2012 Discharged Servicemember Task Force Annual Report

TO THE GOVERNOR AND GENERAL ASSEMBLY

Illinois Department of Veterans' Affairs

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EXECUTIVE SUMMARY

With an estimated 802,834 veterans, Illinois proudly boasts the eighth largest veteran population in the country, representing 3.5 percent of the national veteran population. In addition, Illinois is home to numerous military facilities, including Naval Station Great Lakes, Scott Air Force Base, and the Rock Island Depot. The Illinois Department of Veterans' Affairs continues to work diligently to care for our nation's warriors, their families, and their survivors. We empower veterans, as well as their dependents and survivors, to thrive by assisting them in obtaining the benefits to which they are entitled; by providing long term health care for eligible veterans; and by partnering with other agencies and non-profits to help veterans address education, mental health, housing, employment, and other challenges.

Pursuant to Public Act 95-294, effective August 20, 2007, the Illinois Department of Veterans' Affairs created the Illinois Discharged Servicemember Task Force (Task Force). The Task Force investigates the re-entry process for servicemembers who return to civilian life after being engaged in an active theatre.

The following report includes an overview, Task Force discussion summaries, and Task Force recommendations regarding each of five critical areas of transition concern: post-traumatic stress, prosthetics, education, employment, and homelessness. While recommendations vary for each area of concern, the most prominent common theme is the need for better awareness of resources and collaboration between entities providing those resources.

BACKGROUND

The Discharged Servicemember Task Force included representatives from various federal and state agencies, veteran service organizations, and not-for-profit service providers. At its quarterly meetings, the Task Force also benefited from the participation of numerous subject matter experts from academia, government, not-for-profits and corporate entities.

As of the date of this report, the Task Force is comprised of the following members:

a) a representative of the Department of Veterans Affairs, who shall chair the committee;
Rodrigo Garcia, Assistant Director, Illinois Department of Veterans Affairs

b) a representative from the Department of Military Affairs;
Eric Murray, Service Member and Family Support Services Branch Chief, Illinois Department of Military Affairs

c) a representative from the Office of the Illinois Attorney General;
Grant Swinger, Military and Veterans Rights Bureau Chief, Office of the Illinois Attorney General

d) a member of the General Assembly appointed by the Speaker of the House;
Representative Linda Chapa LaVia, State Representative 83rd District

e) a member of the General Assembly appointed by the House Minority Leader;
Representative Jim Watson, State Representative 97th District

f) a member of the General Assembly appointed by the President of the Senate;
Vacant

g) a member of the General Assembly appointed by the Senate Minority Leader;
Senator Pamela Althoff, State Senator 32nd District

h) 4 members chosen by the Department of Veterans Affairs, who shall represent statewide veterans' organizations or veterans' homeless shelters;
Mark W. Bowman, Sergeant Major, Illinois National Guard
Lt. Col. Jack Amberg (Ret.), Sr. Director of Veterans Affairs, McCormick Foundation
Dr. Cynthia Doil, School Liaison Officer, Scott Air Force Base
Marc Fisher, Regional Emergency Mgmt. Specialist, U.S. Dept. of Health and Human Services

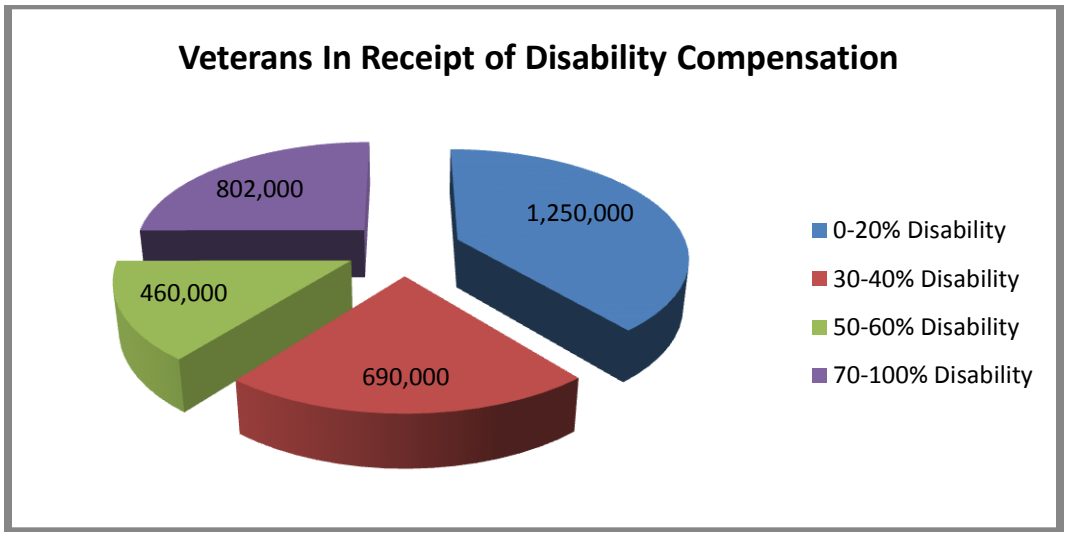
i) one member appointed by the Lieutenant Governor; and
Jim Frazier, Gold Star Father and Survivor Outreach Services Officer, U.S. Army

j) a representative of the United States Department of Veterans Affairs shall be invited to participate.
Duane Honeycutt, Chicago VBA Regional Office Director, U.S. Dept. of Veterans Affairs
Mary Ann Romeo, MSSW, VISN 12 Care Coordinator, U.S. Dept. of Veterans Affairs

OVERVIEW

According to VA's Summary Fact Sheet, dated November 2010, and the 2010 Summary of Benefits, about 5.75 million people were treated in VA health care facilities nationwide, 3.9 million veterans and survivors received VA disability compensation or pensions, more than 564,000 used GI Bill education benefits, and nearly 326,000 home loans were guaranteed by home loan benefits. Nearly 80,000 veterans took advantage of VA's vocational rehabilitation and employment service, and veterans held more than 1.2 million Veterans Group Life Insurance policies. More than 106,000 veterans and family members were buried in VA's national cemeteries, and more than 360,000 headstones and markers were provided for veterans' graves worldwide.

Based on the most recent VA available data, a nationwide total of 3,210,261 veterans had a service-connected disability. Further sub-divided by category, 1.25 million were found to be between 0-20 percent disabled, 690,000 between 30-40 percent, 460,000 between 50-60 percent, and 802,000 between 70-100 percent. This level of detail (percentage compensation) is not available at the state level.



The Veterans Benefits Administration, Office of Performance, Analysis & Integrity provided a breakdown of the top 10 service-connected disabilities for each state in 2011. In Illinois, the top service-connected disabilities were tinnitus, post-traumatic stress disorder, general scars and hearing loss. Each disability affected more than 10,000 Illinois veterans, while diabetes mellitus affected just under 10,000 Illinois veterans.

Type	Number of S-C Disabilities
Tinnitus	13,302
Post-Traumatic Stress Disorder	11,792
Scars, general	11,505
6100-Hearing loss	10,401
Diabetes mellitus	9,872
Paralysis of the sciatic nerve	7,200
Lumbosacral or Cervical Strain	6,553
Hypertensive vascular disease	5,566
Limitation of flexion, knee	5,512
Impairment of the knee, general	5,438

POST TRAUMATIC STRESS

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The US military is a battle-tested and resilient force, and its servicemembers' ability to adapt and overcome adversity is second to none. However, sustained combat has taken a significant toll on the force and the veteran community. Post-Traumatic Stress (PTS) generally commences with a traumatic event in which an individual feels one's own or someone else's life is threatened, and usually involves intense horror, terror or helplessness. After such a traumatic event, it is normal for servicemembers who have been through a trauma to struggle coping with the event and to have amplified nervousness about things related to the event. Withdrawal and avoidance are common signs associated with PTS; therefore, it is highly recommended that the service member's family be fully engaged.

Often, PTS symptoms remain for an extended period of time, although the affected individual may make attempts to avoid the memories and other triggers of anxiety. Typically, this is the junction at which PTS may worsen. Attempts to avoid thinking or discussing the traumatic event can be futile. A servicemember's family may also be greatly impacted by this affliction. Further, some veterans resort to unhealthy coping mechanisms, including drug and alcohol use. Many of those struggling with PTS can receive care through the US Department of Veterans' Affairs or at local support facilities, but their struggles prevent them from seeking help.

SUMMARY OF DISCUSSION

At the PTSD-focused Task Force meeting, Dr. Patrick McGrath, Director of the Center for Anxiety and Obsessive Compulsive Disorders at Alexian Brothers, discussed Virtual Iraq, a simulator to help individuals facing PTS. It supports their prolonged exposure therapy Cognitive Behavioral Therapy (CBT) program. Dr. Eric Proescher, an Operation Iraqi Freedom (OIF) veteran and the Operation Enduring Freedom (OEF)/OIF Outreach Psychologist at Jesse Brown Medical Center, described a different treatment method referred to as Present Centered Therapy (PCT), which studies indicate is also an effective method. According to Dr. Proescher, the primary difference in comparison of the programs was that up to 40 percent of CBT patients quit their programs early, versus less than 10 percent quitting PCT early. Nonetheless, both doctors remarked and agreed that there is "no one size fits all solution to PTS."

Dr. McGrath reported that military servicemembers are twice as likely to be diagnosed with PTSD compared to their civilian counterparts.

Members of the Task Force also focused on a better means to communicate and coordinate resource efforts. This included finding ways to more effectively track servicemembers with PTS and connecting them with the help they need and deserve.

The effects of PTS are not just on the service member. During the ensuing discussion, various Task Force members discussed the impact on families, specifically stating that family members may feel hurt, alienated, or discouraged because their loved one has not been able to overcome the effects of the trauma. Family members frequently devote themselves to those they care for and, in the process, neglect their own needs. Dr. Proescher and Dr. McGrath both mentioned social support is extremely important for preventing and coping with PTS. It is imperative for family members to take care of themselves, for their own sake and for the sake of their loved one struggling with PTS. Task Force Members also discussed the US Department of Veteran Affairs' web site devoted to PTS, noting its ease of use and how it may serve as a central portal where Veterans and/or their family members can go to find additional resources.

RECOMMENDATIONS

The Task Force provided the following recommendations:

1. **Remove the Stigma**. More attention on the screening and education of PTS – and on its associated stigma – is needed. Associated stigma may prevent veterans from accessing and utilizing available services. This may be addressed by working with existing community partners to build a stronger mental and physical health component into transition services. In addition, stronger PTS education may also address the stigma associated with these services in ways that can promote early intervention.

2. **Frequent Screenings of PTS.** Improved outreach is needed in order to ensure our returning servicemembers who exhibit symptoms of PTS receive care promptly. To accomplish this, returning servicemembers may need to be screened at additional intervals such as the 30/60/90/180 day marks.

3. **Build a Community Effort.** Better coordination is needed in order to direct servicemembers to available community resources. No single care solution is perfect for every servicemember, and often a combination of therapies – from counseling to medication to recreational therapy – is needed. Helping veterans find the right solution requires better awareness and understanding of resources on the part of providers and veteran organizations.

PROSTHETICS

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Overview of Advances in Care

The last decade has seen major advancements in prosthetics. New prosthetic advancements included the C-leg for above-knee amputees controlled by a microprocessor; the Power Knee, which synchronizes itself to the motion of the intact leg; the Proprio Foot for below-knee amputees, with a motorized ankle controlled by sensor technology; PowerFoot, with a self-sustained robotic system; and the iLimb Hand, which uses electric signals from existing muscles, enabling users to open and close life-like fingers.

Modern limbs include electric arms which use a small battery, others controlled by a tiny switch, and the myoelectric prostheses which use electrical impulses detected by small electrodes placed on the skin over the remaining arm muscles.

Artificial legs can be fitted with spring-loaded feet, artificial feet constructed with toes, synthetic coverings made to match skin tone and hair patterns, and electrodes in the artificial limb leading to the natural skin which allows the brain to register "feeling" in the prosthesis. Artificial limbs take advantage of plastics and fiberglass for enhanced strength and comfort.

Advances in prosthetics now being developed include:[1]

- A knee-ankle prosthesis with sensors that measure force, position and movement to feed to an embedded microprocessor. The knee and ankle use electromagnets, friction-modulating fluid and polymers to turn electrical energy into mechanical force, thus creating a kind of artificial muscle enabling amputees to walk greater distances.

- Microchips that are bionic neurons – or “bions.” These will be injected into residual leg or arm muscles to pick up movement signals from the brain and send them to the new limb. Bion technology will provide not only output commands, telling the artificial limb what to do, but sensory feedback, so the prosthesis reports back to the brain what it did without needing to be seen.

- New medical techniques, currently being tested. Going beyond robotics and engineering of prosthetics, these medical techniques include surgery to lengthen bone in the residual limb, making it easier to fit the artificial limb and allowing more mobility, and attachment of an artificial leg to a titanium bolt placed in bone to avoid problems of current anchoring methods.

[1] http://montgomery.md.networkofcare.org/veterans/library/detail.cfm?id=1684&cat=444, retrieved Feb. 7, 2012.

Prosthetics at the VA and Hines VA Hospital

The US Department of Veterans Affairs (VA) provides a full range of equipment and services to veterans. These range from items worn by the veteran, such as an artificial limb or hearing aid; to those that improve accessibility, such as ramps and vehicle modifications; to devices surgically placed in the veteran, such as hips and pacemakers. This wide array of equipment and services the VA provides is available to veterans of every era, including the nation's newest veterans, who comprise less than 5 percent of the work of its PSAS staff nationwide.

At the end of fiscal 2008, VA had provided equipment to 89,152 veterans of Operation Enduring Freedom and Operation Iraqi Freedom, in addition to millions of other veterans from earlier periods. According to the VA, this represents a 70 percent increase since the year 2000. The majority of the veterans provided equipment were not seriously wounded and did not require complex devices. The most requested prosthetic devices were inexpensive items such as braces and eyeglasses.

The number of veterans seeking prosthetic services from the VA exceeded 1.9 million in fiscal year 2008. In response to demand, the budget increased from $532 million in 2000 to $1.6 billion in 2008. Additionally, in 2008, VA laboratories and contract prosthetic laboratories created or repaired approximately 12,059 prostheses for veterans at a cost of $75 million dollars, accounting for nearly 5 percent of the PSAS budget.

Although the number of veterans seeking services continues to increase, it seems the increase in spending is also driven by the cost of the products and services provided, especially the cost of new technologies. As of April 3, 2010, according to the Department of Defense, a total of 1,552 servicemembers have suffered amputations, creating a unique population of younger servicemembers requiring extraordinary medical care and rehabilitation.

According to data published by the Armed Forces Health Surveillance Center in 2011, 240 deployed troops had a limb amputated, compared with 205 in 2007, the height of the surge in Iraq. The increase in 2011 coincides with the surge of troops in Afghanistan, who often dismount on foot patrols.[2]

The VA provides items prescribed by appropriate VA clinicians. Items may range from a $2 cane tip to a $100,000 microprocessor-controlled bionic knee that replaces muscle activity to bend and straighten the knee. Regardless of cost, VA's mission is to provide the most appropriate technology to veterans in a timely manner. Veterans and servicemembers with major combat-associated limb loss are a part of the approximately 40,000 individuals with limb loss served by PSAS.

Veterans seeking treatment at Hines VA Hospital for Prosthetics and Orthotics services now receive top quality care in a modern, spacious and newly-renovated Prosthetics and Orthotics

[2] Chicago Sun-Times article, March 15, 2012.

Lab. More than 5,000 Illinois veterans from World War II through the recent conflicts in Iraq and Afghanistan are treated annually in the Hines VA Hospital Prosthetics and Orthotics Lab. Hines VA Hospital is one of 60 locations within the Department of Veterans Affairs that custom fabricates and fits the latest state of the art orthotics and prosthetics components. The Hines VA Hospital orthotics lab has four certified prosthetists, one certified prosthetist/orthotist, and a certified orthotist on staff full time.

Servicemembers are surviving catastrophic disabling blast injuries due to the superior armor they are wearing in combat and the access to combat urgent medical care. The unique injuries sustained by the new generation of veterans clearly demand particular attention.

Seriously wounded veterans can receive high-tech prosthetic devices to help regain their independence and mobility. Hand-held palm computers can read text. GPS systems connected to the veteran can use software to tell a blind person or traumatic brain injury victim where they are and how to navigate to wherever they want to go. Reading machines and computers assist the blind and those with impaired vision and spinal cord injuries.

Finally, no less important than new prosthetic component technology is the overall care a veteran must receive during rehabilitation. The model for that care has changed over the years to improve services to VA patients. The goal is not only to teach amputees to walk or use an artificial arm and hand. Continuing care and long-term support from VA multi-disciplinary teams have shown that patients often can improve their functioning months or years after their injuries or amputation.

SUMMARY OF DISCUSSION

As the Task Force discussed, the goal of early rehabilitation for servicemembers with traumatic limb loss is to restore function and quality of life to the fullest extent possible and provide state-of-the-art prostheses, wheeled mobility, and other assistive devices.

Following limb loss, adjusting to life with a prosthetic and other mobility technologies is a complex rehabilitation process. Each day, individuals with limb loss balance issues of pain and physical and psychological limitations with decisions about activities of daily living, use of prostheses, adaptive devices and wheeled mobility. Other issues can include PTS, mental health problems, depression, etc.

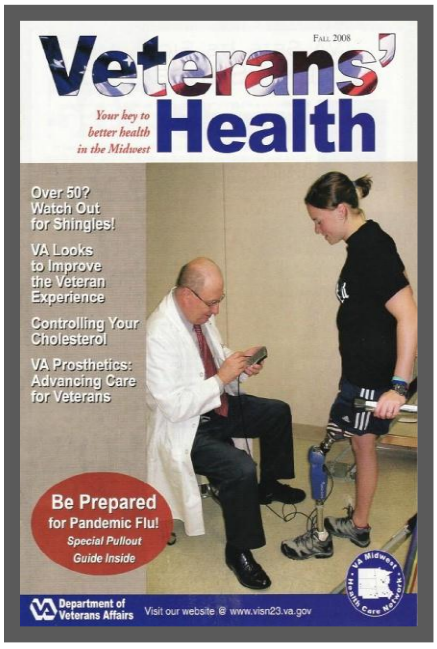
Limb loss is not just about the prosthetic as the patient also deals with emotional and psychological changes. The new amputee may feel very vulnerable and needs to be treated with dignity and respect. The physiological trauma of losing a limb is similar to what one

experiences when diagnosed with a fatal disease. The amputee experiences similar emotional stages including denial, blame, anger, sorrow, and finally acceptance. Each stage takes time. Some people pass quickly through the stages, while others may take years to reach acceptance.

Several factors help determine the level of functionality amputees will have following surgery, including the overall physical condition of the amputee, their emotional and mental state, and their understanding of their situation and cognitive ability. Other factors that directly affect the level of function include the patient's activity level, degree of motivation, vocation, age, and the presence (or lack thereof) of a family and friends support system.

Amputees' support system includes the community in which the veteran resides, and one avenue to assist the veteran integrate back into the community is through proactive case management. The VA also considers family support a priority. Hines VA Hospital has a Fisher House which provides a "home away from home" for military families to be close to their loved ones during hospitalization. Case managers provide active support by coordinating the efforts of clinical staff, voluntary services, and service organizations. They also work with community organizations and businesses to provide lodging, transportation, meals, and recreational activities for families, if needed.

Prescriptions for prosthetics, developed in the VA Amputee Clinic by a multidisciplinary team consisting of a Physician, Prosthetist, Therapist and Prosthetic Representative, are carefully formulated to the patient's specific needs, taking into consideration factors that include vocation, recreational needs (swimming, skiing, archery, etc.), physical health in general and home environment. Based on this information, prostheses can be designed, often using new and emerging technologies.



One corporate partner, the Rehabilitation Institute of Chicago, is conducting research on targeted muscle reinnervation (TMR). This is where the muscle acts as a biological amplifier of the brain and residual nerves are transferred to spare muscles and skin. TMR surgery is used to increase patients' mobility via bioelectric signal decoding and control systems enhancements. This has also been successful at restoring skin sensation for the missing limb. Currently there are more than 50 TMR patients worldwide, including some veterans at Walter Reed Army Medical Center and Brooke Army Medical Center.

"One of the biggest things we're learning in the psychosocial arena from the men and women coming back from Iraq is that going through this together is helping them enormously," says Dr. Danielle Kerkovich of VA's Rehabilitation Research and Development Service. She notes the VA is developing special video games for upper-limb amputees to help them learn to use their

prosthetic arms, and a group of Paralympic athletes offer week-long clinics to teach new artificial-leg users how to run. "Years ago, that wouldn't have happened," says Kerkovich. "Amputees were taught how to walk, and that was it. It shows how rehabilitation has advanced and we're getting better at figuring out that maybe patients can get better months, even years, after the injury, if we keep at it."

Another important development in prosthetics for service members is the 2008 approval by the VA of an Amputation System of Care (ASOC) to help the veteran dealing with the loss of a limb. The ASOC is designed to provide graded levels of expertise and accessibility within four integrated components of care, to assure consistency of amputation rehabilitation across the VA, and to enhance the environment of care for the new generation of veterans. Those four integrated components are:

- Regional Amputation Center: provides the highest level of specialized expertise in clinical care and technology.

- Polytrauma/Amputation Network Site: provides amputation care with a full range of clinical and ancillary services to the veteran closer to his or her home.

- Amputation Clinic Team: located at medical centers with limited inpatient and prosthetic capabilities but have a core Amputation Care Team.

- Amputation Point of Contact: located at facilities with limited amputation treatment resources.

Task Force guest participant Lisa McKenna is the Amputation Rehabilitation Coordinator (ARC) at Hines VA Hospital. Her role is to define, coordinate, and report on patient care. She identifies and secures resources needed as well as strategically plans on how to fill the gaps in the system. The ARC also enhances patient care through personal communication and improved documentation.

In working with veteran amputees, Hines VA Hospital augments its capabilities by using Telehealth, as well as through contracted work. Due to the fact that the VA system is not universally well perceived by veterans, part of the goal is to communicate with veterans that the VA can deliver the care needed.

In looking at the veteran's – and particularly veteran amputees' – reintegration back into the community, Task Force member Jim Frazier stated it takes the three R's: Rapport - who is there to help them; Repetition – consistency for the veteran in seeing the same people; and Reframing – looking for the "new" normal since things are not the same between the time they left and returned. To help cope with the loss of a limb and its side effects, it is often beneficial to speak with fellow veterans who understand and can sympathize.

RECOMMENDATIONS

The Task Force provided the following recommendations:

1. **Build a Community Effort.** Veteran amputees need to connect with their communities once they return from duty. The importance of peer support is particularly important. Community-based resources, whether the VFW, the American Legion, or other nonprofit organizations, can assist veterans with peer-to-peer support and other community-based.

   The State of Illinois can be a leader in education and empowerment of communities to integrate their Veterans back into their communities. For example, the IDVA can provide discussion points for all local community leaders to educate their communities on Veterans experiences, needs, and resources – and on how individual Illinoisans can make a difference.

2. **Improve the partnership between public and private organizations.** Improved access and communication is needed between private and public organizations. Working to develop the best prosthetics practices possible should be a goal of both the VA and the private sector. The main objective is to provide the veteran with access to quality health care, whatever the source.

   Jim Kaiser, President, Illinois Society for Orthotist, Prosthetist, Pedorthist (ISOPP), states that as a corporate partner, the ISOPP currently provides professional expertise on a rotational basis at the James A. Lovell Federal Health Care Center prosthetic clinic to communicate veterans' needs from the clinic team directly to the prosthetic provider.

   Task Force members lauded these type of partnership efforts, but some noted an apparent reluctance on the part of VA facilities to embrace private and non-profit partners. Overcoming obstacles like this – whether real or perceived – is a necessary step in the right direction on the road to collaboration. Community partners can provide critical support and expertise to VA providers.

3. **Improve the VA's Image.** Task Force members noted that there seems to be a disconnection between what veterans thinks the VA can provide and what the VA can actually provide. Many veterans are not aware that the VA has the capabilities to provide the best care, particularly in the field of prosthetics.

   To address this issue, the VA also could work to educate private providers on VA healthcare benefits and capabilities, as well as to develop partnerships with the private and non-profit providers in providing care for veterans. Some members of the Task Force also felt that improved customer service on the front line of VA hospitals was necessary in order to improve perceptions, and therefore use, of VA healthcare.

4. **Central Database.** Task Force members indicated there was a need for a resource database, to include federal, state, and non-profit resources. Members recommended building on previous work and models, such as the existing ISFAC model that has already been developed. This call for a repository of resources, members noted, would help not just in the area of prosthetics but in the entire system of support for veterans.

EDUCATION

EDUCATION

The VA has a long history of providing education benefits for veterans. Education benefits have grown tremendously over the last several years.

In July of 2008, the Post-9/11 GI Bill was signed into law. This monumental piece of legislation expanded the benefits provided by the Montgomery GI Bill and rivaled the WWII-Era GI Bill of Rights. The new Post 9/11 GI Bill, which took effect August 1, 2009, provides education benefits for servicemembers who have served on active duty for 90 or more days since Sept. 10, 2001. Benefits are tiered based on the number of days served on active duty, providing a benefit package that gives current and previously activated National Guard and Reserve members the same benefits as active duty servicemembers. By August 2010, more than 500,000 current and former military members had applied for eligibility certification and just over 300,000 had used the benefits to enroll in higher education.[3]

Veteran Use and Satisfaction with Post 9/11 GI Bill

In surveys conducted by the VA, a majority of respondents using the Post-9/11 GI Bill reported attending public, nonprofit institutions—39 percent at four-year public universities, 24 percent at community colleges—while roughly one in five attended private universities. Three percent attended for-profit "bricks and mortar" institutions, the survey found, while one percent were enrolled in online-only for-profit programs.

Fourteen percent of respondents are studying "business, management, marketing, and related services," while 11 percent are pursuing "health professions and related clinical science." An additional nine percent are focusing on "computer and information sciences."

The Post 9/11 GI Bill appeared to influence the higher education choices of some eligible servicemembers, veterans and family members. According to the VA, approximately 24 percent reported that the existence of the new GI Bill had driven their decision to enroll in higher education. Also, about 18 percent said that the new GI Bill had driven their choice of higher education institution.

Students described their satisfaction using the GI Bill in the following areas:

- Benefits paid tuition and fees directly to the school.

[3] Steele, J., Salcedo N., Coley, J., *Service Members in School*, 2010.

- Received a monthly living allowance.

- Book stipend.

- Did not have to pay into the program to be eligible for the new GI Bill.

- Yellow Ribbon GI Education Enhancement Program which covers tuition and fees at a private institution or a public graduate program if that fee is above the state's tuition/fee cap.

The challenges in using the new GI Bill are in the following areas:

- Payment to the students sometimes took several months to arrive. Some colleges reported extending tuition credit to students whose GI Bill tuition payments were late, but participants at some public institutions said they were temporarily dropped from classes because of late tuition payments from the VA. More than a third of respondents who have used the new GI Bill said they had experienced financial problems given the delay of payments; about one in five said they had taken out additional loans to cover their educational costs.

- In cases where the institution was erroneously overpaid, some students reported receiving debt collection notices from the VA and having their housing allowance suspended.

- Some students said they would have liked an online accounting system that could show their total benefit balance, as well as the dates and purpose of pending and prior payments.

- Some participants reported having difficulty understanding their GI Bill benefit options.

Student veterans are considered non-traditional students, as they are typically older and have been out of a school environment for years. Challenges for student veterans in succeeding on campus include:

- Balancing academic requirements with other responsibilities.

- Veterans are acclimatizing and transitioning to a civilian environment and working on bridging the military/civilian divide.

- Supporting families; relating to non-veterans and particularly those who recently graduated from high school.

- Managing service-connected injuries, including TBI and PTS.

Existing Studies on Challenges & Best Practices

Given the magnitude of the Post 9/11 GI Bill benefits and implementation system, early implementation posed several challenges, especially with delayed and erroneous payments.

In a recent study, the American Council on Education (ACE) partnered with the RAND Corporation to study students' experiences using the Post 9/11 GI Bill in its first year.

The RAND/ACE study resulted in the following recommendations for schools.

- Designate an area on information and admission forms for students to identify themselves as military veterans.
- Verify that veteran program administrators and the schools certifying officials are aware of the latest changes and provisions to veterans' benefits.
- Provide access to disability and mental health staff who have training on veterans' issues.
- Establish guidelines to evaluate credit transfers that are consistent and transparent.
- Provide veteran orientation sessions at the annual student orientations, followed by additional veteran information sessions throughout the year.
- Encourage the efforts of students to create veteran organizations on campus.

RECOMMENDATIONS

Based on its discussion of the above and other member input, the Task Force provided the following recommendations:

1. **Self-Identification and Data Tracking.** All documents related to requests for school information or applications should include a question via which veterans can indicate their veteran status. This would help schools know and support their veteran communities. Moreover, accumulation of that data would assist the state of Illinois in the process of tracking a veterans' academia and graduation rates from admission to

graduation. The process would also be used for to identify various trends such as utilization of the GI bill, graduation rates, number of classes taken, etc.

2. **Cultural Awareness Training for Faculty.** Train educational institution faculty on military culture. Institutions must ensure that veteran program administrators, particularly school certifying officials, and other relevant faculty have adequate training and support to provide the best possible assistance to student veterans.

3. **Increased Education Institution Outreach.**

    a. Have mentors on campus that can assist student veterans navigate the campus and may work in conjunction with student veteran organizations.

    b. Create support programs such as a veterans' center, a veterans' coordinator or a student veteran association/club.

    c. Provide onsite mental-health counseling with professionals who are experienced in working with veterans' issues such as PTS and TBI. If an onsite counselor is not available, alternatives include contracting with a private counselor who can take appointments and treat veterans on campus.

    d. Provide case management and enrollment into VA programs at various veteran events, such as the annual student orientation sessions. At a minimum, have contact information readily available at a kiosk or some prominent location.

    e. Educate veterans on benefits available to them. Ensure that counselors attend various veteran information sessions and have services such as a hotline a veteran can call with questions.

4. **Child Care.** Institutions could provide childcare for veterans with children to maximize veterans' time for studies and class while receiving GI Bill benefits. Accessibility of childcare is very important in veteran parents' decision-making regarding college selection.

5. **Adjustments to Illinois Veterans Grant.** The Illinois Veterans' Grant is provided to all Illinois veterans who are honorably discharged, reside in Illinois six months before entering service, have at least one year of active duty, and return to Illinois within six months of discharge from service. Because of changes in federal Post-9/11 GI Bill rules, it is recommended that Illinois request a waiver to the VA "payer of last resort" clause. This waiver would ensure that the Post 9/11 GI Bill funds is the first payer and Illinois Veteran Grant (IVG) be the last payer, if the veteran does **not** have 100% eligibility for benefits of the Post 9/11 GI Bill.

6. **In-State Tuition Rate for Veterans.** Illinois already offers in-state tuition rates to active duty personnel when stationed in Illinois. In order to best equip veterans for success, as well as to draw highly skilled and experienced leaders to Illinois, it is recommended that all public institutions of higher learning in Illinois permit veterans to be charged the in-state tuition rate regardless of residency.

7. **Tuition Deferment.** Tuition deferment allows students to pay their tuition after the fee payment deadline without being subject to cancellation of registration or a late payment fee. While a number of schools already allow fee deferral, the Task Force recommends that this be an option for veterans at any Illinois institution – particularly given the delays in Post 9/11 GI Bill Payments veterans often experience.

8. **American Council on Education (ACE) credits.** Since 1945, the American Council on Education has provided a collaborative link between the US Department of Defense (DOD) and the higher education community through the review of military training and experiences for the award of equivalent college credits for members of the Armed Forces. The Task Force recommends more robust and systematized use of these ACE credit recommendations by Illinois institution of higher learning. This will allow veterans to capitalize on their military training and maximize their educational benefit.

9. **Deployment policy.** Develop and implement a policy that allows for military members and/or their spouses enrolled in classes to be excused from paying tuition if they are called to active duty or re-assigned. Similar to an existing policy in North Dakota, such a policy would provide that, if a veteran receives orders for active-duty service which require the servicemember to be away from class for longer than 14 days, any paid tuition and fees are refunded to VA and/or the servicemember. This would allow military members and/or their spouses to pursue their educational goals without fear of financial consequences if they receive orders to report to active-duty military service or re-assigned to an assignment out-of-state.

EMPLOYMENT

EMPLOYMENT

America's newest veterans face serious employment challenges. The unemployment rate for veterans who served on active duty in the U.S. Armed Forces at any time since September 2001--a group referred to as Gulf War-era II veterans--was 12.1 percent in 2011, as reported by the U.S. Bureau of Labor Statistics. The jobless rate for all veterans was 8.3 percent.

Credentialing

One of the main challenges in servicemembers transitioning to civilian employment is difficulty in translating military training and experience into a relevant civilian credential or career pathway.

According to a recent report from an advocacy group for Post 9/11 veterans, it showed that 61 percent of employers do not believe they have "a complete understanding of the qualifications ex-servicemembers offer." This is particularly problematic for young returning servicemembers for whom military service is their only working experience.

To address this issue, the Army and Navy both offer Credentialing Opportunities Online (COOL). These programs give transitioning servicemembers the opportunity to find civilian credentials related to rating or military occupational specialty. The COOL website also details a given credential's requirements and informs active-duty servicemembers and veterans on programs that will help pay credentialing fees.

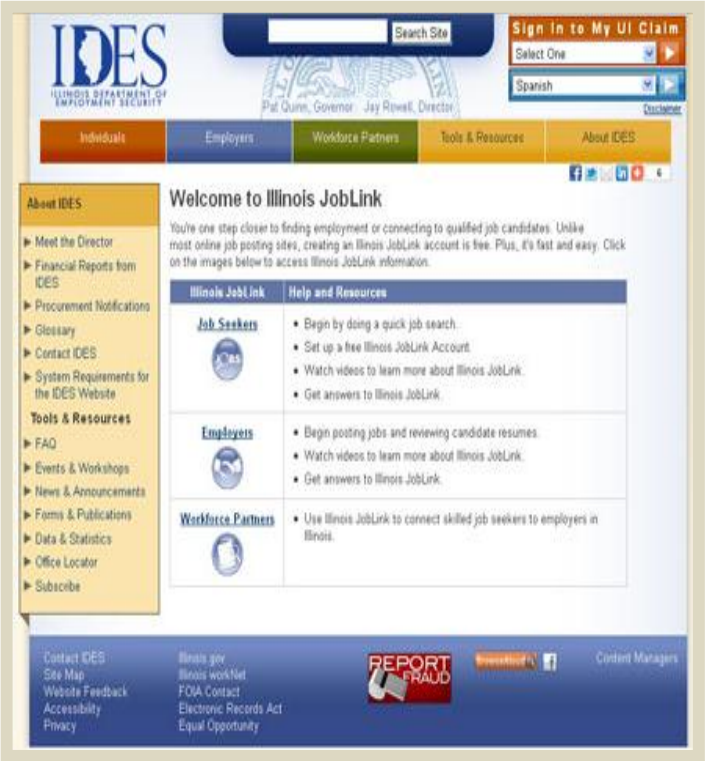
The Air Force offers the Air Force Credentialing and Educational Research Tool (CERT). This is a valuable resource for Air Force personnel in increasing awareness of professional development opportunities applicable to Air Force occupational specialties, crosswalks to Community College of the Air Force degree programs, national professional certifications, certification agencies, and more.

The United Services Military Apprenticeship Program (USMAP) is available to members of the Navy, Marine Corps, and Coast Guard. Those who participate in this program are eligible to receive a Department of Labor Certificate of Completion, which provides an advantage in obtaining civilian jobs.

Employer-Veteran "Matching"

Another key challenge in addressing veteran unemployment is the difficulty of connecting veteran-seeking employers with the right job-seeking veterans.

One of the most powerful tools at State agencies' disposal to address this problem is Illinois Job Link (IJL), a no cost, self-service job matching system for job seekers and employers provided by the Illinois Department of Employment Security (IDES). There are currently approximately 92,000 private and public sector jobs posted to the website and more than 40,000 veterans have resumes posted.



IDES also offers other assistance to veterans through its statewide VETS program, which includes assistance from local Veteran Employment Representatives, workshops on job hunting, resume writing and interviewing techniques, and federal contractors' job listings.

At the national level, powerful career search databases include: Hero 2 Hired, the Employer Partnership of The Armed Forces, VA for Vets, and O*NET online.

<u>New Federal Programs to Address Unemployment</u>

Congress recently passed legislation to encourage businesses to hire more unemployed post-9/11 veterans. The VOW to Hire Heroes Act, first advocated by President Obama in his American Jobs Act, includes the following key provisions:

- Tax credits: employers will get up to $5,600 in tax relief for each post-9/11 veteran hired who has been looking for a job for more than six months. A $2,400 tax credit applies to hiring veterans unemployed for more than four weeks.

- Expanded training: through the Veterans Retraining Assistance Program (VRAP), retraining assistance is now available for eligible veterans aged 35 to 60 at the time of application. VRAP expands education and training opportunities for 99,000 unemployed veterans. The number of veterans eligible is capped at 45,000 from July 1 through Sept. 30, 2012 and at 54,000 from Oct. 1, 2012 through March 31, 2014.

- Mandatory TAP: effective a year after the law's enactment, veterans separating from service must attend a Transition Assistance Program (TAP) for career counseling and

resume writing that the Department of Defense, VA and Department of Labor are preparing.

RECOMMENDATIONS

The Task Force provided the following recommendations:

For Government:

1. **Licensing and credentialing.** One of the most important priorities for veteran employment is better translation of technical military skills and training to state licenses and national credentials. This requires the availability of detailed military training documents from Department of Defense entities, as well as rigorous ensuing efforts on the part of state licensing entities to identify creditable training and experience.

2. **Mobilize and Equip Employers. T**he State of Illinois should do more to mobilize employers on the issue of veteran employment and to equip employers to effectively recruit and retain veteran employees**.**

3. **Improve Outreach Services to Employers.** State agencies and their community partners must do more to inform Illinois-based employers about the benefits of hiring veterans and the tools available to them. These include financial incentives such as existing state income tax credits, as well as assistance in recruiting veterans through the Illinois Department of Employment Security.

4. **Career Fairs by Industry.** Host industry-specific job fairs that are geared toward veterans with unique skill sets, such as in the healthcare, construction, and truck driving industries. Studies show that there is demand for skilled workers in these industries, and various organizations are working towards licensing and credentialing veterans with relevant military training and experience.

For Employers:

1. **Employee Resource Groups/Cultural Awareness**. Employee networking groups for veterans, like those women, minorities, and other employee groups, can be used to help organizations attract and retain talent, identify new consumer markets, build relationships in the community, and improve supplier diversity.

2. **Data/Identification.** Employers should set aside an area on the application where veterans could opt to identify their veteran status.

HOMELESSNESS

HOMELESSNESS

Homelessness is a major, albeit improving, issue for the veteran community. In late 2011, a major national report, the 2011 supplement to the Annual Homeless Report, showed that homelessness among Veterans had been reduced by nearly 12 percent between January 2010 and January 2011. The study indicated that 67,495 Veterans were homeless in the United States on a single night in January 2011 -- a significant reduction from the previous year's single night count of 76,329.

Given the disproportionate number of homeless who are veterans, it is clear why empowering homeless veterans is one the three key priorities of the US Department of Veterans Affairs (VA). In 2009, Secretary Shinseki announced a five year plan to end veteran homelessness by 2015. The plan has six strategic pillars:

- Outreach/Education
- Prevention
- Treatment
- Housing/Supportive Services
- Income/Employment/Benefits
- Community Partnerships

VA Resources

The VA and other federal agencies have implemented a number of grant programs to reduce veteran homelessness. These programs have grown in recent years. For instance, through the HUD-VASH program, which provide funding for permanent housing and supportive services for homeless veterans, HUD plans to award in 2012 almost 48,000 vouchers to public housing agencies to assist homeless veterans.[4] Also, the VA is granting over one billion dollars in specialized homeless program funding through the Supportive Services for Veteran Families (SSVF) program, a first- of- its- kind VA program to provide direct services, including childcare, to veteran families at risk of homelessness.

VA is in the process of developing a Homeless Management Evaluation System (HOMES**).** HOMES is a vital component of a new VA homeless Registry that will offer a real-time resource for service providers, policy makers, administrators, and researchers. The Registry will provide numerous benefits including the ability to track the care of homeless Veterans; evaluate the effectiveness of interventions; target resources that can be used to prevent homelessness; identify best practices; and incorporate data collected through HUD's national Homeless Management Information System (HMIS) database. The Registry will provide a

[4]Produced by the American Legion in collaboration with the National Coalition for Homeless Veterans. (2012). On-Call: Handbook for Homeless Veterans and Service Providers. Washington, DC: Author.

facility, VISN, and national-level snapshot of progress towards the VA's Five Year Plan to End Homelessness among Veterans.

Because a significant number of homeless veterans have been involved in the justice system, the VA and other entities have developed programs to target support to this population. The VA works to assist formerly incarcerated veterans to transition to permanent housing through the Healthcare for Re-Entry (HCRV) program, which provides case management, referrals, and outreach to veterans prior to their release. The VA also developed the Veteran Justice Outreach Initiative (VJO) to stop the criminalization of common crimes associated with behavioral and substance abuse of homeless veterans, as well as to ensure eligible veterans in court have access to medical and substance abuse programs and any other benefits for which they might be eligible; through VJO, the VA requires health clinics to have a VJO specialist readily available for all veterans involved with the justice system.

These efforts for justice-involved veterans involve local leadership and support, as well. This primarily involves Veterans Courts, hybrid drug and mental health courts that use the drug court model to serve veterans struggling with addiction and/or behavioral health issues. While promoting recovery and stability, these courts assist veterans in tapping into the vast networks of veteran-specific support available to them through the VA, state agencies, and various community partners.

SUMMARY OF DISCUSSION

Task Force members discussed their assessment that, while some causes of homelessness are similar for veterans as for non-veterans, the causes most characteristic of the homeless veteran community include substance abuse, Post Traumatic Stress (PTS), traumatic brain injury (TBI), and Military Sexual Trauma (MST).

<u>Special Populations</u>

Incarcerated Veterans

Task Force members concurred that there is more to be done related to assisting incarcerated veterans, particularly at the point of transition back into the community. One important resource for homeless veterans who find themselves ineligible for certain programs and benefits is the Discharge Review Board, which is hosted once a year by the Department of Defense to assist veterans in upgrading their discharge. Also, the lack of an address is a major issue for incarcerated veterans, as it prevents them from being paroled early. Finding housing for paroled veterans can also prove more difficult because they cannot be housed near a school or church. Social workers implement different tactics to find formerly incarcerated veterans housing, because larger facilities are not equipped to handle a formerly imprisoned veteran.

Women Veterans

Another veteran group that is increasingly in need of services are homeless women veterans. Although resources and facilities specifically for women veterans are increasing, additional resources are needed, and specifically for those with families. Historically, the reason for the lack of assistance for families has been due to the fact that the VA can only assist veterans. However, the HUD-VASH program alleviates the issue partially by providing housing for both the homeless veteran and his or her family. Another cause for the dearth of women-specific resources in the homelessness support community could be the community's lack of awareness of this smaller, by comparison, veteran population. However, if a service cannot be found that is exclusive for female veterans, caseworkers do refer female veterans to the non-veteran resources such as domestic abuse centers. Many case managers do not feel that the larger homes are the answer for women veterans and their families; rather, they suggest that small clusters of scattered locations be established to provide housing for female veterans and their families.

Indigent Veterans

Another group of homeless veterans who have not received sufficient attention are indigent veterans when they pass away. Veterans have the VA benefit of a military burial, but if they are not identified as veterans they will not receive the benefit. Organizations have been founded to handle the deceased veterans such as the Missing in America project, which ensures that an indigent veteran receives a proper burial.

Post 9/11 Veterans

According to participants in the Discharged Servicemembers Task Force discussions regarding homelessness, the number of Iraq and Afghanistan homeless veterans is slowly growing. The Homeless Incidence study also reports that younger veterans are more likely to use homeless shelters than their civilian counterparts, and that female veterans who have experienced MST are twice as likely to be homeless than their civilian counterparts.

According to the recent data from The Homeless Incidence Report, homelessness among more recent veterans is occurring most often with younger enlisted veterans with lower pay grades who are diagnosed with behavioral afflictions or TBI. Because TBI is one of the signature wounds of the Iraq and Afghanistan wars, the risk of homelessness in the OEF/OIF veteran community seems great if they do not receive effective behavioral health services and other preventive and supportive services and benefits.

<u>General Discussion</u>

In Illinois, the homeless veteran rate has decreased greatly in the last five years given the level of outreach and coordination among the various service providers in Illinois. According to PIT statistics from a consortium of providers (the Volunteers of America, the US DVA, and the National Coalition for Homeless Veterans), the number of chronic homeless veterans in Illinois has decreased from approximately 9,000 to 10,000 five years ago to between 1,400 and 1,700

as of January 2012. An increase in funding of veterans services, HUD-VASH grants, and pensions appears to be making a difference in decreasing the homeless veteran rate. However, provider collaboration and communication need to improve in order to improve the holistic system of support for homeless and at-risk veterans.

There have been some systematic improvements to existing grant programs. In order to provide better service to its constituents, HUD initiated a continuum of care whereby information is dispersed to other agencies to let them know what services and resources are available, so that they are able to pass that information along to homeless veterans. HUD initially provided money to individuals but reasoned that because homelessness was a community issue, organizations had to work together as a whole. Today, counties have improved the count of homeless veterans and improved the distribution of vouchers and assistance.

Some difficulties in VA grant guidelines remain. For instance, despite the availability of HUD-VASH grants, veterans have difficulty paying the security deposits required to rent an apartment. Although SSVF grants are distributed to social service agents to allocate to homeless veterans, some agencies are reluctant to give homeless veterans funding for the security deposit if they are in receipt of a HUD-VASH voucher. Requirements of the grant need to be made clearer to agencies to alleviate this problem.

Homeless veterans have some unique and unaddressed funding needs. For example, funding is needed for veterans who need to pay for the transferring of their private medical records. Given that, for many homeless veterans, a great deal time has elapsed between discharge and filing for benefits, they have often been treated in the interim by a private doctor. Private doctors often charge a fee for copies of the medical records that a homeless veteran needs to establish their status or disability claim. Homeless veteran typically cannot afford this fee.

Homeless veterans are often in dire need of the VA pension and compensation funding to which they are entitled. VA processing of benefits for homeless veterans is expedited and is treated as a high priority once it has been established that a claim is for a homeless veteran. However, many homeless veterans filing for disability compensation and non-service connected pension status fail to show for the required healthcare examination. Consequently, their claims are denied and benefits are not distributed. This could be partially a funding issue, with veterans lacking funds to acquire transport.

RECOMMENDATIONS

The Task Force provided the following recommendations:

1. **Outreach to Organizations on Existing Resources.** The number of benefits and services available to assist veterans facing homelessness can be overwhelming. Increasing awareness and collaboration between existing organizations is imperative to providing better support to homeless veterans.

2. **Data Tracking.** Although, a great deal has been done to address veteran homelessness in recent years, data tracking is not yet sufficient. As efforts continue, it would be helpful for organizations working on homelessness data to track information not just on numbers of homeless veterans but also regarding the veterans themselves (era of service, age, etc.). This would allow the State, as well as community providers, to better understand the needs and solutions for veteran homelessness in Illinois.

3. **Treat PTS Early and Remove the Stigma.** PTSD is a primary driver of veteran homelessness. The earlier these mental health challenges can be addressed, the better will be the outcomes related to homelessness. Studies suggest that discharged veterans should be assessed for behavioral afflictions prior to discharge; this requires better outreach, more private sector awareness of the issues, and fewer stigmas associated with seeking treatment.

4. **Outreach to Women Veterans.** Studies show that women veterans who have experienced MST and do not receive follow-on care and support have a higher risk of becoming homeless. Increased awareness about the needs and struggles of women veterans on this issue is vital. Pamphlets de-stigmatizing MST and encouraging veterans to seek help should be made widely available. Also, women veterans are far less likely to utilize VA healthcare, so the outreach effort to this community will need to be creative.

5. **Outreach to Incarcerated Veterans.** Many homeless veterans are or have been justice-involved. Further services and attention are needed to better serve this population, particularly at the point of reentry to society. More robust efforts on veteran treatment courts, pre-release VSO services, and other targeted initiatives are vital if veteran homelessness is to end by 2015.

6. **More Affordable Housing.** Many families struggle to afford housing at a reasonable cost. If additional housing would be provided at affordable costs, then many veteran families would avoid homelessness altogether. It is recommended that additional affordable housing solutions be provided to military veterans and their families.

7. **More – and More Awareness of – Funding for Permanent Housing.** An important component in assisting homeless veterans is permanent housing. The VA and HUD-VASH program has greatly decreased the number of homeless veterans, but too many veterans remain homeless. The veteran community and social services community must collaborate to identify and assist in leveraging the full network of resources and grant funding. Lesser known programs include VA's 65% reimbursement of construction, renovation, or acquisition costs of a building for use as service centers or transitional housing for homeless veterans; DOL Homeless Veterans' Reintegration PROGRAM (HRVP) grants available to assist in funding the needs of homeless veterans; and HUD's

Emergency Shelter Grant to assist with shelter facility operational and maintenance costs and to remodel or rehabilitate a building as a new shelter.

APPENDICES:

APPENDIX A:

Meeting Minutes: Post Traumatic Stress

Date: Sept. 22, 2010 **Time:** 10 a.m. – 2 p.m. **Location:** Alexian Brothers, Elk Grove Village	**Task Force members in attendance:** • Sergio Estrada, Assistant Director, Illinois Dept. of Veterans Affairs, **CHAIRMAN** • Mary Ann Romeo, VISN 12 Coordinator, U.S. Dept. of Veterans Affairs • Lt. Col. Jack Amberg (Ret.), Sr. Director of Veterans Affairs, McCormick Foundation • Jim Frazier, Gold Star Father and Survivor Outreach Services Officer, U.S. Army • Marc Fisher, Regional Emergency Mgmt. Specialist, US Department of Health and Human Services • Eric Murray, Service Member and Family Support Services Branch Chief, Illinois Dept. of Military Affairs • Dr. Cynthia Doil, School Liaison Officer, Scott Air Force Base
	Task Force members not in attendance: • Senator Pamela Althoff, State Senator 32nd District • Representative Jim Watson, State Representative 97th District • Representative Linda Chapa LaVia, State Representative 83rd District • Duane Honeycutt, Chicago VBA Office Director, U.S. Dept. of Veteran Affairs • Jack Burns, Sergeant Major, Illinois National Guard **Vacant Positions:** • Office of the Attorney General • Member of General Assembly appointed by the President of the Senate
	Guests: • Erica Borggren, Acting Director, Illinois Dept. of Veterans Affairs • Amy Amizich, Governor's Policy Adviser, Military and Veterans Affairs • Barbara Giacomino, Operation Support Our Troops • Juliann Steinbeigle, IL National Guard Director of Psychological Health • Dr. Patrick McGrath, Director of the Center for Anxiety and Obsessive Compulsive Disorders, Alexian Brothers • Dr. Eric Proescher, OEF/OIF Outreach Psychologist at Jesse Brown Medical Ctr • Denise DeVaan, National Coordinator for ASSETS • Suellen Semekoski, Creative Therapy through the Arts Program

APPENDIX B:

Meeting Minutes: Prosthetics

Date: Dec. 20, 2011 **Time:** 10 a.m. – 3 p.m. **Location:** Edward Hines VA Hospital, Director's Conference Room	**Task Force members in attendance:** • Rodrigo Garcia, Assistant Director, Illinois Dept. of Veterans Affairs, **CHAIRMAN** • Senator Pamela Althoff, State Senator 32nd District • Representative Linda Chapa LaVia, State Representative 83rd District • Grant Swinger, Military and Veterans Rights Bureau Chief,Office of the Illinois Attorney General • Mary Ann Romeo, VISN 12 Coordinator, U.S. Dept. of Veterans Affairs • Lt. Col. Jack Amberg (Ret.), Sr. Director of Veterans Affairs, McCormick Foundation • Jim Frazier, Gold Star Father and Survivor Outreach Services Officer, U.S. Army • Marc Fisher, Regional Emergency Mgmt. Specialist, US Department of Health and Human Services • Eric Murray, Service Member and Family Support Services Branch Chief, Illinois Dept. of Military Affairs
	Task Force members not in attendance: • Representative Jim Watson, State Representative 97th District • Duane Honeycutt, Chicago VBA Office Director, U.S. Dept. of Veteran Affairs • Jack Burns, Sergeant Major, Illinois National Guard • Dr. Cynthia Doil, School Liaison Officer, Scott Air Force Base **Vacant Positions:** • Member of General Assembly appointed by the President of the Senate
	Guests: • Sharon Helman, Director, Hines VA Hospital • Amy Amizich, IL Governor's Policy Adviser, Military and Veterans Affairs • Akeela White, Office of the IL Attorney General • Maureen Dyman, Public Affairs, Hines VA Hospital • Jim Kaiser, CEO Scheck &Siress • Melissa Stockwell, Iraq war vet and amputee • Richard Sakols, Certified Prosthetist, Hines VA Hospital • Dr. Monica Steiner, Chief of Rehabilitation, Hines VA Hospital • Annette Katamay, Polytrauma Coordinator, Hines VA Hospital • Kathy Kirby, Chief of Prosthetics, Hines VA Hospital • Lisa McKenna, Amputation Rehabilitation Coordinator, Hines VA Hospital • Walter Afable, Clinical Operations Manager, Prosthetics Orthotics Clinical Center, Rehabilitation Institute of Chicago (RIC) • Dr. Jon Sensinger, Director, Prosthesis Design & Control Laboratory Center for Bionic Medicine, RIC

APPENDIX C:

Meeting Minutes: Education& Employment

Date: March 13, 2012 **Time:** 9:30 a.m. – 3 p.m. **Location:** Cantigny Park, 1S151 Winfield Road, Wheaton, IL Visitor's Center (Medill Room),	**Task Force members in attendance:** • Rodrigo Garcia, Assistant Director, Illinois Dept. of Veterans Affairs, **CHAIRMAN** • Senator Pamela Althoff, State Senator 32nd District • Grant Swinger, Military and Veterans Rights Bureau Chief,Office of the Illinois Attorney General • Mary Ann Romeo, VISN 12 Coordinator, U.S. Dept. of Veterans Affairs • Jim Frazier, Gold Star Father and Survivor Outreach Services Officer, U.S. Army • Marc Fisher, Regional Emergency Mgmt. Specialist, US Department of Health and Human Services • Eric Murray, Service Member and Family Support Services Branch Chief, Illinois Dept. of Military Affairs • Dr. Cynthia Doil, School Liaison Officer, Scott Air Force Base • Duane Honeycutt, Chicago VBA Office Director, U.S. Dept. of Veteran Affairs • Mark W. Bowman, Sergeant Major, Illinois National Guard • Tim Sury, representing Linda Chapa LaVia, IL State Representative
	Task Force members not in attendance: • Representative Jim Watson, State Representative 97th District • Lt. Col. Jack Amberg (Ret.), Sr. Director of Veterans Affairs, McCormick Foundation **Vacant Positions:** • Member of General Assembly appointed by the President of the Senate
	Guests: • Erica Borggren, Director, Illinois Dept. of Veterans Affairs • Akeela White, Office of the IL Attorney General • Lt Col Tim Franklin, Employer Support for Guard and Reserve • Tom Aiello, Division Vice President, Public Relations, Sears Holding Company • Dan Wellman, Illinois Department of Veterans' Affairs, State Approving Agency • Marlene Julye, National Leadership Council, Student Veterans of America • Mark Slaby, Founder, Illinois Patriot Education Fund • Shelly Mencacci, Coordinator, Veterans and Military Personnel Services, College of DuPage • Liz Belcaster, Helmets to Hardhats and Heroes to Healthcare • Ian Hardie, Director of Workforce Development and Veterans Program Coordinator, Albany Park Community Center • Gil LaRoche, Veterans Service Coordinator, Illinois Department of Employment SecurityJason Fry, Senior Consultant/Veterans Advisory Council, BMO Harris Bank

APPENDIX D:

Meeting Minutes: Homelessness

Date: June24, 2012 **Time:** 9:00 a.m.- 11 a.m. **Location:** James R. Thompson Center, 100 W. Randolph, Suite 5-570, Conference Room	**Task Force members in attendance:** • Rodrigo Garcia, Assistant Director, Illinois Dept. of Veterans Affairs, **CHAIRMAN** • Mary Ann Romeo, VISN 12 Coordinator, U.S. Dept. of Veterans Affairs • Deanna Mackey, Illinois Dept. of Veterans Affairs Program Director, Homeless and Disabled Program • Eric Murray, Service Member and Family Support Services Branch Chief, Illinois Dept. of Military Affairs • Duane Honeycutt, Chicago VBA Office Director, U.S. Dept. of Veteran Affairs Linda Chapa LaVia, IL State Representative • Jim Frazier, Gold Star Father and Survivor Outreach Services Officer, U.S. Army • Dr. Cynthia Doil, School Liaison Officer, Scott Air Force Base
	Task Force members not in attendance: • Representative Jim Watson, State Representative 97th District • Lt. Col. Jack Amberg (Ret.), Sr. Director of Veterans Affairs, McCormick Foundation • Mark W. Bowman, Sergeant Major, Illinois National Guard **Vacant Positions:** • Member of General Assembly appointed by the President of the Senate
	Guests: • Erica Borggren, Director, Illinois Dept. of Veterans Affairs • Akeela White, Office of the IL Attorney General • Olumayowa A. Famakinwa, VARO CHANGE Management Agent

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