money
2 they save by not seeing a particular patient
3 and, then, going to a Medicare provider.

4 Just in my mind, and I'm not
5 trying to disparage the military or VA
6 healthcare system -- I think it is an
7 excellent system. I go to Walter Reed
8 routinely. I just don't see, when you balance
9 everything, I don't see really a downside to
10 recommending something like this, which will
11 probably get turned down anyway. But I don't
12 see a downside to recommending something like
13 this even as a stop gap for what is going on
14 right now, until everything is sorted out. It
15 is going to take six months, a year, or longer
16 to sort out the issues.

17 And the other aspect of it -- and
18 I don't know how important this is -- whether
19 it is real or perceived, the public has
20 perceived this as a very negative event, what
21 has happened in the VA and now with the
22 Military Hospital Systems. And I don't really

1 agree with it, but that is the way it is
2 written up and that is the way it is
3 perceived.

4 And perhaps in some obtuse way
5 this is an answer from our Committee to say,
6 "Listen, we understand there's an issue.
7 Let's do this. And when the system is fixed
8 or improved, it can be taken away."

9 That's just my thoughts and my
10 argument. I don't see a real downside to it,
11 but --

12 DR. STONE: I'm feeling
13 uncomfortable from the following point: we
14 are a DoD committee. Therefore, our focus has
15 been on Service members and, as Admiral Nathan
16 has already pointed out, all of those Service
17 members have access through TRICARE and can
18 either choose MTF-based care or private access
19 to care.

20 What this really is is about
21 solving a problem within the VA. And I am
22 feeling uncomfortable with us making that

1 recommendation. I happen to believe that part
2 of the solution to the VA's problems are
3 placing them under the same pressures that the
4 military healthcare system is today, where it
5 has to go out and earn your trust.

6 So, specifically, you are talking
7 about a subset of veterans. And I am just
8 thinking we are solving a problem that is
9 beyond our charge and which already has
10 tremendous attention of the American public,
11 as well as the American Congress and
12 leadership.

13 So, I am feeling pretty
14 uncomfortable with this one as it is.

15 DR. PHILLIPS: Well, I know there
16 is legislation with the thoughts about, if you
17 live more than 40 miles from a VA hospital,
18 you have other options, and so forth.

19 Well, whatever; I just wanted to
20 express my opinion.

21 MS. MALEBRANCHE: Yes, I think it
22 is similar, though, in VA. And you're all

1 right in that it is going to take a lot
2 earned-back trust. But, in terms of the VA,
3 when people are part of that system, they have
4 the VA; they also have, many of them still
5 have the MTF. They have TRICARE. Where the
6 VA cannot provide the care, they have fee
7 basis. And now, the VA Administrators,
8 Directors, have access to another venue of
9 this PC3 contract. They have the sharing
10 agreements. They have agreements with
11 universities.

12 We have had this issue of the
13 appointments and the waiting times and those
14 things. And the VA does not have the TRICARE
15 for life. So, people often have a menu of
16 options. But perhaps the group that we're
17 talking about, the Recovering Warriors, or the
18 younger ones, may not have Medicare. Some may
19 if it has been over the two years with the
20 Social Security piece.

21 So, I don't know that we can
22 expand any more other than the whole issue of

1 the timing. Like if you need to have an
2 appointment, those access times, those times
3 are pretty critical for your specialty care,
4 for routine care, those sorts of things, which
5 is what the VA is looking at right now.

6 So, I don't know that it offers a
7 lot more by saying they can do Medicare
8 because, frankly, if the VA can't get a
9 neuropsychiatrist in "Wherever, Montana,"
10 chances are there's not one there anyway. I
11 mean, you know, you don't have all these
12 places. And the VA has facilities in more
13 rural places oftentimes than DoD.

14 So, there's a lot of nuances of
15 this, and I am a little uncomfortable in it,
16 but I am not sure that we can put out for the
17 others. I mean, I don't know if it is
18 expanding access or creating access.

19 DR. PHILLIPS: I'm getting the
20 message.

21 (Laughter.)

22 Again, I just don't see a real

1 downside to doing it.

2 CO-CHAIR NATHAN: Well, let me,
3 first of all, compliment your perception and
4 your desire. You recognize that there are
5 access problems. I think we are all agreed on
6 that.

7 What I don't know is, is that the
8 best answer, Medicare, TRICARE, CHAMPUS VA?
9 I don't know if that is the best answer.

10 I agree with you, Steve. I think
11 you have hit on something that needs a more
12 creative solution. What I don't know is if
13 there is something better than
14 Medicare/TRICARE. And combining what Karen
15 and Rich Stone said together, there are people
16 at work in the VA right now who are talking to
17 the Medicare people, who are talking to the
18 federal employees' benefit unions, who are
19 talking to Aetna and other private insurance
20 companies, and are crafting solutions that are
21 probably more erudite than we have access to.
22 So, it is not really in our purview.

1 And then, secondly, there are
2 second- and third-order effects that have to
3 do with the way we fund our TRICARE plans and
4 our TRICARE supplemental plans that are beyond
5 the purview.

6 So, you have me as far as, if we
7 wanted to make a recommendation -- and I think
8 we have done this over the years, so I don't
9 know if it is necessary -- but if you wanted
10 to make a recommendation, we need to have more
11 creative solutions for expanding access across
12 the MHS and the VA and the veteran population.
13 That is true. The Surgeons General are united
14 in that our patients don't get the access they
15 need, especially those who live outside our
16 catchment areas, who live in what we call sort
17 of the interstitial space or the white space.
18 That is true.

19 What I just can't sign up for, me
20 personally at this point, is saying that I am
21 comfortable as just a Task Force member saying
22 that the best thing to do is throw out to

1 Medicare, TRICARE, CHAMPUS VA, because I would
2 love to hear Medicare stand in front of us or
3 CHAMPUS VA stand in front of us and say, "Boy,
4 would this help us. Thank you for doing it
5 because this is what we need." Or would they
6 stand in front of us and say, "And this is the
7 last thing in the world we need, is to try to
8 take care of your population."?

9 So, I just don't have enough data
10 to tell you that that is the best solution.
11 I agree wholeheartedly with you that there is
12 a problem. I think it is being looked at.
13 And whether it will be fixed or not I can't
14 tell you. I just can't in confidence
15 recommend that particular solution set because
16 I don't have the data, the findings, or the
17 experience talking to those people to see if
18 that is what they think is best.

19 CAPT SANDERS: Without going into
20 the solution or recommendation to the solution
21 of the problem, is it incumbent upon as a body
22 looking at these areas to recognize the

1 problem and to state the fact that we have
2 recognized the problem someplace other than in
3 a recommendation?

4 LTCOL WONG: It is a pernicious --

5 CO-CHAIR NATHAN: Well, we are
6 technically a Recovering Warrior Task Force.
7 So, do we believe that Recovering Warriors
8 have, that subset of the military, the
9 Recovering Warrior who is also a veteran or
10 who becomes a veteran, has access problems?
11 And I think we know, through certain dramatic
12 anecdotal issues, that it does happen on
13 occasion. We see people who can't get into
14 mental health, who have PTS and dramatic
15 things happen as a result. So, we know that.

16 But, if you believe, as a Task
17 Force, that our Recovering Warriors -- and
18 that includes the individual who, from the
19 minute they are injured or ill to the
20 continuum of care when they are transitioned
21 to either the VA or private sector, isn't
22 getting the access they need -- to answer your

1 question, we can decide if we still feel that
2 needs a recommendation to call attention to
3 that.

4 CAPT SANDERS: Or something less
5 than a recommendation.

6 CO-CHAIR NATHAN: Or something.

7 CAPT SANDERS: And I would say
8 your span of Recovering Warrior-ness in terms
9 of the injury moment through the end of the
10 cycle, I think any part of that cycle that we
11 think is significant is something that we need
12 to address, since they are a Recovering
13 Warrior the whole time.

14 And if we see that as an issue,
15 whether we decide to put an answer to it, I
16 think we also have a role as an issue-spotter,
17 and to lay those things out, in someone said
18 in a pernicious way -- someone used another
19 word a minute ago -- and lay that into the
20 body of the document that goes forward.

21 And I am not quite sure how you
22 would lay that out, Denise, but as a though

1 process, is that something that fits into the
2 way we have done business?

3 MS. DAILEY: Well, yes, you have
4 got several issues in the introduction,
5 Chapter 2 -- is that correct? -- Chapter 1.
6 You have several locations in Chapter 1 where
7 we have said you need to continue to watch
8 PTSD; you need to continue to watch your EHRs.
9 We added yesterdays Centers of Excellence.

10 Now we have built quite a body, a
11 knowledge of these three issues over the last
12 four years. Yes, we could put it at that
13 location. It would be a one-liner. I don't
14 have a lot over the last three years about it,
15 but, yes, we can put it in the introduction.
16 We can put it in Chapter 1 and say, "Continue
17 to monitor your access issues and consider
18 Medicare possibly as an option." That is what
19 it would consist of.

20 DR. PHILLIPS: Before we vote it
21 down, I just want one final comment.

22 (Laughter.)

1 It is my surgeon's culture and
2 personality that I want to fix it; I don't
3 want to discuss it. You know, it's bleeding.
4 Let's stop the bleeding and we will figure out
5 how to fix it later on.

6 CO-CHAIR NATHAN: I appreciate
7 that.

8 MR. REHBEIN: One comment for the
9 staff, if they are going to put this the
10 pernicious issues area. One of the groups of
11 Recovering Warriors that has not been
12 addressed here today is those of the Reserve
13 component. The problem is not as big as it
14 was, but many of those Reserve component
15 people came back home to states where
16 geographically access to the VA was difficult.
17 And it was their only choice because they were
18 sent home to go to the VA.

19 And so, that is a group that
20 really needs to be kept in mind. It is not
21 just waiting time for appointments. It is not
22 just access to specialty care. It is the fact

1 that a 25-year-old National Guardsman has to
2 take most of a day off work to go to the VA
3 for a one-hour appointment. That makes it
4 hard to continue employment.

5 And so, there is that group out
6 there that I think we need to keep in mind as
7 we do whatever we decide to do in Findings or
8 pernicious issues. I think there is basis
9 there for the need for continued attention to
10 the problem.

11 MS. MALEBRANCHE: You know,
12 actually, Mr. Rehbein, you reminded me of
13 something, too. Just a sidebar for one
14 second, a little tangential here. I do like
15 Medicare as an option for those. I think that
16 is at least another venue.

17 But one of the things that is
18 being explored, and we haven't talked a lot
19 about in this or put a suggestion in, but
20 telemedicine for those rural areas is a huge,
21 huge thing. And I think probably more ought
22 to be putting it out. Because, for that hour

1 appointment, you can have a specialist, I mean
2 far away, too far to travel, but not take so
3 much of the Service member or the veteran's
4 time by doing some of the telemedicine.

5 And we haven't done much as a
6 committee for that. I know people are working
7 it, just not working all that fast. But that
8 is a huge area to consider.

9 DR. PHILLIPS: It works very well
10 in certain areas like dermatology, and so
11 forth. Behavioral health is a little
12 different. But it is something that we do a
13 lot at the NIH.

14 CO-CHAIR NATHAN: I think I speak
15 for everybody when I say the most astonishing
16 fact that has been brought up so far is that
17 you're 73 years old.

18 (Laughter.)

19 Okay. Any further discussion on
20 this recommendation, on this submission for a
21 recommendation?

22 (No response.)

1 If not, I need a motion, if
2 someone so desires to vote this up or down.

3 DR. PHILLIPS: So moved.

4 CAPT SANDERS: So moved to vote.

5 CO-CHAIR CROCKETT-JONES: Okay.

6 Let me just say let's me clear in that
7 "create" was not the language.

8 So now, I am ready for a second.

9 Did someone second yet?

10 DR. PHILLIPS: If you move, I'll
11 second.

12 CO-CHAIR NATHAN: Okay. So, there
13 is a motion before us to adopt D13 and order
14 a vote. In the affirmative means that you are
15 adopting as a recommendation, in order to
16 expand access to care for Service
17 members/veterans, provide an option to use
18 Medicare, TRICARE, CHAMPUS VA.

19 A vote in the negative means not
20 to adopt this.

21 All those in favor of adopting
22 this as a recommendation, please raise your

1 hand.

2 Keep them up. Keep them up.

3 (Laughter.)

4 All those opposed?

5 Those abstaining?

6 One abstention. One abstention,
7 okay.

8 DR. PHILLIPS: Well, I feel like
9 I'm talking to my wife.

10 (Laughter.)

11 CO-CHAIR NATHAN: No, but we
12 actually listen to you. We listen to you.

13 (Laughter.)

14 CAPT SANDERS: A point of order,
15 sir. At the next moment, I would like to ask
16 the group to move this into a pernicious area
17 of our report as a problem.

18 CO-CHAIR NATHAN: Okay. So,
19 Captain Sanders is asking that this be put in
20 part in our pernicious category.

21 MS. DAILEY: Yes, we will put in
22 the pernicious issues section of the

1 introduction. We will align it along the
2 lines of access to care possibly as an option
3 to increase access, to be considered.

4 CAPT SANDERS: And you could even
5 align it, if it feels appropriate, with the
6 access to legal support in the long-distance
7 scenario that we have going on now where that
8 has also been identified as a problem. But it
9 actually made it into a recommendation.

10 MS. DAILEY: Okay. Okay, good.
11 Good.

12 CO-CHAIR CROCKETT-JONES: I think
13 we have reached the end of our rest of the
14 recommendations, but we have, I believe, a two
15 o'clock --

16 MS. DAILEY: Yes. So, Dr. Guice
17 has arrived.

18 CO-CHAIR CROCKETT-JONES: Okay.
19 Shall we take a break first?

20 MS. DAILEY: A very brief break,
21 yes.

22 CO-CHAIR CROCKETT-JONES: A brief

1 break. Ten minutes?

2 MS. DAILEY: Uh-hum. And we will
3 bring Dr. Guice up for presentations of
4 awards, ladies and gentlemen.

5 LTCOL WONG: And then, Denise, are
6 we going to, similar to what we did yesterday,
7 re-review all we voted?

8 MS. DAILEY: Yes, right after the
9 ceremony. It might be a little anti-climatic.
10 We will go back to our seats and we will just
11 tie up some details.

12 (Whereupon, the foregoing matter
13 went off the record at 1:46 p.m. and went back
14 on the record at 1:58 p.m.)

15 DR. GUICE: All right. Well,
16 first of all, I want to thank Denise for
17 asking me to come do this.

18 I must admit, although there's
19 some new faces at the table, I feel like this
20 is a little bit of a coming-home for me. I
21 was here when this thing started and had the
22 privilege and the pleasure of going on a

1 couple of site visits and working on the first
2 report. And then, life changed for me and I
3 went over to the Department of Defense.

4 But I can tell you all that I
5 think your work has been incredibly important.
6 I think the contributions you have made over
7 the years that this Task Force has been
8 working have been sound, good recommendations
9 for both the Departments and how we care for
10 our Wounded Warriors.

11 I hope that you will be able to
12 look back on the body of the work that you
13 have done and be extraordinarily proud of the
14 changes that have been made.

15 You also need to remember that,
16 while not everything will get enacted the way
17 you envisioned or implemented in the way that
18 you thought it should be done, the fact that
19 you spent the time and effort, the fact that
20 you went out and you actually got data from
21 people, talked to them on the ground, got to
22 ground truth on a variety of issues, and then,

1 thoughtfully derived recommendations in a
2 process that was collaborative and sharing, is
3 really important. And I think you all should
4 be extraordinarily proud of what you have
5 done.

6 So, I personally would like to
7 give you guys a round of applause, and you
8 should give yourselves one, too.

9 (Applause.)

10 DR. PHILLIPS: And the staff, the
11 extraordinary staff.

12 DR. GUICE: Oh, the staff are the
13 reason you guys look good. They're the only
14 reason you look good.

15 (Laughter.)

16 You can't do this kind of work
17 without extraordinary backup and help and
18 assistance. So, yes, the staff has been there
19 for you, and that is just priceless,
20 absolutely priceless.

21 So, I understand we have awards to
22 give now. All right?

1 MR. McKELVIN: Good afternoon.

2 We begin with those receiving the
3 Task Force Certificate of Appreciation. The
4 Certificate of Appreciation citation reads as
5 follows:

6 "For exceptionally meritorious
7 service while serving with the Recovering
8 Warrior Task Force.

9 "The Task Force member was
10 instrumental to the Task Force as a subject
11 matter expert on topics that impacted the
12 future for wounded, ill, and injured Service
13 members.

14 "Through the member's keen insight
15 and experience, the Task Force member
16 contributed to the Task Force's development of
17 numerous recommendations to the Secretary of
18 Defense.

19 "The member's dedication and
20 outstanding work ethic reflects great credit
21 upon himself and the Department of Defense.

22 As your name is announced, please

1 come towards the front, where Dr. Guice is
2 standing, and receive your award.

3 The first award goes to Technical
4 Sergeant Alex Eudy. He is receiving a
5 Certificate of Appreciation for exceptionally
6 meritorious service as United States Air Force
7 and Special Operations Command Representative
8 for the Recovering Warrior Task Force.

9 (Applause.)

10 Command Sergeant Major Steven
11 DeJong will be receiving a Certificate of
12 Appreciation for exceptionally meritorious
13 service as the United States Army National
14 Guard Representative for the Recovering
15 Warrior Task Force.

16 (Applause.)

17 Lieutenant Colonel Sean Keane will
18 be receiving a Certificate of Appreciation for
19 exceptionally meritorious service as the
20 United States Marine Corps Representative and
21 the Reserve Component Representative for the
22 Recovering Warrior Task Force.

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(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

1 Secretary of Defense Award for Outstanding
2 Achievement as well as the Office of the
3 Secretary of Defense Award for Excellence.

4 The Office of the Secretary of
5 Defense Award for Outstanding Achievement was
6 established to recognize significant
7 contributions to the mission of activities
8 receiving operational support from the
9 Washington Headquarters Service Directorate
10 for Personnel and Security Customer Support
11 Operating Office or the Organization of the
12 Joint Chiefs of Staff.

13 The Office of the Secretary of
14 Defense Award for Excellence was established
15 to recognize career civilian employees
16 assigned to the Washington Headquarters
17 Service Directorate for Personnel and Security
18 Customer Support Operating Office or the
19 Organization of the Joint Chiefs of Staff, to
20 have made significant contributions to the
21 mission of activities.

22 The citation for each award reads

1 as follows:

2 "For meritorious service as a non-
3 Department of Defense member for the
4 Recovering Warrior Task Force.

5 "During their time on the Task
6 Force, they provided significant contributions
7 in various areas relating to wounded, ill, and
8 injured Service members and families.

9 "Over 120 man-days were
10 contributed to attend scheduled Task Force
11 business meetings and installation visits to
12 military and Department of Veteran Affairs
13 facilities.

14 "Through the many installation
15 visits, the members met with over 500 Service
16 members and family members through focus
17 groups held at CONUS and OCONUS military
18 facilities.

19 "The members were also
20 instrumental in the Task Force's development
21 of four Annual Reports which encompassed
22 numerous recommendations provided to the

1 Secretary of Defense regarding a number of
2 recovering warrior policies and programs.

3 "These recommendations have had
4 such an impact on the Department of Defense
5 that 75 percent of the recommendations have
6 been conferred with and/or taken action upon."

7 As your name is announced, please
8 come towards the front and receive your award
9 from Dr. Guice.

10 Ms. Suzanne Crockett-Jones will be
11 receiving the Office of the Secretary of
12 Defense Award for Outstanding Achievement for
13 meritorious service as a non-Department of
14 Defense Co-Chair for the Recovering Warrior
15 Task Force.

16 (Applause.)

17 Mr. Ronald Drach will be receiving
18 the Office of the Secretary of Defense Award
19 for Outstanding Achievement for meritorious
20 service as a non-Department of Defense member
21 for the Recovering Warrior Task Force.

22 (Applause.)

1 Mr. David Rehbein will be
2 receiving the Office of the Secretary of
3 Defense Award for Outstanding Achievement for
4 meritorious service as a non-Department of
5 Defense member for the Recovering Warrior Task
6 Force.

7 (Applause.)

8 Dr. Richard Stone will be
9 receiving the Office of the Secretary of
10 Defense Award for Outstanding Achievement for
11 meritorious service as a non-Department of
12 Defense member for the Recovering Warrior Task
13 Force.

14 (Applause.)

15 Ms. Karen Malebranche will be
16 receiving the Office of the Secretary of
17 Defense Award for Excellence for meritorious
18 service as a non-Department of Defense member
19 for the Recovering Warrior Task Force.

20 (Applause.)

21 And last, Dr. Steven Phillips will
22 be receiving the Office of the Secretary of

1 Defense Award for Excellence for meritorious
2 service as a non-Department of Defense member
3 for the Recovering Warrior Task Force.

4 (Applause.)

5 All right. This concludes the
6 awards presentation portion of the business
7 meeting.

8 Congratulations to the Task Force
9 members for their awards.

10 And thank you, Dr. Guice, for
11 making time to join us today.

12 DR. PHILLIPS: I would just like
13 to applaud our Co-Chairs and everybody else.
14 You guys were great.

15 (Applause.)

16 MS. DAILEY: Very good, ladies and
17 gentlemen. Thank you very much for your vote
18 and our set of recommendations.

19 I do want to pull up our last set
20 of recommendations. I should have guided you.
21 Did we have a chance to clean them up, so we
22 could review them? Excellent.

1 So, we are going to go over what
2 we have done today one last time and review
3 those items. We will do what we did
4 yesterday. We will send them out to our
5 stakeholders.

6 We will start with where we left
7 off, and then, we will go back.

8 The 9 July items. Okay, ma'am,
9 can I get you to read these again. And you
10 will see, we need to kind of get a feel. We
11 don't want to do a lot of changing here.
12 There might be some items that we will need to
13 pluralize or something, but let's just review
14 what we have accomplished.

15 CO-CHAIR CROCKETT-JONES: All
16 right. D8, which is our seventh
17 recommendation.

18 "To optimize the family and
19 significant other contribution to warrior's
20 recovery, facilitate the participation and
21 socialization throughout the continuum of
22 care, management, and transition. HIPAA rules

1 that potentially constrain family involvement
2 should be mitigated."

3 D9, "Pre-DD214" --

4 MS. DAILEY: Hang on just a
5 minute.

6 CO-CHAIR CROCKETT-JONES: Okay.

7 MS. DAILEY: And on that one, we
8 are going to ask Warrior Care Policy Office to
9 address this one. Okay.

10 CO-CHAIR CROCKETT-JONES: For D9,
11 "Pre-DD214, facilitate the transfer of each
12 Service member to the VA by automatically
13 registering him or her in a system that
14 populates the VA database with all
15 transitioning Service members."

16 MS. DAILEY: Yes, this one, it
17 falls under USD P&R. Probably it would end up
18 in the Warrior Care Policy Office or DMDC,
19 which is also an entity of the USD P&R.

20 Good.

21 CO-CHAIR CROCKETT-JONES: "Take
22 affirmative steps to ensure DoD's and the

1 Services' employment programs are meeting
2 expectation. These include: creating a
3 dashboard, reporting RW employment metrics,
4 allowing ongoing monitoring and visibility of
5 how well RWs are doing in the job market.
6 Matching skill sets to employers' needs.
7 Taking steps to make veterans advantageous
8 hires. And Congress should ensure integration
9 of effort among DoD, VA, and DOL employment
10 programs."

11 MS. DAILEY: Again, this one is
12 going to fall under USD P&R, the Warrior Care
13 Policy Office, and also probably the Office of
14 Transition, the Office of Service Member
15 Transition, Dr. Kelly's office.

16 Okay, we've got it, yes.

17 MS. MALEBRANCHE: Denise?

18 MS. DAILEY: Yes?

19 MS. MALEBRANCHE: I'm sorry. Just
20 to go back one on the automatic registering --

21 MS. DAILEY: Right.

22 MS. MALEBRANCHE: -- would we not

1 also ask VA to respond to that?

2 MS. DAILEY: Okay. Yes, put VA in
3 there also. Put it right after USD P&R.

4 Okay.

5 CO-CHAIR CROCKETT-JONES: "Upon
6 Reservist transfer to a Reserve unit, require
7 health insurance, TRS, or other private health
8 insurance as a condition of continued
9 employment in the Reserve component.

10 MS. DAILEY: This would go to the
11 ASD Reserve Affairs.

12 And that brings you to the last
13 one. You have a total of 10 recommendations,
14 ladies and gentlemen, that you will be going
15 forward with. All right?

16 We had another one we wanted to do
17 some tweaking on, which was Mr. Rehbein had
18 concerns.

19 MR. REHBEIN: I just didn't want
20 that to read like there was going to be just
21 one policy.

22 MS. DAILEY: So, would you all,

1 without a vote, be comfortable with "these
2 policies"?

3 CO-CHAIR CROCKETT-JONES: No, I
4 think "such policy". I think Mr. Rehbein's
5 word is actually the right one.

6 MS. DAILEY: Okay. Okay, good.
7 Okay. All right.

8 CO-CHAIR CROCKETT-JONES: It says
9 to respond Congressman Jack -- okay, I was
10 just wondering if we needed DoD or VA to
11 respond to that.

12 MS. DAILEY: Okay, very good.
13 This is your embodied recommendations for this
14 final year, 10 recommendations.

15 Okay, any questions?

16 (No response.)

17 We are going to email this out to
18 you. We are going to email it out to the
19 stakeholders.

20 All right, very good job.

21 All right, one last thing I want
22 you all to touch, and I want to bring your

1 attention to, if you haven't already done it.
2 I would like, everyone, let's turn to Tab E.
3 Tab E is your Executive Summary and Chapter 1.

4 Now your Executive Summary is
5 going to be modified to reflect your
6 recommendations. It is non-controversial. It
7 is just a listing of your recommendations.

8 We have introductory comments in
9 the Executive Summary that encompass the last
10 two years, kind of summarizes them very
11 quickly. But, again, it is about these
12 recommendations.

13 And if you haven't had a chance,
14 you need to kind of read through this real
15 quickly. But, again, it is very directed at
16 doing a quick synopsis of the recommendations.
17 It will be modified to reflect the 10 instead
18 of the 13.

19 It guides you into Chapter 1,
20 which is a more substantive chapter on the
21 work that you have done this last year. It
22 encompasses kind of a history. It talks about

1 your mission, your charter.

2 And then, I think the most
3 controversial part is going to be page 6,
4 where we really kind of task Congress to
5 utilize this report and to utilize our
6 recommendations over the last two years to
7 monitor and to provide oversight to the
8 Department of Defense. This is also where we
9 have pernicious issues.

10 Page 7, where you see "Looking to
11 the Future," we guide people to look at the
12 Best Practices because we think we have
13 encompassed in the Best Practices for you good
14 partnerships, good models for the way forward,
15 good templates for linking your
16 recommendations and programs with the
17 Department, with outside resources, with
18 industry, with nonprofits.

19 And the theme here is, as we draw
20 down, don't lose your connectivity with these
21 services. They are out there. Reach out
22 there to capitalize on them. Your "Looking to

1 the Future" section talks about reaching into
2 society, reaching into the nonprofits, and
3 integrating them better and utilizing them to
4 pick up services that you, as a government
5 agency, may not be able to deliver.

6 So, your introduction is a longer
7 one than you have done in the past, and it has
8 a number of components. It has your
9 pernicious issues, and it also takes you into
10 the future, a vision for the future.

11 Then, I do want to refer you to F,
12 I believe. We have Best Practices at F.

13 Based on your guidance from the
14 May meeting, we have captured a number of Best
15 Practices that we came across this year. Most
16 of them, again, are about bridging, linking
17 your current DoD services to civilian,
18 nonprofit, non-government resources that DoD
19 can tap into as good models and good templates
20 for continued care, continued services in the
21 face of drawdowns.

22 And very, very quickly, we talked

1 about San Diego's model. We have talked about
2 the University of Florida, the Augusta Warrior
3 Project, San Antonio Health System, the
4 National Abilities Center out at Utah, the
5 Apprenticeship Program as your Recommendation
6 -- what is it now, the employment? -- 9 or 10.

7 You know, this is one example of
8 how you can prepare people for continued
9 employment through a very good apprentice
10 program which has been set up out at Lewis-
11 McChord.

12 We saw a good program out at
13 Hawaii for employing Service members in the
14 VA.

15 And then, we also wanted to
16 highlight the Marine Corps' efforts with their
17 Reserve component as the last, not last but as
18 the Best Practice on page 48.

19 So, your recommendations tie into
20 a lot of these Best Practices as the next
21 step, as the template that the DoD could go to
22 to implement and to continue to deliver

1 services in the face of declining resources,
2 declining budgets.

3 All right. I also want to draw
4 your attention, then, to Tab G. We are going
5 to capture in this report all the statuses of
6 the recommendations of all the previous years.
7 So, Tab G is updated to the best of our
8 ability what we feel is the current status of
9 recommendations.

10 The "Continue to Follow," there is
11 some subjectivity here over the years, ladies
12 and gentlemen, that we have had. "Continue to
13 Follow" means that we really would like
14 possibly Congress to continue to follow them.
15 Obviously, we aren't going to be here.

16 The tenets still hold that these
17 programs need to continue to get to the vision
18 that the recommendation has laid out. Some we
19 have said they have been met; some we just
20 think that they haven't gotten there yet. And
21 as Dr. Guice said, it may never seem to be in
22 the vision that we had for the DoD to

1 implement, but it isn't there and you feel it
2 needs to continue to be followed.

3 And we have done a percentage. I
4 have to report this every year. What do we
5 think is the percentage of completion? And,
6 David, I heard you use the one, 75 percent, in
7 your language.

8 David? Yes, okay.

9 On page 55 of Tab G, we do kind of
10 wrap it up, where we thank Service members; we
11 thank the Services.

12 LTCOL WONG: Denise, is there a
13 difference between "Continue to Follow" and
14 "Continue to Address"?

15 MS. DAILEY: David, did I have a
16 nuance in there at one time, "Continue to
17 Follow" and "Continue to Address"?

18 MR. McKELVIN: So, "Continue to
19 Address" was supposed to be something that the
20 Task Force would potentially make another
21 recommendation for.

22 MS. DAILEY: Okay, yes. Yes.

1 "Continue to Address" means that we probably
2 had a follow-on or a recommendation the next
3 year that refined the recommendation or
4 continued the recommendation. So, we
5 continued to address it.

6 Okay, that is another one of your
7 Annexes. And I would like, then, Tab H,
8 ladies and gentlemen. We do have a timeline
9 for what is going to be coming up.

10 In July, this report, the first
11 voted draft is going to come back to me with
12 all these changes on the 18th of July. And I
13 will make any changes that are needed, and
14 there will be any graphical changes, any
15 typos, which I rarely see. So, it is kind of
16 a quick turnaround.

17 And then, I will return it to the
18 Research Team, and they are going to do the
19 final editing on it. And you are going to get
20 a pretty close to final document on the 29th
21 of July.

22 Your feedback to me is going to be

1 due on the 5th of August. And any changes you
2 make we will incorporate. I need to send it
3 to Security. We are going to send it back to
4 the desktop publisher on the 15th.

5 And then, we think we will have
6 delivery of a final product on the 19th. And
7 we are releasing on the 2nd. And somewhere
8 between the 19th and the 2nd, we will outbrief
9 DoD. We do not have the dates yet for
10 outbriefing Congress.

11 All right?

12 CAPT SANDERS: On the outbrief, is
13 that an event that members attend?

14 MS. DAILEY: Generally, because
15 DoD is so fluid -- that is, they will make an
16 appointment; they will cancel it; we will
17 reschedule -- I am the only one who outbriefs
18 DoD because I have that flexibility.

19 I take the two Chairs up to the
20 Hill because that is more of, when they lock
21 in a date, they lock it in.

22 So, we have been through Tab H.

1 We reviewed the final
2 recommendations.

3 And I will turn it back over to
4 the Co-Chairs for any closing comments.

5 CSM DEJONG: Ma'am, one quick
6 question?

7 MS. DAILEY: Sure, sure.

8 CSM DEJONG: Do we need to do the
9 signature page now?

10 MS. DAILEY: The signature page is
11 complete. Please, the signature plate is
12 complete.

13 CSM DEJONG: It never made it to
14 this side of the table.

15 MS. DAILEY: Last year we were
16 chasing it. It is done right there. David
17 has got it. I think we did it in April,
18 frankly. I think I stewarded some of my staff
19 last year, so they got it out to you early
20 this year.

21 MS. MALEBRANCHE: On this current
22 set of recommendations where we have got

1 responsible agency, in the past we have seen
2 where they have said they concurred or non-
3 concurred. When does that come or do we ever
4 hear? Or how does that work?

5 MS. DAILEY: Yes. Ninety days.
6 So, on around 2 December, but it is really an
7 internal Department of Defense requirement to
8 respond to Congress. The bottom line is we
9 have had the courtesy of having access to it
10 over the last few years, but on the 2nd of
11 December, when their first response to
12 Congress is due, you will have sunset. You
13 will have officially sunset.

14 So, you know, the answer is,
15 theoretically, no, you will never see those
16 responses. That is theoretically -- you know,
17 I mean, I can probably reach into friends. I
18 can call over to Drew at Warrior Care Policy
19 Office, "Hey, give me a copy of that
20 document," and/or the same thing on March the
21 3rd, when the Implementation Plan is due.

22 So, it is only after the 24th of

1 November, after you have sunsetted, it is only
2 the good-buddy network that gains you access
3 to that information.

4 CO-CHAIR NATHAN: I think, Denise,
5 though, I think I speak for everybody that,
6 since that information is not sequestered and
7 is in the public domain, if we could get
8 access to it or have somebody send it out to
9 us, we would very much appreciate it.

10 MS. DAILEY: Okay. Good, good.
11 We will keep that in mind.

12 LTCOL WONG: Will the website
13 still be up and be able to populate through
14 there or will that be shut down as well?

15 MS. DAILEY: It will not be shut
16 down. I can freeze the website for a year.
17 And when I say "freeze" it, I mean I can't
18 post anything to it or I have got to find
19 someone to post something to it, because the
20 staff is gone. But what is on the website on
21 the 29th of September will be the last
22 postings.

1 CO-CHAIR CROCKETT-JONES: I just
2 want to say, in closing, as we are finishing
3 this work, this has been an amazing four years
4 for me. I couldn't have imagined this group.
5 I couldn't have created you out of whole
6 cloth. I am just thoroughly amazed at the
7 knowledge, expertise, the compassion, the
8 cooperation, and the energy that everyone I
9 have worked with has had.

10 I am so utterly impressed to have
11 been here to see this happen and to have been
12 included among it, and to have learned so much
13 from each one of you. I cannot even find the
14 right -- me, I can't find the right words to
15 tell you how honored and impressed and proud
16 I am of the work that was done and the people
17 I have spent time with.

18 I am a bit brokenhearted that this
19 is coming to a close, not even a bit. I am
20 pretty much completely brokenhearted that this
21 work is coming to a close. And I will never
22 be able to express it all to you, and it goes

1 not just for the Task Force members, but also
2 to the amazing staff.

3 And I can only say that most of
4 you know where I live. And the only way that
5 this broken heart will heal is if somebody
6 comes out and visits me from time to time.

7 Thank you all very, very much.

8 CO-CHAIR NATHAN: I would echo all
9 of that. I believe this nation owes everybody
10 here two debts of gratitude, the first being
11 just for the service that you have performed
12 over the years in all the various capacities,
13 be it in the federal or non-federal sector, be
14 it as supporting spouses, be it as mentors and
15 leaders, and those of you who have fought and
16 suffered the wounds of war.

17 And the second debt is for what
18 you have done collectively to make a
19 difference. I recognize, I think we all
20 recognize that this can be pretty tedious
21 stuff, and a lot of it is fighting bureaucracy
22 and a lot of it is wondering, if we fire

1 around into the void, does it really fall
2 anywhere that makes a difference.

3 And I am convinced that, I
4 certainly know that, from our site visits and
5 meeting and focus groups, we have occasionally
6 turned around a situation in one individual.
7 That I know for a fact. But I also know that
8 somewhere in this massive landslide of
9 recommendations over the last few years, some
10 of them take hold and have made a difference.
11 And we don't get to see that, but somewhere
12 there is a Service member or their spouse or
13 their child who has a better life, who has a
14 better outlook, who has a better chance
15 because of the work you all have done. It is
16 never going to be as many as we wish it would
17 be, but it is going to be as many as we are
18 grateful for.

19 And so, I thank you on behalf of
20 those who aren't here to thank you. And I
21 thank you on behalf of those that are doing
22 well right now and whose life will deal them

1 a hard left turn, and they will have the wind
2 knocked out of them. And maybe they will get
3 up a little faster and feel a little better
4 because of the work you all have done.

5 So, that goes to everybody in here
6 who has had their hands on this, be it the
7 people who have come to stand before us to
8 give us their public opinions, to the amazing
9 staff, and, Denise, you and your team, to my
10 colleagues. And I am indebted to Suzanne and
11 all of you for allowing me to make a
12 difference.

13 I think, at the end of the day,
14 all you can say is you tried to leave the
15 place a little better than you found it. And
16 I am convinced that you all have done that.
17 And I have been very energized by the
18 collective discourse on the issues that has
19 allowed, I think, the best way forward,
20 because everybody brought a different
21 perspective and it opened my eyes to a lot of
22 things.

1 And I guess I would just simply
2 finish, Denise, by saying that we here,
3 speaking for Suzanne and myself and the rest
4 of the Task Force, we here want to applaud you
5 and your staff for, indeed, making us look
6 good and, indeed, making this almost seem
7 effortless, both in the logistics of traveling
8 as well as the final report.

9 So, thank you, Denise, and your
10 staff very much.

11 (Applause.)

12 And with that, I think we are
13 done.

14 MS. DAILEY: Would any of the
15 members like to -- I know I don't want to drag
16 this out, but if there is anything else any of
17 the members would like to say, this is your
18 chance.

19 LTCOL KEANE: Admiral, you opened
20 with you echoed all of Ms. Crockett-Jones'
21 comments. We went to her house. Could you
22 please give us your address, so we could by

1 and visit you, too?

2 (Laughter.)

3 CO-CHAIR NATHAN: I didn't forget
4 not to give you my address.

5 (Laughter.)

6 CAPT SANDERS: Just a quick
7 comment. As a late-bloomer on the Task Force,
8 thank you for the welcome and the engagement.

9 It was very, very, very rewarding
10 to actually see this from a different
11 perspective. Because, as the attorney for
12 these individuals through the PEB process, I
13 got to see one side of it, and this is a
14 different piece.

15 MS. MALEBRANCHE: I would like to
16 say also, just on behalf of the VA, because
17 you know we're going through some awful times
18 right now, but I want to assure you that we're
19 working hard.

20 And it was an emotional piece for
21 us, I think, to hear that. And in the midst
22 of all this, it was a horrible thing to hear

1 for us, but I have to say the work on the Task
2 Force and the issues that I have learned
3 throughout the time have been amazing.

4 I carry a little special piece --
5 I am like Suzanne; I am a very emotional
6 person. I wear everything right out. But I
7 carry a little piece of every one of you from
8 a different time, a different trip.

9 Denise, I have to say you and your
10 staff have been amazing.

11 And if I ever get the chance to
12 work with any of you again, I would hope that
13 some of you would consider coming to the VA at
14 some point in time to work, if not as a
15 patient.

16 But I especially have enjoyed
17 Suzanne's stories and I loved meeting her
18 family. I think they were not surprised that
19 we knew a little bit, a piece about every one
20 of them.

21 But I take a little bit of each
22 and every one of you, that you have added

1 something to my life. And I thank you.

2 DR. PHILLIPS: I want to say it
3 has truly been a privilege. I mean, I feel
4 like you were all combat buddies. I mean,
5 this tough cardiac surgeon/paratrooper was
6 actually brought to tears many times during
7 some of these site visits.

8 I shared with Denise way back, and
9 really almost quit because psychologically it
10 was just getting to me. And then, I looked
11 around at my colleagues and friends and said,
12 you know, we really have to continue to do
13 that.

14 I may not have been the best
15 person to do it, but, with all of you, I think
16 you made me the best person. So, thank you.

17 MR. REHBEIN: When I first came to
18 this group, coming from the Midwest, not being
19 involved in DoD for a long time, my learning
20 curve looked more like the wall of a four-
21 story building than it did any kind of an
22 incline. Many of you put up with dumb

1 questions, sometimes maybe a not-so-quite-
2 intelligent comment.

3 I have learned an awful lot from
4 you. I will endeavor to tell this story back
5 in the Midwest because there are parts of the
6 country that don't understand the work that
7 goes on out here. And so, I want to thank you
8 for that, for allowing me the knowledge to
9 help tell that story.

10 And I really want to say thank you
11 to Denise and her staff because I have heard
12 the frustration in her voice at us at times,
13 and she has put that frustration down and
14 continued to lead us and help us in what we
15 have done. Denise, thank you.

16 CSM DEJONG: I can echo everything
17 from everyone that is here. This is really
18 one of the highlights of my career.

19 I did make the mistake one time of
20 saying that the only place I haven't been
21 assigned is the Pentagon or Washington, and
22 that was almost done before the end of the

1 day, but I was able to fight that off.

2 I have learned a lot from all of
3 you. I have got some truly good friendships
4 out of this, and it is an honor and a
5 privilege to do what we have done. I never
6 would have imagined being selected or assigned
7 to anything like this. And I thank you all.
8 I wish you all the best in your future
9 endeavors.

10 DR. STONE: Well, as one who
11 served in both positions, both in uniform and
12 out, Denise, thanks for having me back. It
13 seems like a very short time ago you arrived
14 in my cubicle in the Pentagon, or whatever
15 building we were in, and told me, "Hey, we're
16 going to do this." And then, it was six
17 months later before we got approval to get
18 moving.

19 And I am smiling because I am
20 looking at our Recovering Warrior Task Force
21 emblem here and thinking about the intense
22 emotional arguments we had as we put that

1 thing together and what will we call
2 ourselves.

3 (Laughter.)

4 Sir, you didn't have a chance to
5 participate in that, but if you ask General
6 Green, it was one of the points that he did
7 lay his head on the table, not sure that we
8 could go another inch.

9 But, look, we all worked hard at
10 this, and we did some good stuff, and we made
11 good friends.

12 However these are all used in the
13 future, they are an enduring legacy to some
14 really hard work in which we reached out to
15 the beneficiaries that needed our help so
16 much.

17 So, thanks very much for letting
18 me be part of it.

19 MR. DRACH: Yews, I would just
20 like to add my two cents and thank Denise and
21 the staff.

22 I have been in Washington now for

1 45 years and been on a lot of task forces,
2 commissions, and advisory committees. And I
3 can say without any hesitation that the staff
4 of this particular Task Force is second to
5 done in terms of their responsiveness, their
6 professionalism, their desire, their
7 willingness to go the extra mile. It is not
8 an eight-hour-a-day job for any of them.

9 And it actually started before the
10 Task Force first met, when I first started
11 talking with Denise. And Denise met me in the
12 parking lot of the Pentagon for me to sign
13 something for her for me to move forward on
14 this. And that was before the Task Force had
15 even started.

16 And I remember the first meeting
17 and we had our ethics briefing, and so forth,
18 and I got to meet a lot of the people here and
19 thought, boy, this is going to take a long
20 time. We have got four years to do this. And
21 where did the four years go to?

22 And I have just enjoyed it

1 immensely, and I want to thank everybody for
2 all the support and patience they have given
3 to me. Thank you very much.

4 LTCOL KEANE: I, too, would like
5 to thank Denise and her staff for all the hard
6 work you did. But I also would like to
7 publicly thank Denise and General Stone for
8 thinking out of the box and allowing me to
9 come in as a new persona, as the Marine Corps
10 rep, as a Reserve rep. I have talked to you
11 both personally, but publicly thank you very
12 much for thinking out of the box to allow me
13 to continue on and see this to the end.

14 TSGT EUDY: I would like to thank
15 all of you for your mentorship. As many of
16 you and those that have left the Task Force
17 have taken off the uniform, and some of you
18 will here in the future, or you may not be
19 involved with something like this further on,
20 thank you for your time and your patience with
21 me. I am coming up on about the middle point
22 of my career. So, I have plenty to look

1 forward to. But thank you for investing in me
2 as a leader. And what I can take back on the
3 Special Operations side and to the Air Force,
4 I know that I will do my best.

5 And if any of you want to come
6 back, maybe we will see each other in
7 Afghanistan, sir, if you've got some time, or
8 you, sir, or Sergeant Major, before they
9 finally get to the Board.

10 But take care. Everyone take
11 care. As you always know, my sense of humor
12 is what gets me through. So, just keep
13 laughing, keep enjoying things, and I am sure
14 I will see you all again at some point.

15 MR. REHBEIN: I want to say one
16 last thing because Alex brought it to mind,
17 talking about some folks taking off the
18 uniform. We have one member in the room that
19 is about to put on the uniform and begin a
20 career. And I think we all ought to say thank
21 you to Heather for what she has done and what
22 she is about to do through OCS and the United

1 States Marine Corps.

2 Heather, congratulations. Good
3 luck. We look forward to seeing you.

4 (Applause.)

5 CO-CHAIR NATHAN: And we're
6 through.

7 MS. DAILEY: Thank you again,
8 ladies and gentlemen. Very well done. Very
9 well done.

10 (Whereupon, at 2:42 p.m., the
11 meeting was adjourned.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Recovering Wounded Task Force

Before: US DOD

Date: 07-09-14

Place: Washington, DC

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