

U.S. DEPARTMENT OF DEFENSE

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

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MEETING

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TUESDAY

OCTOBER 4, 2011

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The Task Force met in Salon E of the Regency Ballroom of the Hyatt Regency Crystal City, 2799 Jefferson Davis Highway, Arlington, Virginia, at 8:30 a.m. Suzanne Crockett-Jones, Non-DoD Co-Chair, and the MG Richard A. Stone, M.D., Acting DoD Co-Chair, presiding.

PRESENT:

SUZANNE CROCKETT-JONES, Non-DoD Co-Chair

MG RICHARD A. STONE, M.D., USAR,

Acting DoD Co-Chair

JUSTIN CONSTANTINE, J.D.

CMS STEVEN DeJONG, ARNG

RONALD DRACH

LTC SEAN P.K. KEANE, USMC

STEVEN J. PHILLIPS, M.D., USAR

ALSO PRESENT:

DENISE F. DAILEY, Executive Director,
Designated Federal Officer

ANNE E. SOBOTA, Alternate Designated Federal
Officer

BERNARD D. ROSTKER, RAND Corporation

MARGARITA COCKER, Vocational Rehabilitation
and Employment (VR&E) Service,
Department of Veterans Affairs

CAPT SHARON L. LUDWIG, U.S. Public Health
Service/U.S. Coast Guard, Chief,

Epidemiology and Analysis Division,
Armed Forces Health Surveillance Center

LESLIE CLARK, Epidemiology and Analysis
Division, Armed Forces Health
Surveillance Center

KIMBERLY D. MUNOZ, Executive Director,
Quality of Life Foundation

BARBARA COHOON, Deputy Director of Government
Relations, National Military Family
Association

SUZANNE LEDERER, Task Force Research Team

JESSICA JAGGER, Task Force Research Team

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

Page

Task Force Members After Action
Review of FY 20116

Dr. Bernard Rostker, RAND History
of Care of the Wounded Warrior in
DoD 42

Veteran's Rehabilitation and
Employment, Department of
Veterans' Affairs Vocational
Rehabilitation and Employment
(VR&E Service) 99

Armed Forces Health Surveillance
Center, Overview and Current
Research176

Quality of Life Foundation,
Care Giver Issues229

National Military Family
Association Care Giver Issues269

Installation Visit Review322

Closing373

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

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

(8:38 a.m.)

MS. DAILEY: Good morning, ladies and gentlemen. We'll bring the meeting to order. Welcome, everyone.

I'm going to turn it over to our co-chair, Ms. Crockett-Jones, at this time.

CO-CHAIR CROCKETT-JONES: Welcome, everyone, to our first meeting of the second year of effort. I'd like each member to start us off by introducing themselves.

Mr. Drach.

MR. DRACH: Mark Drach.

LTC KEANE: Lieutenant Colonel Sean Keane.

MR. CONSTANTINE: I'm Justin Constantine

DR. PHILLIPS: Steven Phillips.

CSM DeJONG: Command Sergeant Major Steve DeJong.

CO-CHAIR CROCKETT-JONES: Would you like to introduce yourself?

1 MG STONE: No. You can go ahead.

2 CO-CHAIR CROCKETT-JONES: I'd like
3 to mention that we've had -- Commander Coakley
4 has retired. He is our Navy representative,
5 so we will be getting a new representative
6 from the Navy soon, I hope.

7 Our DoD co-chair, General Green,
8 is unable to join us today, so General Stone
9 will be working with me today to run the
10 meeting.

11 And I'll turn it over to you.

12 MG STONE: Suzanne, thank you.

13 I am Rich Stone. I'm the Deputy
14 Surgeon General of the Army, and I represent
15 the United States Army Reserve on this task
16 force.

17 We're going to begin today with an
18 after-action review for fiscal year '11 in our
19 report, which was sent to the Secretary of
20 Defense on the 2nd of September. The
21 information is behind Tab B in your books.
22 And I'll give it back to Ms. Dailey.

1 MS. DAILEY: Good morning again.
2 I will be running this next hour, and I have
3 put in Tab B an after-action review, and we're
4 going to talk a little bit about the products
5 that you all used over the first year and the
6 value of those products were to you.

7 So, let's start that. Steven, can
8 I get you up on the after-action report, this
9 document.

10 Good. Well, we have an hour here.
11 We'll work till about 9:30, and then we'll
12 take a break. During the course of this, I do
13 think that we will have time to talk a little
14 bit about the report, any feedback that you've
15 received.

16 So, this is kind of warm-up for
17 everyone. Let's just talk a little bit about
18 what I have there. We'll look over the
19 briefings that we had last year, and how we
20 went through each one of those, were they
21 valuable to you.

22 The next part we're going to talk

1 about will be results from the focus group.
2 That was a tool that we gave you. We gave you
3 a report on focus groups we are going to talk
4 about, if that had any value or any changes
5 you would like to that.

6 We are going to talk about other
7 documents, the effectiveness documents that
8 everyone received last year, how valuable was
9 that to you, do you want to do it again like
10 that or would you like a different process.

11 The evening phone calls that we
12 had last year, were they valuable? Was that
13 a process you would like to utilize again this
14 year?

15 First draft of the report, how
16 valuable was that a tool for crafting your
17 annual report? The business meeting and the
18 voting session that we conducted in July, was
19 that a process that was valuable to you? Do
20 you have other recommendations for where you
21 would like, or how you would like the business
22 meeting for the voting session to be

1 conducted.

2 And then, we are going to talk a
3 little bit about the visit agenda. Our visit
4 agendas, our site visit agendas, and the
5 content.

6 So, I'm looking for feedback from
7 you on how valuable these tools were to you
8 over the course of last year in building your
9 report, and do you want something else, do you
10 want to use this process again, where can we
11 tweak it, where can we bring greater clarity
12 for you.

13 Steven, let me ask you -- and let
14 me ask you to go to the briefings. There's a
15 listing of briefings. There it is. And let
16 see if we can bring that up to maybe 110
17 percent. You're at 117, a little more, if we
18 can do that, please.

19 Okay. So, January of last year we
20 started with a lot of business of creating the
21 right -- you all, as members, had some
22 administrative issues to take care of, so in

1 that first meeting, really the only thing we
2 covered was the centers of excellence.

3 We will need to readdress the
4 center of excellence this year. We'll assess
5 their progress. Any other ideas on how you
6 might want to get at this briefing format,
7 were these helpful to you? Did it get you
8 where you wanted to be on understanding where
9 these institutions are?

10 MR. CONSTANTINE: Denise, I think
11 -- are you going to the format that we used?
12 I did like all the briefings. Do you think we
13 should use more individuals coming in, like
14 when Ms. Horan came in and talked about her
15 husband and the difficulties at Walter Reed,
16 to counterbalance.

17 Perhaps even the same day as we
18 hear the official something about those
19 programs, because it will be good for us to
20 hear the personal side and the reality,
21 besides going to the site visits, and also to
22 hear what the officials had to say about those

1 personal stories.

2 MS. DAILEY: Okay. All right.

3 So, we are seeking to bring in more personal
4 accounts, first-person experiences with the
5 process. Okay. Okay. Good. Good.

6 CO-CHAIR CROCKETT-JONES: I'm
7 wondering, sometimes I feel that -- the
8 briefings are very helpful, but sometimes they
9 are not as targeted as they might be, and I'm
10 wondering, sometimes I would like to know what
11 questions we sent them.

12 MS. DAILEY: Okay.

13 CO-CHAIR CROCKETT-JONES: In --
14 when I'm hearing them.

15 MS. DAILEY: Okay.

16 CO-CHAIR CROCKETT-JONES: So, a
17 copy of the questions we send them at the time
18 would be good.

19 MS. DAILEY: Okay. All right.
20 How I ask them to brief us would be good
21 material to put in the agenda. So, you can
22 just look down and see if they are answering

1 the questions. Okay. All right.

2 MG STONE: I think now that we've
3 made a number of recommendations, I think part
4 of the prep of all briefers should be if any
5 of our previous-year recommendations affected
6 their organization and to how they are
7 responding to them or how they feel about
8 them, or whether they disagree with that
9 conclusion would be very helpful.

10 MS. DAILEY: Okay.

11 MG STONE: Anything that can get
12 us past the PowerPoint depth of some of these
13 things is of value, and having a contrarian
14 view is very helpful.

15 MS. DAILEY: Okay.

16 MG STONE: And so I would strongly
17 support the idea of bringing someone else in
18 who has been a recipient of services and has
19 some other viewpoint besides what we get,
20 which often is no deeper than PowerPoint.

21 MS. DAILEY: Okay. Good. Good.
22 We will schedule the services. You'll see

1 here we -- we did Army presentations, Air
2 Force presentations, Marine Corps
3 presentations. We're going to bring them back
4 in.

5 I'm going to wait and I'm willing
6 to bring you in on this. I'm willing -- you
7 know, I want to bring them in later in the
8 year. We have a February meeting. That would
9 put them a year out from where they briefed us
10 before and it is a six months, if I bring them
11 in in February, or five months from the
12 publication of the report.

13 And so, General Stone, we will ask
14 them to talk about their recommendations,
15 their response to the recommendations, and we
16 can ask them to tell us what changes they've
17 made since the last meeting.

18 Now, that would be the February
19 meeting, so that's still five months from now.

20 DR. PHILLIPS: To add on to what
21 General Stone had said -- and this may be a
22 bit sensitive, but if those folks would share

1 with us what their continuing problems are,
2 what their stumbling blocks are and what
3 issues are needed to get to the next level.

4 MS. DAILEY: Okay. Good. Good.
5 Thank you.

6 Okay. So, we'll sequence the
7 other services coming in. We'll bring in
8 counterpoint, and we'll ensure that they're
9 answering -- and that you have the questions
10 we've asked them to answer for us. Okay.
11 Good.

12 Let's go to focus group results.
13 Why don't you go back to this sheet of paper,
14 please, Steven.

15 So, these were tools used to
16 prepare the report. The first thing we gave
17 you, and it was about the first of May, ladies
18 and gentlemen, was this two 40- or 50-page
19 documents of nothing but focus group results.

20 That's kind of a deliverable from
21 my researchers, and I want to make sure it's
22 -- and I'm going to have to just draw on your

1 memory because I didn't want to make a dozen
2 copies.

3 And so, I need you to kind of
4 remember back to that document, and I need you
5 to try and remember was that a valuable
6 document for you, ladies and gentlemen. Did
7 you go through the focus group results? Was
8 it helpful in identifying themes that came
9 out?

10 Because, it is the document that
11 we provide you that has all the focus group
12 results in one place, before we integrate it
13 into the report.

14 CO-CHAIR CROCKETT-JONES: I found
15 it very valuable.

16 MS. DAILEY: Okay.

17 CO-CHAIR CROCKETT-JONES: My only
18 complaint in the focus group process would be
19 that transcription has to be really accurate.

20 There were just two small
21 instances where something I remembered from
22 the focus group did not get captured.

1 MS. DAILEY: Okay.

2 CO-CHAIR CROCKETT-JONES: But the
3 document that collates that information and
4 puts it into a thematic, give us some ideas,
5 I was very happy with that.

6 MS. DAILEY: Okay. Anyone else
7 have any thoughts about that document?

8 MR. DRACH: Yes. I thought it was
9 really helpful.

10 Yes, I thought it was very good.
11 It was very, very helpful.

12 MS. DAILEY: Okay.

13 MG STONE: You won't be as
14 enthused tomorrow afternoon. I found that
15 there was a lot of stuff in the focus groups,
16 but I didn't feel like it really captured the
17 emotion of those groups.

18 Each of the focus groups that we
19 participated in seem to have very substantial
20 emotion from those people providing testimony
21 to us. And I just didn't feel like I captured
22 it back.

1 And I think of some of those
2 sessions that we had. Maybe if we could
3 summarize the demographics of the -- of the
4 group in advance of the testimony, I think
5 that the transcribers were doing the best they
6 could to capture it, but it just -- I felt
7 like it brought me back to the session, but it
8 was my memory of the session that had most
9 value, and I could see the people giving
10 testimony.

11 It just -- we need to figure out a
12 way to get that better, maybe record them. I
13 don't know how to get there. I don't know how
14 to get there, but I thought about, when I went
15 back and had this 40-, 50-page document, I was
16 often thinking, well, what were the
17 demographics of this group if I wasn't in the
18 room. You know, what did we have in the room
19 that was giving his.

20 So, I thought we could do a little
21 bit better with -- than the product we were
22 given.

1 MS. DAILEY: Okay. Okay. All
2 right. We will take that -- yes. Good.
3 Good. So, I appreciate the feedback. I
4 really do.

5 DR. PHILLIPS: At least my
6 impression was, there was some staff and cadre
7 that came by the focus groups to talk to us
8 privately, and were expressing issues that
9 supported the service members issues, though
10 it wasn't a formal activity on our part.

11 And in the general meeting we had
12 with the brass and the staff, those weren't
13 expressed, and I'm just wondering if there's
14 some consideration to voluntarily invite the
15 cadre and the staff who are actually in the
16 trenches with the -- with the troops, to sit
17 in a private focus group with us.

18 I just throw that out. I had that
19 impression from some of them.

20 MS. DAILEY: Yes, I can get to
21 that this year, in that my thought was,
22 particularly when -- I'm compartmentalizing

1 that site agenda a little bit more, and so the
2 cadre gets a piece of it and then I ask them
3 to leave, and then like the medical case
4 managers will come in and we will -- we will
5 have the cadre moved out of there, so that the
6 medical case managers can talk a little more
7 candidly.

8 So, I'm -- I'll work that one
9 through that. I -- so -- so, yes, I believe
10 there's a piece there from the cadre that we
11 might be missing that they don't get to be
12 that candid when they are briefing everybody.

13 Okay. Okay. But good.

14 CO-CHAIR CROCKETT-JONES: And on
15 the topic of the little private one-on-one
16 sessions, can we find some more formal way of
17 capturing some of that information, because I
18 can think of a couple significant revelations.

19 MS. DAILEY: Right.

20 CO-CHAIR CROCKETT-JONES: From
21 those private meetings, but we had no way,
22 really, of putting it down.

1 MS. DAILEY: Okay. Okay.

2 LTC KEANE: Ma'am, General Stone
3 brought up a good idea. I'm not sure if we
4 can do this. Can we have -- can we record the
5 sessions to help the transcribers?

6 MS. DAILEY: I do not have that
7 programmed into my contract right now. I
8 would have to do a modification to my
9 contract, and more money, probably.

10 I mean, this -- this man here is a
11 -- is a chunk of change.

12 MR. CONSTANTINE: It seems like it
13 would be a valuable resource to have -- I
14 understand that once you have a contract,
15 you're limited to that, but if we could record
16 it, obviously with the participant's
17 permission, then the researchers, when they
18 run their report, they're referring to
19 something, whether it's the notes, to take
20 longhand, the notes they type, or of course
21 they can play on a tape recorder that they had
22 there, they get the value, then, of instead of

1 just -- instead of reading it where it's like
2 six members said this, one member -- the
3 statistics, it's -- you know, personal details
4 which there's no way we can remember. There's
5 no way they can capture, like trying to write
6 furiously.

7 And so, I recognize there's some
8 contractual issues, but if it's as simple as
9 recording, and I'm playing while they're doing
10 their report, maybe that would help them and
11 make it even quicker than what they were doing
12 before.

13 MG STONE: Yes. Let me -- let me
14 make one other comment. We promise anonymity
15 to people when we start this, and we have to
16 be cognizant, and if some professional needs
17 to tell us that if we record it, will we then
18 limit what people actually say to us.

19 And so, I don't know how to
20 capture this. Maybe it is recording. Maybe
21 it's not, but we'll need to work our way
22 through that, but I did not find the document

1 really capturing the emotion and the depth of
2 the thought process that these very articulate
3 families and individuals brought to us.

4 MS. DAILEY: Okay.

5 DR. PHILLIPS: On the other side
6 of the coin, obviously, we need to get some
7 legal input onto whether we can record or not.

8 There were some episodes-- and one
9 episode -- that were somewhat sensitive and
10 actually created an investigation and
11 recording of that -- of those sessions that
12 stimulated might either have nipped in the bud
13 some of the excess activities or told exactly
14 the folks who were investigating exactly what
15 they needed to do. So --

16 MS. DAILEY: Okay.

17 DR. PHILLIPS: I don't know how
18 that fits in with us, but --

19 MS. DAILEY: Okay. All right.
20 Okay. Let's talk about our effectiveness
21 documents.

22 Steven, can I get you to pull up

1 an example of the effectiveness documents we
2 used last year?

3 And let's pump that up a little
4 bit. All right. These documents we used to
5 synthesize everything. We brought focus group
6 results -- and let me get you to scroll down
7 a little bit.

8 We brought in time lines. We
9 crafted them -- there you go. There you go.
10 That will be fine right there for now.

11 We crafted them on the model of
12 assessing effectiveness from the University of
13 Wisconsin. It has four domains, inputs,
14 activities, outputs and outcomes.

15 We inserted into each one of those
16 domains the appropriate research questions,
17 and then upon -- upon the synthesization
18 process, we were able to assess each one of
19 those domains against the research questions,
20 and against the data we gathered.

21 It starts with this type of time
22 line. This is the time line for the medical

1 case management. We would update this.
2 There's a new bullet we would put in for
3 medical case management.

4 The DoDI has been updated as of
5 August, so we put another bullet in here. You
6 have the DTM on that last bullet there, 08033.
7 It's been updated as of August of 2011. So,
8 you'd see an update.

9 And then, Steven, let me -- let
10 you scroll down. So, here's a resource
11 research question. All the data we gathered
12 for resource, resourcing this. And then go
13 down one more, would you please, Steven.
14 Thank you. To -- stop.

15 This is an activities. These are
16 activities happening, so this was a -- we call
17 it an effectiveness document. It was a one-
18 stop shop for you guys to assess all the data
19 we'd gathered, both research, briefings, and
20 focus group.

21 Big deliverable, big product from
22 my research team to put out. Does work for

1 you? Should I use something else?

2 CSM DeJONG: Denise, I found these
3 pretty much invaluable as far as coming on
4 late last year and getting caught up. This
5 could kind of -- and I know we got some new
6 members being replaced, and some seats being
7 replaced for this upcoming year.

8 But, coming on late, being able to
9 kind of -- it gave me a focus point and
10 everything that you all had done up until that
11 point, and your staff had done up to that
12 point to get kind of caught up and understand
13 what was going on where.

14 So, I mean, I think, this document
15 was pretty much invaluable all the way
16 through. One for me getting caught up and,
17 two, in the final decisionmaking on the -- on
18 the recommendations in the report.

19 MS. DAILEY: Okay. All right.
20 Okay. Good. That we'll keep. All right.
21 Let's take a look at evening phone calls,
22 ladies and gentlemen.

1 You can pull that down, Steven.
2 If you'd go back to this document. There we
3 go. Good. Okay. I had varied participation
4 in this. I'm happy to do it again, but I've
5 actually attempted this year to replace these
6 evening phone calls with two additional
7 meetings.

8 A lot of the work we did here, we
9 could easily have done with a meeting. It
10 creates a better synergy. The
11 compartmentalization required by this doesn't
12 really give you guys an opportunity to bounce
13 ideas off each other.

14 DR. PHILLIPS: Yes. I agree. In
15 theory, it seemed like a nice idea, but
16 practically it didn't work very well.

17 MS. DAILEY: Okay.

18 DR. PHILLIPS: I'll leave it at
19 that.

20 MS. DAILEY: It's good. I mean,
21 you all get to day, "Boy, do you miss them on
22 that." So, please. I need this guidance. I

1 need to go whether to go left or right on some
2 of these products.

3 MR. DRACH: I saw some value in
4 the evening phone calls, but not as an
5 alternative to face-to-face meetings. I would
6 prefer the face-to-face meetings when
7 possible, but in certain situations, the
8 evening phone call may be necessary to kind of
9 fill in some gaps between meetings or
10 something.

11 LTC KEANE: I thought it was
12 challenging having the phone calls during the
13 evening. I think if we had to have phone
14 calls, during the work day would be better for
15 me, personally.

16 MG STONE: Yes. I was very
17 surprised. I thought, as we participated in
18 the phone calls, I thought we were making
19 really good progress, but when we brought the
20 product out, the product was substantially
21 disconnected from where the committee wanted
22 to be.

1 And I think, in hindsight, it
2 probably did not have much value. I think the
3 second thing was, is to really disconnect from
4 the day's work and begin thinking about fairly
5 complicated issues, and to really reengage in
6 this.

7 I think, coming into a meeting,
8 you've got the whole group together. I think
9 it was much more productive. I think when you
10 broke us out into subgroups in a meeting was
11 way more productive, that we could then come
12 back and really reality-test against the rest
13 of the committee, was way more productive than
14 those phone calls.

15 And I would -- I would certainly
16 suggest that we consider giving up those
17 evening phone calls in this year's process.

18 MS. DAILEY: Okay. All right.
19 Good. Very good feedback. I don't think I'll
20 have any trouble taking those off the
21 calendar. So, okay. Good. Good feedback.
22 Very appreciative, ladies and gentlemen.

1 Okay. So all of that brought us
2 to the first draft of the report. We put that
3 out on the website on the 15th of June, I
4 believe. No, 15 July. Okay.

5 So we put that out on the web the
6 15th of July. And large document, 38 -- not
7 large. It was not a large document. Thirty-
8 nine recommendations. Thirty-nine pages of a
9 recommendation and findings beneath it which,
10 in your subsequent meeting, you compressed
11 down into 22.

12 So, I know a long time ago, now,
13 man, our whole lives have moved so far beyond
14 that we are --

15 MG STONE: Okay. Denise, the
16 first draft wasn't the first draft till the
17 committee reviewed it. And so, what went up
18 on the website was the work of the
19 subcommittees with 39 recommendations.

20 MS. DAILEY: Right.

21 MG STONE: And it caused a
22 conflagration of response.

1 MS. DAILEY: Correct.

2 MG STONE: I can tell you I had a
3 very heart-to-heart meeting with my boss over
4 those 39 recommendations. A number of them,
5 I've never even seen --

6 MS. DAILEY: Right.

7 MG STONE: -- because they came
8 out of the subcommittees. So, your definition
9 of "first draft" is not "first draft" until
10 the committee looks at it and says "We're
11 pretty comfortable with this. We're ready to
12 have this go up on the website."

13 Then the recommendations, I think,
14 we'll take the hits on, or what is factually
15 incorrect, which a number of people, a number
16 of organizations came up and corrected facts.
17 That was very effective at providing a good
18 product.

19 But, so I would strongly suggest
20 that we consider not putting anything up until
21 the whole committee looks at it and says,
22 "Okay, we're comfortable with getting this out

1 as a first draft."

2 MS. DAILEY: Okay. Okay.

3 CSM DeJONG: I agree with General
4 Stone on that one, on some of them that we've
5 never seen, but I think the feedback that we
6 got from the forces of that -- so sometimes I
7 guess rustling some feathers and getting --
8 that caused kind of a rapid feedback.

9 And that feedback, again, I
10 thought was invaluable in making the final --
11 final report, and making finite changes that
12 some of the stuff had actually been
13 implemented within that month.

14 So, I liked the time frame of it,
15 but I also agree with General Stone of
16 agreeing as a whole before we put it up.

17 MS. DAILEY: Okay. Any other
18 comments?

19 (No response.)

20 MS. DAILEY: Okay. Working our
21 way through this. And the last one is our --
22 yes. Our last one is our installation visit

1 agendas and content. We have --

2 CO-CHAIR CROCKETT-JONES: We need
3 to do the business meeting on voting session
4 before we --

5 MS. DAILEY: Whoops. I'm sorry.
6 Did I miss that? Okay. Yes, you're right.
7 Business meeting and voting session, ladies
8 and gentleman.

9 Three days. We had open sessions.
10 We had sessions where we were working in small
11 groups coming back to open sessions. Those
12 first two days crafted your recommendations.
13 The last day was a review of appendices, the
14 foreword, and the introduction.

15 Long time ago. I can bring out
16 the report if you want to jog your memory.

17 DR. PHILLIPS: I'll just throw
18 something out for the group. I'm just
19 wondering if part of that process shouldn't be
20 in an informal environment. We sit around,
21 maybe no coats and ties, and spend a couple of
22 hours working through it.

1 I find that when I do that with
2 staff, sometimes it's a little easier to get
3 things done and people are more relaxed and
4 are not -- I don't know what the rules, you
5 know, what rules you have to adhere to, but if
6 we could think about something like that, as
7 we get to the next step, it might be a little
8 easier for us.

9 MS. DAILEY: Okay. Business
10 meeting.

11 DR. PHILLIPS: I meant in the vote
12 and -- you know, in the voting --

13 MS. DAILEY: Right.

14 DR. PHILLIPS: -- set part when we
15 get ready to finalize these drafts and vote to
16 it to have some sort of informal gathering
17 where we can all discuss it.

18 MS. DAILEY: Okay.

19 CSM DeJONG: I think it was a busy
20 three days, but I think it was a -- I wouldn't
21 change it for next year. I think the way that
22 we broke it up, worked through a few issues,

1 brought it back, presented it to the group, I
2 thought it was -- with following whatever
3 rules you have to file with what has to be
4 open, what doesn't have to be open. I thought
5 it was effective and we met the time line, so
6 I wouldn't change too much.

7 MS. DAILEY: Okay. Good. That
8 notes there. We should -- again, we will have
9 -- if we're having face-to-face meetings, and
10 added two meetings this year, ladies and
11 gentlemen.

12 So, I can't say the process is
13 going to be exactly the same as last year.
14 There will be some dynamics that come out of
15 those two additional meetings, so we will see
16 next year where were we at.

17 You won't be in the same place for
18 this last meeting that you were last year when
19 you walked into the last meeting. And you
20 will be one more year of experience under your
21 belt.

22 I assure you, having done this

1 many times, things that were big obstacles
2 this year will be -- you'll breeze right
3 through them next year. But more time always
4 helps.

5 Okay. And then the last tool that
6 we used to develop our report is our
7 installation visit agendas and our contents
8 for the installation visit agendas. Hard to
9 believe we're starting out on one of those.
10 Well, we'll be on an airplane next week this
11 time -- well, maybe next week this evening.

12 So, I stuck with the two-day
13 format. They are very busy agendas, still
14 trying to cover all of our mandated topics.
15 We have, this year, more. I have a full 15.
16 I'm only -- 15 installation visits.

17 I have ten more focus groups that
18 will take longer to process that type of
19 volume, focus group responses, briefings.
20 Again, coalescing all those briefings into the
21 effectiveness documents.

22 So, we are on the same template as

1 we were last year. I'm still early. I can
2 make some changes. Good, bad, works, doesn't
3 work.

4 DR. PHILLIPS: It's me again. I
5 have one suggestion, and I don't know how to
6 find the time to do this, but after we finish
7 a visit, I think it would be very helpful to
8 sit with the staff and us for an hour or two -
9 - probably two, and really debrief us and get
10 the information down so that we're not looking
11 back at a focus group six months later and
12 reading a report, to perhaps have some kind of
13 draft summary before we all get on airplanes
14 and go home.

15 CO-CHAIR CROCKETT-JONES: I just
16 want to say that the first visits felt a
17 little more compartmentalized as far as who
18 did what, and I think it was really
19 advantageous when we started maneuvering that
20 a little differently so that wasn't -- you
21 know, we weren't only doing focus groups or
22 only being briefed.

1 To get an overall picture, it was
2 better to have those roles shifted around, and
3 I hope we stick with that this year. It was
4 much more helpful to not just hear a very
5 segmented part of every installation story.

6 Also, in having lots of role
7 changing and interaction, it meant if you were
8 getting some serious disconnect between users
9 and providers you could start addressing that
10 and figure out where to drill down.

11 So, I just want to say that we --
12 we got better as we went along on the
13 installation visits and I hope we continue in
14 that trend of sort of moving people around
15 within each visit.

16 MS. DAILEY: Are you talking about
17 members of the task force?

18 CO-CHAIR CROCKETT-JONES: Yes.

19 MS. DAILEY: Or the installation
20 members?

21 CO-CHAIR CROCKETT-JONES: Members
22 of the task force.

1 MS. DAILEY: Members of the task
2 force. Okay.

3 MR. DRACH: A couple things that
4 struck me on the installation visits, and I
5 can't remember which one specifically was
6 which one, but I thought that it was very
7 obvious that the task force was being slighted
8 by the command when some of the command didn't
9 show up, and some of the people that did show
10 up had no idea why they were there.

11 How do you solve that? I'm not
12 really sure, but perhaps there needs to be
13 some form of accountability put into it when,
14 you know, when you're sitting across the table
15 from somebody and they have no clue who you
16 are or why you're there, or why they're there,
17 you know, it's pretty much, not a total waste
18 of time but, you know, where are they.

19 You know, they didn't know what --
20 the one site visit, they didn't know what they
21 were supposed to talk to us about. How do you
22 solve that? I don't know, but -- you know,

1 from the top-down, somebody needs to be made
2 accountable.

3 MS. DAILEY: Okay.

4 MG STONE: I think you bring up an
5 important point, and that is two separate
6 services really serve the committee very --
7 the task force very poorly in their being ill-
8 prepared for the visit.

9 By the same token, we pretty much
10 last year stayed in the medical care lane, and
11 it's extraordinarily important, as we have
12 seen, to engage the line leadership,
13 especially in those services who have chosen
14 to keep so many wounded warriors within the
15 line.

16 I think we have to add line
17 leadership and to our discussions, and know
18 that the line is connected to the medical care
19 delivery system and the wounded warriors, and
20 just to see what that connection is.

21 And one of the areas of
22 investigation -- and I shouldn't use the term

1 "investigation." -- of review for this
2 committee, I think is to see that connection
3 between medical care and the line, and really
4 reach out to those.

5 Now, I was frustrated in -- in
6 both the Air Force response, and it was early
7 on in the task force. I was very frustrated
8 when we were out on the west coast at Balboa
9 at the lack of senior leadership involvement
10 and the fact that we got a deputy commander
11 who had not a clue what we were there for.

12 And we got the right word spoken,
13 but we got no preparation from the staff at
14 all. Now, we tried not to capture that
15 frustration in our report out of courtesy, but
16 I think in -- I think, Denise, if you think
17 you have an area that's ill-prepared for us,
18 then we need to really engage with our chairs
19 in advance of that visit to express our
20 concern before we show up and waste people's
21 time on both sides.

22 MS. DAILEY: Okay. Good. Good.

1 Okay. That's it. That was my opportunity to
2 kind of walk you through this product, see if
3 they're helpful to you. Thank you very much
4 for your feedback.

5 MG STONE: Alibis, anybody?

6 MS. DAILEY: Yes.

7 LTC KEANE: Ms. Dailey, is there
8 any way or method that you use to go back to
9 the installations that we had to see if they
10 implemented the suggestions we had? For
11 example, getting the wounded ill and injured
12 family members or caretakers access to the
13 base, those type of things.

14 Was there any follow-up, or is
15 that what we will do in the following visits?

16 MS. DAILEY: No. I do not go back
17 and do it. We can assess it. I can bring it
18 into the briefings. Our role is advice and
19 recommendations. We do not have an
20 enforcement arm. We can go back and review
21 where they're at in their progresses.

22 It is up to the Department of

1 Defense to implement and include in their
2 processes.

3 MG STONE: If there are no other
4 alibis, our next session begins at 9:45. If
5 you could be back in your seats at 9:40 so we
6 could start back in a timely manner. Thank
7 you very much. We are no on break.

8 MS. DAILEY: Thank you. Thank
9 you, sir.

10 (Whereupon, the above-entitled
11 matter went off the record at 9:18 a.m. and
12 resumed at 9:38 a.m.)

13 CO-CHAIR CROCKETT-JONES: All
14 right, folks. I'm going to welcome everyone
15 back. We now have Dr. Bernard Rostker, a
16 senior fellow with RAND and previously the
17 Under Secretary of Defense for Personnel and
18 Readiness.

19 His information can be found in
20 Tab C. I'm looking forward to this. If you'd
21 like to go ahead with your briefing.

22 DR. ROSTKER: I'd like to do this

1 as informal as possible. There's a lot of
2 material to cover, but if you have questions,
3 please don't hesitate to ask. Next line.

4 This -- what we're going to talk
5 about is a project that is funded by P&R. The
6 American experience through history is covered
7 in two volumes. The first volume is in the
8 review process now and covers the period from
9 the, if you will, the dawn of history through
10 World War II, and then there will be a second
11 volume which is also funded which will cover
12 the period from the Korean War to the end of
13 the Bush Administration.

14 We're not going to try to sort out
15 what's been happening over the last two years.

16 In the volume we start by defining
17 what I mean by care for the casualties of war,
18 and that is in-service care and care as
19 veterans.

20 We're talking about care for
21 medical conditions and psychological,
22 psychiatric conditions, but not the whole

1 range of services provided to veterans which
2 might include educational benefits, housing
3 benefits and the like.

4 So, we're talking about those who
5 were wounded in combat and how they were cared
6 for in combat and -- and through -- this is --
7 turns out to be a fairly unique approach
8 because we have a number of histories that
9 deal with medical services of armies, but they
10 don't deal with the hand-off to the veterans
11 and how that played, and so this continues
12 that continuum.

13 As a point of motivation, I
14 highlight a statement in the 2010 QDR. It's
15 a hope that, by looking how policies changed
16 over time, evolved over time, that that will
17 give us a better understanding of their roots
18 and help us understand policies today.

19 I will tell you that, having
20 served for a number of years in high positions
21 in the Clinton and Carter Administrations, I
22 was completely unaware of this history.

1 I ran the Gulf War Illness
2 Program, but had no idea of where that came
3 and how it related to the broad sweep of
4 history. So that's what we hope to fill in
5 here. Next slide.

6 So, let me start off by broadly
7 telling you what we have learned. The care
8 that we have come to expect today in the broad
9 sweep of human history is less than a hundred
10 years old.

11 From the dawn of civilization
12 through World War I, just being a soldier was
13 an invitation to be stricken with disease and
14 if you weren't killed by disease, then the
15 wounds and the medical care that you got were
16 more likely to kill you.

17 This was exacerbated by the
18 organization of medical resources on the
19 battlefield, evacuation, movement of
20 casualties. And if you survived all of that
21 and were disabled, you might get some cash
22 payments and a place in -- I use the word

1 "asylum," because that's the historic word for
2 the medically indigent. That was the way the
3 historical mode evolved up until World War I.
4 Next slide please.

5 World War I is the great turning
6 point in care. It is firmly built upon the
7 evolution -- it evolved from the past, but
8 even as it evolved, it broke with the past in
9 very meaningful ways, in ways that we could
10 not really have predicted and is the
11 antecedent of the entire system of in-service
12 care and medical -- and veterans' care.

13 Before World War I, things were
14 entirely different. After World War I, they
15 change and they change permanently. Next
16 slide.

17 We're going to try to trace some
18 broad themes through the history. The nature
19 of conflict, the tactics used, the weapons
20 used and how those impacted on the nature of
21 wounds, medical logistics, both the
22 organization of medical services and

1 particularly the care a soldier, a wounded
2 soldier would receive on the battlefield.

3 This all is played out against the
4 state of knowledge at the time and we'll look
5 at how an understanding of human anatomy, an
6 ability to control disease and then infection
7 changed the way care was given, and then
8 finally a better understanding of the
9 psychological impacts of combat really comes
10 in very, very late.

11 In terms of care for the veterans,
12 we'll look at the changing role of the state,
13 how compensation was provided and then how the
14 care of indigent veterans were provided.

15 In the book, we start with the
16 Greeks but I think I can cut that short by
17 moving it forward to Rome, and say that in the
18 early history of Rome, they were nothing more
19 than a city-state on the Greek model. Change
20 the slide.

21 This was a citizen army. It
22 fought near home and it was family and friends

1 who were generally responsible for the care of
2 those who were wounded.

3 As Rome expanded beyond its
4 borders, it had to move towards a more
5 professional army, but medical care was in the
6 hands of individual commanders. It wasn't
7 stabilized. It wasn't standardized, and
8 doesn't change until Augustus, in the forming
9 of the Roman Empire.

10 Augustus creates the first formal
11 medical corps, and we'll look at how Rome
12 differed. Next slide.

13 The services that a Roman soldier
14 would get were unique in the ancient world.
15 The Roman medical corps had their own training
16 programs, their own training manuals and we
17 note that some of the procedures prescribed in
18 those manuals were used as late as World War
19 I.

20 There was a separate logistics
21 train for the wounded. There were ambulances,
22 separate carts and conveyances and a series of

1 hospitals for convalescing.

2 A Roman garrison would have a
3 hospital and it was generally sized at ten
4 percent of the legion that was partaking of
5 the garrison and more larger hospitals on the
6 frontiers.

7 The Romans had an early form of
8 antiseptic in the form of wine that was
9 fortified and actually was more effective than
10 the early antiseptics used by Lister, but they
11 still could not control disease and they
12 couldn't control infections.

13 They had a theory inherited from
14 the Greeks of the laudable pus. In other
15 words, a wound would only heal if pus was
16 present. We now understand that as an
17 indication of an infection. They thought that
18 was an important part.

19 That notion of laudable pus
20 extends into the 19th century. There's book
21 that was just published on the death of
22 President Garfield, and the main thesis of the

1 book is that the President died, not from the
2 wounds, but the infection, and it was the
3 probing of wounds with unclean hands, it was
4 a failure to wash, it was based upon the
5 theories that were prevalent for over 2000
6 years.

7 The Roman soldier received a
8 generous retirement. As we see today, the
9 retirements were designed to keep soldiers in
10 the Roman legion. If they had served for 20
11 years, they received a retirement bonus equal
12 to 14 percent -- 14 times their annual pay.

13 The Romans did not generally value
14 medical care. There were no hospitals in
15 Rome, per se. The hospitals of the era were
16 in the Roman army, but the Romans did extend
17 the opportunity to enlist physicians from the
18 East, generally Greece, with the promise of
19 Roman citizenship.

20 And again, you see a repeating
21 today where we talk about bringing people into
22 the Army with the promise of -- foreigners

1 coming into the Army with the promise of
2 citizenship.

3 The Romans had a system of care
4 for those who were maimed and could not
5 continue. Authors talk about soldiers being
6 invalidated out. They received the same
7 retirement benefits as a person who had
8 completed his service of 20 years, and that
9 also was an allotment of land, generally on
10 the frontier.

11 Roman -- retired Roman soldiers
12 were exempt from a number of civil obligations
13 and those retirements -- those benefits
14 extended to his family and his children for
15 generations. So, it was not just the Roman
16 soldier.

17 Roman soldiers banded together to
18 create burial societies. They made voluntary
19 contributions while they were in service, and
20 they were paid upon their death or retirement
21 or disability. These were more than just
22 payments for the cost of a burial, but

1 represented a very early form of life
2 insurance.

3 This notion of soldiers paying for
4 some portion of their retirement benefits is
5 a recurring theme that we will see over and
6 over again, and exists today in the payments,
7 for example, that sailors make to maintain the
8 Navy home in Biloxi, Mississippi. It can all
9 be traced back to payments for veterans in the
10 Roman army.

11 With the fall of Rome, the West
12 fell into an age of feudalism, the Dark Ages,
13 with extreme decentralization. The whole
14 system was replaced by a system of lords and
15 serfs and underlords paying an obligation to
16 serve at times that they might be called.

17 Over time, this evolved into a
18 system of payments rather than actual giving
19 of services, so you see taxes rising and
20 eventually the rising of a professional class.

21 It was the responsibility of the
22 lord to maintain his knights and that includes

1 the medical care of the knights. As far as
2 the average soldier was concerned, as this
3 quote says, he was brought to the battle to be
4 sacrificed. He was used while he was healthy,
5 and when sick or wounded, left to die.

6 And the notion was that it was
7 cheaper to recruit a new serf than to care for
8 an old one. That's a theme that reappears in
9 history, but is very much countered by a
10 growing understanding of the importance of
11 keeping those in the military safe.

12 So you see, by the Middle Ages and
13 later, more of a concern for caring for
14 soldiers so that they might be returned to
15 duty, rather than just to allow them to die on
16 the battlefield.

17 The average soldier received what
18 care he could get, not from the lord, but from
19 the church, and it became a church
20 responsibility to maintain hospices and
21 hospitals, largely for those who could not be
22 maintained by their families or by -- by the

1 lords of the manor.

2 The role of the church returns
3 medicine to an intrusion by religious doctrine
4 which was very common in the ancient world,
5 and in the 13th century, the church decrees
6 that surgeries are to be forbidden because of
7 the spilling of blood, and you see medicine
8 then dividing into two branches, of physicians
9 and surgeons.

10 And it fell to those who were the
11 servants of the monks who shaved their heads,
12 who had sharp instruments for shaving and the
13 whole institution of the barber/surgeon arises
14 as a really second-class citizen compared to
15 the study of medicine.

16 But the study of medicine is very
17 much dominated by the notions of the Greeks,
18 carried forward by the Romans and carries
19 forward this laudable pus theory which is very
20 detrimental to the health of the wounded
21 soldiers.

22 Jumping forward to the

1 Renaissance, you start seeing things change.
2 You see the break-up of the church in England.
3 For example, Henry VIII has a program called
4 the Suppression of the Monasteries, which
5 destroys the backbone of the medical care for
6 the average person and for the average
7 soldier.

8 It now, as professional armies
9 start to grow, as national armies start to
10 grow, it behooves the local rulers to provide
11 medical care. And you see medical care really
12 provided for -- for four reasons.

13 One is the conservation of forces.
14 If we can patch them up and get them back on
15 the line, that's important. Another is if we
16 can't and we don't provide for the veteran,
17 the disabled veteran, then we will see large
18 increases in those who are beggars and that is
19 destabilizing to these regimes.

20 The state starts to be concerned
21 about recruiting and if they can't show
22 prospective recruits that there's -- they will

1 be cared for, that will be a problem.

2 And finally, we see that leaving
3 medically -- leaving soldiers who are wounded
4 on the battlefield is destabilizing to the
5 morale of units.

6 So, for those four reasons,
7 recruiting, morale, concern about veterans and
8 the conservation of the force, there's a rise
9 in concern for medical, and individual rulers
10 start bringing in medical care, most notably
11 was Isabel of Castille, of Ferdinand and
12 Isabella, and there was a large medical
13 establishment that came with the Spanish army.

14 In the book we do that, and then
15 trace more the evolution in France and in
16 England, England particularly as the precursor
17 of American medical care.

18 So, you see, as I note there,
19 improved living conditions, better medical
20 services, and in 1633, Cardinal Richelieu
21 starts work on the Maison des Invalides, the
22 famous building in Paris, and that becomes the

1 model for care for pensioned, old -- pensioned
2 and disabled soldiers.

3 One word on the Invalides. At the
4 same time they created a Corps of Invalides.
5 They too those who were not capable of full
6 service, but still could provide some service
7 and had them man garrisons on the frontier,
8 have them do light duty, and that institution
9 of a Corps of Invalides is repeated in the
10 American Army during the Revolution and in the
11 Union Army during the Civil War. Next slide.

12 So things are starting to improve.
13 We're starting to get back to a level of care
14 that might sort of look like what a Roman
15 soldier might have gotten, and then we have
16 the widespread introduction of gun powder, and
17 that changes everything.

18 Previously wounds were crushing
19 wounds or slashing wounds or stabbing wounds.
20 They were relatively clean. Now with gun
21 powder we have what one author called gruesome
22 wounds, and the death rate increases sharply.

1 The ability to control bleeding is much
2 reduced. The ability to control infection is
3 reduced.

4 If you received a gunshot wound to
5 the torso it basically was a death sentence,
6 and that continued until World War I. And it
7 continues, certainly, through the Civil War.

8 If you received a gunshot wound
9 that shattered a bone, a serious wound to one
10 of your limbs, then that, then, would most
11 likely be amputated.

12 And so there rises in Europe a
13 large number of amputees, which adds to the
14 whole notion of indigent. They can't work.
15 They have to be provided for by the state.

16 Then, in the volume, I tried to
17 trace two signature wounds, if you will. One
18 is amputations and how that changed over time.
19 And the second is psychological,
20 neuropsychiatric wounds and how that has
21 become more prevalent over time, or at least
22 more noted over time.

1 But with the widespread use of gun
2 powder you see the widespread increase of
3 amputations. Here I noticed the French king,
4 Louis XV. His first reaction to these large
5 numbers of indigent amputees was to make
6 begging -- outlawed begging and throw them
7 into prison.

8 Eventually he came around and
9 established a pension system for the disabled
10 and then the -- as I mentioned, the Corps of
11 Invalides.

12 The pension system was
13 interesting. They were provided a place at
14 the Invalides, but the capacity was quite
15 limited, and so they were furloughed with a
16 cash payment in lieu of a place at home, so
17 the cash payment could help them or their
18 families provide services to the amputee, and
19 that's really the rise of cash pensions in
20 lieu of a place at a home. Next slide.

21 Britain is the precursor of the
22 American system. The events in Elizabethan

1 England, and they were well-known to the
2 colonists, this is the country they had come
3 from, and you see, in the colonial period and
4 the early revolutionary period a mimicking of
5 the British system.

6 The situation in England became so
7 much of a concern that Parliament was forced
8 to act in 1598. A concern, because of the
9 Twenty Years' War with Spain had upwards of
10 800,000 veterans roaming the countryside.

11 This was a terrible period of
12 unemployment, of social unrest in Europe and
13 here we have a group that is trained in arms
14 and is unable to provide work and it falls on
15 the state to address it, address it in a way,
16 though that Queen Elizabeth did not want to
17 spend very much money.

18 And so, in the Act of 1598, they
19 provide a rationale for pensions, both on
20 compassion and on practical grounds -- the
21 Queen rationales that will be repeated in
22 American legislation in the colonies.

1 But they set up a mechanism for
2 decentralized care, not only decentralized
3 care but to be paid for by the local, if you
4 will, taxpayers.

5 Parliament provided an ability to
6 raise local fees and turn to the local
7 officials, justices of the peace to, in fact,
8 tax the local community to pay for veterans
9 who had been disabled in the war with Spain.

10 The local communities refused to
11 use the authority granted by Parliament and
12 there is a standoff for decades in terms of
13 how these poor people will be taken care of.

14 What Parliament said is, if you
15 cannot work, you are entitled for a pension
16 for life. What the local communities said
17 was, we're going to pay for a specific loss,
18 a loss of an arm, loss of an eye, loss of a
19 leg, and it will be reevaluated continuously
20 to see if you can actually go back to work or,
21 if you find some employment, then these
22 payments from the local communities would

1 stop.

2 The system continued through the
3 English Civil War of 1642 to '49. That war,
4 incidentally, is considered the deadliest in
5 English history. Great Britain suffered more
6 casualties in that war than in World War I or
7 World War II, in fact 20 times more than they
8 received in World War -- proportionately in
9 World War II.

10 Eventually, after the Restoration,
11 the crown took on the responsibility of caring
12 for the medically indigent. That settled the
13 issue of whether it was a national or a local
14 responsibility, but not to the benefit of the
15 average soldier.

16 This was made a charity of the
17 crown, rather than an obligation of the state,
18 and soldiers were forced to pay for their own
19 health care in a series of wage garnishes
20 which have an echo in the way we have funded
21 the military homes in this country to today.

22 Military homes are paid for as a

1 check-off, a garnish of sailors, and also for
2 fines that are levied in court-martials, and
3 booty, and that exactly carries through from
4 the terms of our English forbears. Next
5 slide.

6 The Eighteenth Century sees a
7 remarkable increase in the professionalization
8 of the British army. This starts during the
9 reign of William and Mary and Queen Anne and
10 extends all the way through the time of the
11 American Revolution, including the British
12 regulars who came to this country and fought
13 the Revolution.

14 Medical services were routinized,
15 and I include there kinds of things that were
16 common in the British army. There were
17 medical exams for recruits. Officers received
18 salaries, uniforms, daily ration, a series of
19 hospitals, even a medical school.

20 This is the first time when we see
21 the care of soldiers falling to a professional
22 corps of nurses. It was very common for

1 soldiers to be tended to by a female, who
2 generally carried the term camp followers.
3 They were often the wives of the soldiers or
4 others.

5 Here this is a recruited,
6 professional nurses' corps that is trained and
7 dispatched with the military hospitals as part
8 of the British army as they fight on the
9 continent, campaigns of Lord Marlborough, and
10 then into the -- into the colonies.

11 In the mid-Eighteenth Century,
12 there are a series of battles where the care
13 of wounded are outrageously neglected,
14 particularly by the British, and this led to
15 a treaty between France and the Allies,
16 Britain, Holland, for the care of those
17 wounded on the battlefield that provided safe
18 havens for hospitals, provided care, special
19 treatment for medical practitioners, doctors,
20 orderlies, in the care. They could not be
21 taken prisoners of war. They were to be left
22 in place to care for the wounded. And both

1 sides had an obligation to care for the
2 wounded of not only their own side, but the
3 other side.

4 And this clearly is a forerunner
5 of the Geneva Conventions that we operate
6 under today.

7 Life for the ordinary soldier in
8 the 18th century, however, was not easy.
9 Their pay was low, they were really refugees
10 of the early Industrial Revolution. They were
11 displaced middle-class tradesmen and
12 craftsmen, and their service to the crown
13 represented one of the few places where they
14 could get employment. The unemployment rates
15 in England at the time were extremely high.

16 The British Articles of War of the
17 period provide that one day's pay be deducted
18 each year for the provision of hospitals and
19 for those who were taken to hospitals, their
20 wages were garnished to reimburse the treasury
21 for the care.

22 We do not see that kind of

1 treatment of soldiers carrying over to the
2 colonies or to the new republic, but it is
3 true through the 18th and really through most
4 of the 19th Century that there is a disdain
5 for the common soldier.

6 In the 19th Century, Wellington
7 talked about the common soldier as being the
8 scum of the earth, and we may have, in our
9 minds, people who were really the dregs of
10 society. That was really not the case. It
11 was a general disdain for the working class by
12 the idle class in -- next slide.

13 All of this kind of comes to
14 fruition in the Crimean War. The Crimean War
15 is a watershed of the victorious British army,
16 the army that defeated Napoleon some 40 years
17 earlier. It is not reformed with the general
18 reforms of England in the early part of the
19 19th Century.

20 When England -- when Great Britain
21 goes to war in the Crimea, the medical
22 department is completely unprepared, has no

1 plans for an expeditionary -- to support an
2 expeditionary force, and, as it says here,
3 that it was not the wounds, however, that
4 killed, it was disease, and these are the
5 casualty rates.

6 So this is about what, 150, 160
7 years ago. We are seeing death from disease
8 eight times that of deaths from wounds.

9 It created quite a scandal in
10 England. Parliament was forced to act. The
11 exploits of Florence Nightingale are a story.
12 Parliament dispatched a select committee of
13 inquiry and eventually created something
14 called the Sanitary Commission, which is sent
15 into the Crimea with the authority to overrule
16 the medical services of the army and to make
17 changes on the spot.

18 Kind of an NGO, but this was an
19 NGO with some real teeth and is a forerunner,
20 a direct forerunner of the Sanitary Commission
21 in the American Civil War, and the Red Cross
22 of today. Next slide.

1 By the late 19th century, reforms
2 start to slip in. They slip in because of
3 changes in medical technology, knowledge,
4 because of the horrendous performance of the
5 French and the British during the Crimean War
6 and, as a result of the advances made in this
7 country during the Civil War.

8 The changes result in a
9 professionalization and an integration of the
10 medical staffs. Before this time, the medical
11 staffs were adjunct to the military staffs.
12 They were kept aside. They were kept apart.

13 Here you see them bring -- being
14 brought in, medical physicians get military
15 rank. They are eventually allowed to command
16 their own hospitals and would eventually, by
17 World War I, be integrated into the planning
18 for the campaign, rather than as an
19 afterthought.

20 Britain, in the 1870s, you see the
21 institution coming directly out of the Civil
22 War experience and the German experience. In

1 the 1870s, a whole improved system of
2 battlefield care.

3 There is moveable hospitals. This
4 is tested in the Boer Wars, particularly the
5 Second Boer War, and it's the forerunner of
6 the British system that goes to war in World
7 War I.

8 So, the system that the British
9 take to World War I really is no more than 30
10 or 40 years old, and up to that point we have
11 the horrendous performance of the British and
12 the French. Next slide.

13 So we've talked about how things
14 fared for the soldier on the battlefield.
15 What about the veteran? In this case, France
16 took the lead. In 1831 they passed a general
17 military pension program that stayed in effect
18 until World War I.

19 It provided for service pensions
20 after 30 years of service and a disability
21 pension if the soldier was 60 percent
22 disabled. They tend to have a standard of 30

1 percent disabled. The French standard of the
2 day was 60 percent disabled.

3 But interestingly, what arises in
4 France is a concern that the whole program of
5 pensions and placing the invalids is
6 debilitating, that this is warehousing the
7 wounded and that they deserve better. They
8 deserve rehabilitation.

9 And you start to see the whole
10 movement towards rehabilitation, use of
11 prosthetics, physical therapy and that is --
12 really comes full-blown in World War I.

13 The British, consistent with their
14 previous behavior, their programs were
15 completely inadequate. So much so that there
16 was public appeals of private donations for
17 care of veterans, and Parliament, without
18 blinking an eye, established a group to
19 coordinate the private contributions.

20 After the Boer War, the private
21 organizations set up retraining shops in
22 London for those disabled in the war. The

1 government did not take any real
2 responsibility. Next slide.

3 So we're going to jump back in
4 history and talk about the American
5 Revolution, remembering that the colonial
6 period and the early republic is firmly rooted
7 in the British -- in the British past.

8 The early colonial legislation, 11
9 out of the 13 states had established programs
10 for those who were maimed in service to the
11 colony, and this carries over into the early
12 days of the Continental Congress when it was
13 really a confederation of colonies, rather
14 than a united -- a United States.

15 The army has an excellent volume
16 on the mobilization for wars, and in it they
17 note that as many as 400,000 may have served
18 on the American side during the Revolution,
19 but at no time was the army that was fielded
20 more than 17,000.

21 Enlistments were for short periods
22 of time, generally less than a year and it was

1 not uncommon for soldiers to have multiple
2 periods of enlistment as the needs of battle
3 changed, as the flow moved from north to south
4 and then to north again.

5 As was the case that we saw in the
6 Crimean War as the historical case, the main
7 thing that a soldier had to fear was living in
8 camp, not being wounded on the battlefield.

9 Only ten percent of the deaths in
10 the American Army were from battle wounds.
11 Ninety percent was from disease. The British,
12 with their system of hospitals and discipline
13 were a little better. Only about 85 percent
14 of the British soldiers who died, died from
15 disease.

16 If you were captured, things were
17 not good. After the battles in New York where
18 the American soldiers were kept on prison
19 brigs in the harbor, and 67 percent of
20 Americans taken captive during the Revolution
21 died of disease while in captivity. I'm
22 sorry, 47 percent.

1 If you had to have an amputation,
2 the doctors couldn't control infection and the
3 rates of mortality for those who were having
4 an amputation were as high as 67 percent.
5 That was for the amputation of a leg.

6 And I note here that, following
7 the French model, upwards of 15,000 disabled
8 soldiers were enrolled in a Corps of Invalides
9 to provide the manning at stores garrisons.
10 The garrison at West Point, for example, was
11 manned by the Corps of Invalides. Next slide.

12 Unlike the British, the American
13 system of pensions has been very generous, and
14 it has grown over time. During the war,
15 Congress authorized the grant of land for all
16 those who would serve, a throwback to the
17 Roman period.

18 There's a fascinating history of
19 the give-and-take of service pensions for
20 officers, which were basically modeled after
21 the British and were half-pay for life.

22 During the Articles of

1 Confederation, the government didn't pay those
2 and the officers tended to sell those for
3 pennies on the dollar and given, in the new
4 constitutional government, Alexander Hamilton
5 redeemed them at face values and the
6 speculators made fortunes.

7 It was not until 1828 that that
8 was rectified for the 800 or so remaining
9 Revolutionary War officers who were given
10 pensions for life.

11 There was tremendous fights
12 between the aristocracy in the South who
13 modeled themselves after Britain and in the
14 New England colonies who saw officership as
15 just an extension of the common soldier and
16 resented paying for these benefits for life,
17 and it took the personal intervention of
18 George Washington to institute this half-pay
19 for life. We still see echoes of the half-pay
20 in the 20-year retirement of today.

21 The ordinary soldier received,
22 when he was mustered out for a year of pay and

1 no further, at least at the time, further
2 commitment of funds.

3 Washington argued that those
4 soldiers had received bonuses during the war
5 and that that was sufficient.

6 We inherit from the British this
7 distinction of officership and enlisted, and
8 it comes down to as recently as World War II.

9 As best I can tell, disabled
10 officers in World War II were allowed to have
11 a medical retirement and disabled enlisted in
12 World War II were discharged. And the value
13 of medical -- sorry -- of medical retirement
14 for officers, and the value of the medical
15 retirement was much greater than just the
16 payments that would be received for a
17 disability through the VA. Very unequal
18 treatment.

19 Disability pensions are voted in
20 the second year of the war. It was originally
21 voted as a national standard to be employed by
22 the states. The states were tardy in doing

1 this, and eventually the Congress takes over
2 the responsibility for war pensions and
3 relieves that responsibility from the state.

4 Half-pay for officers just repeats
5 what their normal pension was, \$5 for enlisted
6 men with partial payments for partial
7 disabilities. Again, the carrying over of the
8 English tradition.

9 And we start to see limited
10 provisions for widows and orphans. Originally
11 the only provision for widows were for the
12 widows of officers, not for enlisted men.

13 Next slide.

14 Pensions grew dramatically in the
15 first part of the 19th century. The coffers
16 of the government were swollen with revenues
17 from tariffs, so that by 1818, pensions were
18 no longer based on disability but based on
19 service alone. Everybody got a pension.

20 By 1820 there was so much concerns
21 about abuse that they start to call the rolls,
22 but then the coffers swell again after 1830

1 and full pay for life, regardless of income or
2 property, and at that time the numbers who had
3 applied for full pay for life was greater than
4 all of the white males who were in the
5 colonies at the time of the Revolution.

6 1833, concurrent receipts. I
7 think that's a topic that is of interest
8 today. And in 1836 widows and orphans were
9 added, and we're not talking about the
10 original widows and orphans, we're talking
11 about the widows and orphans of the --
12 whenever the Revolutionary War soldier died,
13 so that we were paying pensions for the
14 Revolution as late as 1906, and for children,
15 as 1911.

16 That will be repeated in the Civil
17 War, and we were paying Civil War widows
18 pensions up until the 1950s. It's a great
19 deal for older men. They'd marry young women
20 to take care of them, and those women would be
21 then paid for the rest of their lives with the
22 Civil War or Revolutionary War pension. Next

1 slide.

2 We see the establishment of
3 domiciles and hospitals. The first, in 1798
4 coming for the Merchant Marine, followed the
5 next year by the -- for the Navy. Again, with
6 a check-off, and this is the birth of the
7 Public Health Service.

8 And we still have Public Health
9 Hospitals who maintain care for able-bodied
10 seamen, Merchant Seamen.

11 I love the term Disabled and
12 Decrepit Naval Officer Seamen in the Marines.
13 1851, the Soldier's Home here in Washington is
14 established, and in 1855, St. Elizabeth is
15 established to care for the mentally ill
16 soldiers. Next slide.

17 In all of our wars, we have been
18 largely unprepared. We've largely had medical
19 establishments that have been geared to the
20 garrison, caring for the garrison army and
21 unable to expand as the army expanded.

22 This was true in the War of 1812

1 and in the Mexican War. I haven't mentioned
2 this before, but there is, through history, a
3 huge conflict between surgeons in regimental
4 hospitals that come with the troops in these
5 wars came from the states with the volunteers
6 from the states and the central hospitals that
7 are established by the federal government.

8 And we don't see that break,
9 really, until the Civil War where the numbers
10 just overwhelm the regimental system, but it
11 has been a great theme through history, from
12 European history to American history.

13 The deadliest war in American
14 history is the Mexican War, and you see it
15 there because of disease, again. Fourteen
16 times, almost fifteen times greater than
17 battle casualties for the volunteers.

18 The regular army was able to
19 control it somewhat, but with poor discipline
20 in the volunteers and militia, we see the
21 disease being rampant, a process that will
22 continue in the early days of the Civil War.

1 Next slide.

2 So now we go to the Civil War.
3 This is the first industrial war. It sets the
4 standard. It is the precursor of World War I.
5 No conflict before, and no conflict after,
6 until World War I is on the scale of the
7 American Civil War.

8 You see here the number of people
9 engaged, not in the thousands, but in the
10 millions. We have a mismatch of technology
11 and weapons. We're fighting the war with new
12 weapons and trying to fight it with soldiers
13 standing breast-to-breast through a good deal
14 of the war, making charges like Pickett's
15 Charge at Gettysburg.

16 At first the care is very poor.
17 The care in the camps, leading up to Bull Run,
18 the care during the Battle of Bull Run, and
19 then afterwards is horrendous. But then it
20 all changes.

21 And there are really two names
22 that are associated with this. One is William

1 Hammond, who was the Surgeon General of the
2 Union Army, and the other is Letterman, who is
3 the chief medical officer in the Army of the
4 Potomac, and they institute changes over a
5 whole range from military hospitals to
6 battlefield evacuation and revolutionize the
7 care of medical facilities.

8 By the end of the war, there were
9 -- you can see the statistics there, but more
10 than three hospitals had 3,000 beds. The
11 beginning of the war there was hardly a
12 hospital in the United States. By the end of
13 the war we were administering hospitals as
14 large as 3,000 beds.

15 In the Washington area there were
16 -- 14,000 beds were occupied. There were no
17 rehabilitative services. These were strictly
18 medical, and it soon became clear that there
19 was a need, between the hospital and returning
20 to duty, and the Union developed convalescent
21 camps, much like the Warrior Transition Units
22 of today. Next slide.

1 We start by noting that the
2 treatment that a Civil War soldier got was
3 more akin to what a Roman soldier would get
4 than what an American soldier would get just
5 50 years later.

6 There is the notion of mortality
7 from disease. Chloroform had been invented,
8 but all it did was make amputations less
9 difficult to perform, and amputation of an
10 extremity was the norm.

11 And those are the death rates.
12 Interestingly, the government takes on the
13 responsibility of providing prostheses for
14 those who have been amputated, who have an
15 amputation. It doesn't kick in until after
16 the war, but it makes the United States the
17 leader in this area and you see that coming to
18 play in World War I. But this is the first
19 time a government took on the responsibility.

20 The early handbooks, the medical
21 service talked about the care that should be
22 taken in performing an amputation based on the

1 social status of the amputee because if he was
2 an officer or was a wealthy person, he could
3 afford to buy his own prosthesis and then a
4 certain flap would be needed.

5 If he wasn't, then he was on his
6 own and a different kind of closing for the
7 amputation was necessary. That changes with
8 the commitment of the government to provide.
9 Next slide.

10 Provision of Civil War veterans.
11 The General Law of 1862 is considered to be
12 the most generous pension program that had
13 been established at the time. It provided
14 both a general payment for those who could not
15 work, but then specific additional payments if
16 the disability was from a loss of a limb or
17 sight or the like.

18 It provided for widows and in
19 1866, it provided extra pay to the veteran who
20 needed to have the care of a caregiver. And
21 again, as contemporaneous today, where we're
22 talking about payments for family members who

1 take care of a disabled veteran.

2 In 1873, a disease was recognized
3 and in 1879 you could get -- if a disability
4 was noted late, you could get all of the
5 payments from the time of the war to the time
6 the disability was noted as a back payment in
7 the Arrears Act. Next.

8 The Dependency Act is really quite
9 interesting. 1890 it said, incapable of
10 manual labor, you receive pension even if it
11 is not service-connected. So we break the
12 whole notion of service connection.

13 Death benefits are paid to widows,
14 and the size of the -- by that, by 1893, it's
15 almost half the size of the federal budget.

16 I like to say there's a case that
17 has been argued that, during this period, the
18 South paid war reparations to the North. It
19 paid it in the form of tariffs on imported
20 goods.

21 Those tariffs were used by the
22 Republicans in the Congress to increase

1 pensions, and therefore increase their support
2 among the Civil War veterans who voted them
3 into power.

4 And so you see this rising in
5 veteran's payments. And, as I noted, in 1980,
6 a Civil War veteran could marry a young lady
7 who then would take care of him and receive
8 payments through her life and the life of any
9 of his children at the time.

10 This federal government starts to
11 provide care in homes. These were generally
12 state homes providing -- provided -- but the
13 federal government paid for those, and by 1910
14 there was still 32,000 veterans, about five
15 percent of the total who were in state homes
16 paid for the federal government. Next slide.

17 After the Civil War, the Army fell
18 asleep. It disbanded everything that had been
19 done and provided, simply to maintain the Army
20 in its garrison state. It's not really tested
21 until the Spanish-American War, a short war,
22 but demonstrated the complete lack of

1 preparedness of the Army. Next slide.

2 The Army starts to transform --
3 the medical service starts to transform in
4 1901 after the Spanish-American War with the
5 whole transformation of the Army, the creation
6 of the general staff, the creation of the
7 notion of officers would be -- medical
8 officers would be an integral part of the
9 system.

10 Manuals are established for
11 battlefield care and it's field-tested in --
12 along the Mexican border in 1916.

13 Importantly, a whole system of
14 medical reserve corps is established in 1908.
15 This is the first time we see a federal
16 reserve independent of state militias or, at
17 the time, the National Guard, and this
18 provides a basis for mobilization.

19 Based upon the model of the
20 Sanitary Commission, there's the rise of the
21 Red Cross and it takes a major role in
22 providing for the reserve nurses and in

1 establishing reserve hospitals. These are
2 called into service World War I.

3 We were very lucky in World War I
4 that we could go to school on two years of
5 experience by the British and the French and
6 it changed the way we organized so that when
7 we went to war we were much better prepared
8 than we had been, certainly, for the Spanish-
9 American war. Next.

10 World War I is noted, really, for
11 three -- three things. One is, by the time of
12 World War I, we had completely incorporated
13 the medical advances of the previous 50 years,
14 and that means the issues of controlling
15 infection and antiseptics and communicable
16 diseases through vaccinations.

17 It made a tremendous difference.
18 In fact, if it wasn't for the flu, World War
19 I would have been the first conflict where
20 more soldiers died from battlefield injuries
21 than from disease. The flu was uncontrollable
22 and in the last months of the war, changes all

1 of that.

2 There's tremendous advance in the
3 medical logistics, incorporating Letterman's
4 triage systems from the Civil War, but
5 introducing motorized vehicles, motorized
6 ambulances, a whole echelonment of hospitals
7 from -- from the battlefield all the way to
8 the rear.

9 And, as an outcome of the
10 Progressive Era, a new commitment to
11 rehabilitation. The standard was to return
12 the soldier to be a fully productive member of
13 society and that meant extensive
14 rehabilitation, and even programs for the non-
15 disabled veteran.

16 The Army Surgeon General at the
17 time was so into this that he proposed that
18 soldiers not be released from active duty
19 until they had been fully rehabilitated and,
20 if necessary, called back on active duty so he
21 could take care of them.

22 The Army had to be reminded that

1 there were other institutions that were
2 charged with this. Vocational rehabilitation
3 was the purview of a federal committee. The
4 Public Health Service ran the hospitals, and
5 the Army eventually acquiesced and we see a
6 rapid demobilization at the end of World War
7 I. Next slide.

8 The first bullet talks about how
9 the Army grew. Three times -- 3.7 million,
10 and then reiterates the issues of
11 vaccinations. Amputations became relatively
12 rare.

13 One thing that is not well
14 understood, and that is almost all battle
15 casualties in the World War I took place in
16 100 days. We were really engaged from August
17 until November, and our battle casualties were
18 very different from the battle casualties of
19 the British and French.

20 We were on the attack. Most of
21 our casualties were from bullet wounds rather
22 than artillery, which was the case of the

1 previous campaigns of the British and French.

2 Moving on --

3 MG STONE: Dr. Rostker.

4 DR. ROSTKER: Yes.

5 MG STONE: We had, unfortunately,
6 only scheduled 60 minutes for this, and we're
7 especially appreciative of the fact that this
8 is really good information for us.

9 We have a couple of options, and
10 I'll defer to the Committee. Number one, we
11 can set the schedule back and allow you to get
12 us into this last century.

13 DR. ROSTKER: Almost finished.

14 MG STONE: Or we can schedule an
15 additional hour of time in order for you to
16 bring us up to speed.

17 At least you have a -- I don't
18 want to be disrespectful to our other speakers
19 and set us behind.

20 MS. DAILEY: Sir, I'm very happy
21 to schedule Dr. Rostker back in the January
22 meeting. We can -- we can take this to

1 January and --

2 DR. ROSTKER: At your -- whatever
3 -- when is the January meeting?

4 MS. DAILEY: It will be the middle
5 of January, 17 and 18 January.

6 DR. ROSTKER: I may not be here.

7 MS. DAILEY: Okay.

8 MG STONE: About how much more do
9 you have?

10 DR. ROSTKER: I could -- give me
11 five more minutes. Okay?

12 MG STONE: Is that -- okay.

13 DR. ROSTKER: This is what I
14 mentioned, the institutions that were charged
15 with providing the care, payments were from an
16 insurance program, Federal Vocational
17 Education and Public Health.

18 In 1921 these were combined in the
19 Veterans' Bureau, and in 1924 a little-known
20 provision was passed that allowed veterans
21 access to VA hospitals on a space-available
22 basis without regard to service connections.

1 In 1930 the VA is born by
2 combining previous programs with the Veterans'
3 Bureau. Next slide.

4 The main point here is the attempt
5 to cut back on veterans' programs. During the
6 heat of the Depression which was, by the
7 administration, overruled by Congress. And as
8 the VA approaches World War II it now has
9 become a program largely for the medical
10 indigent, and I daresay that was mainly
11 alcoholics.

12 It was a backwater system. Almost
13 none of the admissions were service-connected
14 or from World War I. It was the place where
15 a veteran could go as a matter of last resort,
16 and the VA was completely unprepared for World
17 War II.

18 World War II, we again had the
19 advantage of two years of mobilization. You
20 can see the -- lies in the numbers that were
21 brought into service in both World I and World
22 War II, and the substantial rise of the

1 medical department.

2 In June '39 there were 11,000 in
3 the medical department. In June 45 there were
4 664,000 in the medical department. Whole new
5 occupations were created. Medical
6 administrators, physical therapists, physical
7 rehabilitation programs, all created.

8 The war was fought on a
9 decentralized basis. The Surgeon General
10 basically lost control, and the war was fought
11 in theater after theater. He had more control
12 in the zone of the interior when people were
13 brought back to the continental United States,
14 and you see here the major advances that
15 occurred, use of blood plasma, antibiotics,
16 medical evacuations and the increased use of
17 air evacuations which will take a -- make a
18 tremendous impact on the Korean War and later
19 wars. Next slide.

20 We start to see the major concern
21 for psychiatric programs. The original notion
22 was that we could screen out those who were

1 prone to have psychiatric disabilities. That
2 proved wrong, and eventually we reestablished
3 the Division of Psychiatrists and saw a
4 substantial increase in the return-to-battle
5 rate -- return-to-service rate for those who
6 were disabled.

7 As consistent with the theme of
8 history, the whole purpose of the medical
9 system was return to service. And so,
10 soldiers were sent back to service even
11 knowing that they were likely adding to their
12 ultimate medical problems, but it was a system
13 geared to return soldiers to the line. Next
14 slide.

15 System of hospitals established in
16 World War II, general and specialized medical
17 hospitals. Convalescent annexes echo the
18 convalescent camps of the Civil War, a place
19 between the hospital and the line unit.

20 It's initially resisted by the
21 medical community, but the Air Force, only Air
22 Forces find that it's necessary for crew rest

1 and finally it gets it's biggest impetus when
2 President Roosevelt, in 1944 -- at the end of
3 '44 directs that no veteran -- no wounded
4 veteran from overseas shall be sent out of the
5 military system.

6 The VA cannot handle the system,
7 and the Army starts building convalescent
8 hospitals.

9 After the war, most of those
10 hospitals were turned over to the VA, but some
11 disabled people were kept on active duty for
12 additional rehabilitation, and I highlight the
13 case of Senator Dole who was kept on active
14 duty an additional three years as an officer
15 and given a medical retirement, rather than
16 sent to the local VA hospital that one might
17 have expected. Next slide.

18 I'm going to let you read that.
19 We made a commitment to disability
20 rehabilitation in 1943. Care for the indigent
21 veteran became available on a space-available
22 basis regardless of service connection. That

1 was continued.

2 As far as disability is concerned,
3 the great GI Bill really does not address the
4 care of disabled veterans. It was the extra
5 provisions after the war. Next slide.

6 So, the VA is faced with an
7 increase of -- in the first line it says '48,
8 18 million living veterans of which 16 million
9 were from World War II, and very few of those
10 16 million were seen by the VA during the war,
11 and that starts to change after the war, but
12 only as the capacity of the VA is -- is
13 increased, and that comes with the assignment
14 of Omar Bradley to be the post-War
15 administrator of the VA.

16 And he brings in a number of
17 reforms. He takes the physician population
18 out from under the Civil Service System. He
19 affiliates with medical schools. He builds
20 medical -- new facilities at medical schools,
21 and that sets the whole course of the -- of
22 the -- for the VA.

1 In '47 he goes back to be Army
2 Chief of Staff. There's some roll-back
3 including, in 1953 when the VA becomes
4 bifurcated by creating this strong medical
5 service and a strong benefit service which
6 exists today. Next slide.

7 I have nothing to say about the
8 Korean War. I haven't gotten there yet, and
9 that's Volume II. Next slide.

10 So, at the beginning I said focus
11 on the nature of conflict and the like, and
12 this is sort of the summary. Warfare is much
13 more deadly. We've seen great advances in
14 medical logistics, great advances in our
15 ability to understand human anatomy and
16 control disease and infection and an
17 increasing problem with psychiatric.

18 A case can be made that it has
19 been there all along, and there are authors
20 who have traced the symptoms of psychiatric
21 disabilities back to descriptions in the Iliad
22 and the Odyssey of Odysseus coming home.

1 But there was no basis for
2 understanding psychological concerns until the
3 middle of the 19th century. You start seeing
4 it in the Civil War. They start talking about
5 soldiers' hearts. They start to see large
6 numbers of ineffectual soldiers who can't
7 fight after the Battle of Antietam, for
8 example, but they didn't know what to do with
9 them.

10 In the early days of World War I,
11 a person who was psychologically disabled on
12 the battlefield was shot. And it's only when
13 they start to understand that maybe it's
14 related to shell-shock, being near an
15 explosion, and then they noticed that they
16 were having these disabilities without people
17 being even near explosions that we start to
18 see the rise of modern psychiatry in the
19 military, set back by the notion, Freudian
20 notion that this could be screened out, and
21 then coming forward with the changes late in
22 the -- in World War II.

1 But clearly, this has become a
2 great concern. I'm not sure whether or not
3 the changes in amputations, the drop in
4 amputations created some wiggle room where
5 people now could be concerned about PTSD and
6 the like, but they certainly come at -- one
7 goes up and the other -- and the other comes
8 down.

9 The role of the state has
10 increased, both in the provision of pensions,
11 but also in the commitment for rehabilitation
12 services. And as I note, that is in the
13 history, long history, something that is very
14 new.

15 And that is the completed
16 briefing. I hope by January, we may have a
17 volume we can release to you and you can read
18 it in a lot more detail than I've been able to
19 go through today.

20 MS. DAILEY: Thank you, Dr.
21 Rostker.

22 DR. ROSTKER: Thank you.

1 MS. DAILEY: We'll take a brief
2 break. I think we can take maybe five, ten
3 minutes. Okay. And we'll meet back then.

4 (Whereupon, the above-entitled
5 matter went off the record at 10:59 a.m. and
6 resumed at 11:09 a.m.)

7 MG STONE: We are now going to
8 hear from Ms. Cocker, who is the deputy to Ms.
9 Ruth Fanning, Director of the Department of
10 Veterans' Affairs Vocational Rehabilitation
11 and Employment Services. This presentation is
12 behind Tab D in your books.

13 Ms. Cocker, thank you very much
14 for being here today.

15 MS. COCKER: Thank you. It's my
16 pleasure.

17 So, I have a presentation that's
18 going to go into an in-depth overview of our
19 program, the Vocational Rehabilitation and
20 Employment Program. I welcome any questions
21 along the way.

22 We also have a segment on our

1 initiatives that we're currently working on,
2 so without further ado, we'll get started.

3 Is there a slide advance, or is
4 that going to be you? Okay. Thank you. Go
5 ahead and go to the agenda slide.

6 So, you can see the agenda has a
7 lot of items on it. We'll jump right into the
8 mission and eligibility. Next slide.

9 So the mission of our program is
10 to help veterans with service-connected
11 disabilities return to employment, to suitable
12 employment.

13 We also, for those veterans for
14 whom disabilities are so severe that they
15 cannot return to the work force, we have an
16 independent living track that I'll tell you
17 about that can help them to become more
18 independent in their communities and within
19 their families and their homes. Next slide.

20 I'd like to talk a lot about our
21 outreach and early intervention. This is a
22 slide that sort of captures the different ways

1 in which we reach out to service members that
2 are transitioning out and also to veterans who
3 are already out of the military but who are
4 receiving new disability ratings and increased
5 disability ratings.

6 So, you'll see we have an OEF/OIF
7 Coordinator Outreach Program. We have a
8 coordinator in every one of our 57 regional
9 offices around the nation.

10 Through our Coming Home to Work
11 Program, they reach out to the individuals who
12 are transitioning out at the medical hold
13 units, and we use our Chapter 36 program,
14 which is a part of the Voc Rehab and
15 Employment Program, but it's a different
16 benefit.

17 We have two benefits that we
18 administer, Chapter 31 and Chapter 36.
19 Chapter 36 allows us to reach service members
20 who are approaching discharge, within six
21 months pre-discharge or one year postdischarge,
22 and also veterans who are pursuing an

1 educational benefit.

2 And what Chapter 36 is, it allows
3 us to provide them with educational and
4 vocational counseling, both to help them
5 direct their educational benefits to a career
6 track that will be good for them, and also to
7 help them in an intervention sense if they are
8 having difficulty academically.

9 So, prior to separation from
10 active duty we have the DTAP program which
11 I'll talk a little bit about which is the
12 Disabled Transition Assistance Program where
13 we brief the service members who are coming
14 out with the disability on what our program is
15 about.

16 We help them to obtain a
17 memorandum rating, which is a transitional,
18 temporary rating, not for the purpose of
19 compensation, but for the purpose of enabling
20 their eligibility to our program.

21 And we also do, as much as
22 possible, we participate in the PDHRA and

1 Yellow Ribbon Programs.

2 The VAAP program, the acronym that
3 you see there stands for the VA Assistance
4 Program, and this is a unique program that's
5 in the San Diego area at Balboa where we do a
6 full-blown assessment with every individual
7 coming through that -- those exit briefings.

8 The other thing that we do for
9 outreach with veterans, if you look at that
10 third section, anytime a veteran receives
11 either an increase to their disability rating
12 where it establishes an eligibility that
13 wasn't there before for voc rehab, they get an
14 application and a fact sheet about our
15 program.

16 Also, when they get a new
17 disability rated -- so they might have been
18 rated for disability A, but now they are just
19 rated for disability B, because it's a new
20 disability condition, that could enable them
21 to be eligible to our program, whereas the
22 other disability might not have been disabling

1 in and of itself enough to warrant the
2 eligibility.

3 And then the ongoing outreach. We
4 work closely with our VetSuccess on Campus
5 Program, and also I'll talk a little bit more
6 about the initiatives that we have in place
7 where we're working with the IDES Initiative
8 to include more early intervention there.

9 The VetSuccess on Campus Program
10 is where we have a voc rehab counselor
11 stationed, and I'll talk a little bit more.
12 I've got some slides on that.

13 On the campus is to help provide
14 intervention for those veterans that are
15 currently pursuing their educational benefits
16 to help them to be successful.

17 Okay. So what does it take to be
18 eligible and entitled, and those are two
19 distinct things. To be eligible, for an
20 active duty service member, they have to have
21 what's called that memorandum rating, which is
22 the temporary rating solely for the purpose of

1 our program, and all that is, is the VA
2 determines that there is at least one
3 disability that is at least 20 percent or more
4 disabling.

5 They don't need to have all the
6 evidence built up for what that exact rating
7 is going to be, just that they know it's going
8 to be 20 percent or higher. And a rating
9 specialist makes that call.

10 Or, a DES rating. So, if they are
11 going through the IDES program and they get
12 their DES rating, but it's not promulgated yet
13 because they haven't been discharged and they
14 don't have their DD-214, that still provides
15 them with the eligibility to our program.

16 For veterans, they do have to have
17 a 20 percent or higher disability rating and
18 are entitled then with an employment handicap.

19 For those veterans with ten
20 percent ratings, they have to have what we
21 call a serious employment handicap, which are
22 significant barriers to employment, above

1 those that can be corrected simply with
2 education.

3 There is a 12-year delimiting
4 date. There is a 12-year eligibility period
5 which starts on the date of the first
6 disability rating. So, if a service member
7 begins their participation in our program
8 while they are still active duty, that 12
9 years begins at the discharge date.

10 If, however, they have a serious
11 employment handicap, they -- that 12 years can
12 be waived and they can be provided services
13 beyond the 12 years. Next slide, please.

14 This slide sort of speaks to the
15 general flow of our program, what happens from
16 point A to point B and everything in between.
17 So, I'll go through this in a little bit more
18 detail just to make sure that you have a
19 thorough understanding of what our program
20 provides and how the veteran or the service
21 member flows through the program.

22 So, the first thing we need is an

1 application. Now, when we're talking about
2 active duty service members, what we're doing
3 is, we're working with them under Chapter 36,
4 and we do not have to have an application for
5 vocational rehabilitation benefits.

6 However, at that point at which
7 the service member says, "Yes, I need that.
8 I want that. I want to pursue," we do ask
9 them to fill out -- it's a very brief, one-
10 pager. It's very short, easy to fill out.

11 We've established their
12 eligibility, as I discussed before with a
13 memorandum rating or the DES rating, or if
14 they're a veteran, with the service-connected
15 disability rating.

16 We schedule them for initial
17 counseling with a vocational rehabilitation
18 counselor. During that meeting with the voc
19 rehab counselor, the voc rehab counselor gets
20 their educational history, work history, does
21 a series of assessments around their interests
22 and aptitudes and helps the veteran, first of

1 all, with that first decision point that's so
2 important which is, "Are you entitled to
3 benefits? Do you have an employment
4 handicap?"

5 And that, in the simplest terms,
6 means their service-connected disabilities in
7 some way limit their ability to seek to obtain
8 or to maintain gainful suitable employment.

9 CO-CHAIR CROCKETT-JONES: Can I
10 ask you a question? What's the time line
11 between an application being received and an
12 initial counseling appointment being made
13 right now?

14 MS. COCKER: The way we measure
15 that timeliness right now is based on the
16 notification of the decision. That's how our
17 end product is tracked. Typically that
18 happens during the first appointment.

19 I would say 98 percent of the time
20 that happens in the first appointment, and the
21 average number of days from the day we receive
22 their application to the date of that

1 notification is, on average, 45 days.

2 So that includes the time it takes
3 for our counselor to talk to the service
4 member, establish a date and time that's
5 agreeable to them, establishing the
6 eligibility, scheduling that appointment,
7 actualizing the appointment.

8 And in some cases, as you all
9 know, we all have schedules, and so that first
10 appointment might not be actualized, then we
11 do reschedule it at the veteran's convenience.

12 So, during that assessment, once
13 the entitlement is decided, if the veteran is
14 not entitled to services, meaning they already
15 have suitable gainful employment and they
16 don't need our program to get there, or their
17 service-connected disabilities are not the
18 reason they don't have suitable gainful
19 employment, at least in some substantial part,
20 they will be referred to other benefits and
21 other services outside of our VR&E program as
22 appropriate.

1 If they are entitled to our
2 program, the next step is to help them to
3 assess or to help us assess -- we assess their
4 interests, aptitudes and abilities, and we
5 help them to come up with a career plan.

6 Our program is about careers.
7 It's not just about getting into a job. So,
8 a service member, for example, coming out who
9 has no educational accomplishments, no degrees
10 or no certificates or anything like that that
11 would make them competitive for suitable
12 employment, we might be able to get them a
13 transitional job, and that would be great, but
14 that's not the goal of our program.

15 If they need transitional
16 employment so that they can put food on the
17 table while they are getting their retraining
18 for their suitable career we will do that, but
19 our focus is on employment careers.

20 So, you'll see the next -- the
21 yellow part, we talk about identifying the
22 track, the vocational goal or independent

1 living goals and then we develop a written
2 plan of services.

3 The written plan of services is
4 sort of the who, what, when, where, how of how
5 they are going to get to that end state goal.

6 Then, you'll see in the light
7 blue, you've got the five tracks.

8 Reemployment is really about USERRA, and this
9 is about us helping them navigate that, who do
10 I report this to if there's a problem, how do
11 I get help with disability accommodations if
12 I can't go back to my previous job without
13 disability accommodations.

14 And we will provide that, those
15 accommodations to them if they need them and
16 the employer cannot provide them.

17 Rapid access to employment. This
18 is for the individual who comes to us who has
19 what they need for competitive employment from
20 the standpoint of educational accomplishments,
21 so they have a -- either a higher education
22 degree, they have certificates, they have

1 certifications, they have licenses, they have
2 what they need to get into a job, but they
3 don't have a job.

4 So these individuals that come to
5 us, typically what they need is help with how
6 do I make a resume work in the civilian world,
7 how do I make my resume really highlight my
8 skills, how do I translate my military skills
9 to the civilian world, and how do I dress for
10 the interview, how do I answer those difficult
11 questions about why I left the military, if I
12 left because of a disability reason.

13 One thing that we found -- I used
14 to be a counselor and the most difficult thing
15 I found was helping them to understand, you're
16 not being dishonest if you say -- if you don't
17 answer that question by saying "I got out
18 because of a disability."

19 You're being honest, in that,
20 under ADA, you don't have to respond to that,
21 so you find another way to respond to that
22 question without being dishonest.

1 So, we help them, we guide them
2 with that difficult -- those difficult
3 questions that have to be answered. And then
4 we help them to transition into that
5 employment.

6 The self-employment, that's for
7 individuals for whom disabilities are so
8 severe that traditional employment is not an
9 option. We can pay for them to start up their
10 own business.

11 We pay for a lot of the start-up.
12 We can't pay for real estate or cars, but we
13 do pay for start-up -- start-up things like,
14 for example, an individual who becomes a
15 barber, we can establish their barber shop in
16 the sense that we can get them all of their
17 supplies and tools and licenses and training
18 and everything that they need to set up shop,
19 but they will need to find other funding which
20 we help them with to actually lease the space.

21 We can also provide -- we can help
22 individuals who don't qualify for that severe

1 disability category in establishing their
2 self-employment only to the degree that we
3 train them to be able to carry out the skill.

4 So, in that case of the barber,
5 the self-employment track would only include
6 the barber training and the license and
7 certification, but not the setup of the
8 business.

9 Employment through long-term
10 services is the one we use the most and this
11 is because we are in a knowledge-based
12 economy, and so a lot of times we do end up
13 retraining our individual veterans and service
14 members through institutes of higher learning,
15 noncollege degree, OJT, apprenticeship, votech
16 school, all those educational avenues that are
17 out there to help them get the skills that
18 they need to be competitive in employment.

19 Then, the independent living
20 program is for those individuals for whom
21 employment is not an option, and so what we do
22 is, we help them to be more independent in

1 their daily activities.

2 We help them with their basic
3 independence and daily activities, bathing,
4 dressing themselves, cooking for themselves,
5 taking care of their home, and also with
6 access to the community.

7 So, if they can't work, perhaps,
8 full time, but they could volunteer a few days
9 a week, we will help them get into that
10 volunteering assignment to give them some
11 purposeful activity.

12 We also help them navigate other
13 things that they might need to navigate. For
14 example, for an individual with a TBI who has
15 memory issues, we'll help them with PDA's and
16 other tools so that they can use public
17 transportation and get around in the community
18 safely.

19 The one thing I'd like to
20 highlight about all five of those tracks is
21 that the first four are service members and
22 veterans are eligible for, entitled to.

1 The independent living track,
2 currently, until the NDAA piece has been
3 finalized, an individual cannot receive
4 independent living services as a sole program
5 by itself unless they are a veteran.

6 However, if they are on the track
7 to employment, we can provide independent
8 living services as part of that employment
9 track. So, an example of that would be an
10 individual with severe disabilities who is
11 going to school for an employment goal, but
12 needs independent living services as well to
13 help them be independent in their homes and in
14 the school.

15 With all five of those tracks we
16 pay for everything that is needed for the
17 veteran to achieve rehabilitation, their
18 subsistence allowance on a monthly basis if
19 they are in training, their books, supplies,
20 fees, tuition.

21 There are no out-of-pockets for
22 these individuals in our program. None.

1 There are no limits. So, there's -- the only
2 -- the only cost limit issue is an approval
3 limit, so a voc rehab counselor can approve to
4 a certain cost limit, then it has to go up a
5 certain chain of command if it exceeds that
6 limit.

7 But, there is no limit on what the
8 veteran can receive financially to achieve
9 rehabilitation. It's tailored to that
10 individual veteran's needs.

11 Employment services in the -- I
12 guess that's dark pink. We do provide ongoing
13 case management to -- during the time they're
14 seeking a job and after they get a job to help
15 them stabilize.

16 There's a maximum of 18 months in
17 that status. So, for an individual who
18 retrains for a new occupation, once we've
19 determined that they are trained and
20 competitive, we declare them job-ready.

21 It's from that job-ready
22 declaration point to the point that they are

1 declared rehabilitated, we have 18 months in
2 that process.

3 What typically happens is, once
4 the individual gets the job they usually don't
5 need more than a couple of months of follow-up
6 because we've worked with them, typically, at
7 that point, anywhere between one and four
8 years, and sometimes longer to get them to
9 that point.

10 So, we've been helping them with
11 employability skills all along. But, once
12 they get that suitable job the very minimum we
13 will provide follow-up is 60 days, and then
14 the maximum is 18 months, and the voc rehab
15 counselor makes that decision on how much
16 follow-up the veteran needs based on their
17 conversations with the veteran and that case
18 management and that relationship.

19 We do help them with all the
20 things that are listed up there. The
21 interview skills, job placement. We do refer
22 them to DOL and we do work collaboratively

1 with DOL VETS program.

2 We have disabled veterans outreach
3 program coordinators in all -- almost all of
4 our 57 regional offices.

5 vetsuccess.gov I'll talk about in
6 a moment in terms of our website. That's sort
7 of the big picture, all of our program in a
8 nutshell. Next slide.

9 Our workload, just to give you a
10 snapshot, in 2010, at the end of the year we
11 had 105,000 veterans in all statuses and -- I
12 will make a correction. Veterans and service
13 members, because some of those individuals
14 were still in transition.

15 We had about 70,000 applicants
16 during the year, and then the Chapter 36
17 program, we had about almost -- almost 14,000
18 recipients, and you'll see the numbers there
19 on the number of DTAP briefings that we did
20 and participants who participated in DTAP.

21 We have 57 regional offices and
22 over 100 satellite locations, and you can see

1 how much money we paid out in benefits. Our
2 voc rehab counselors work face-to-face with
3 our veterans, so that's why we have to be
4 spread out all over the country. Next slide.

5 This sort of gives you an idea of
6 our workload, how it's been sort of ebbing and
7 flowing. In 2008 we expanded our Coming Home
8 to Work Program. That's where we really
9 increased our outreach, and you can see that
10 our workload bumped up quite a bit at that
11 point.

12 The Post-9/11 GI Bill kicked in,
13 and you can see that our workload started to
14 decline because the Post-9/11 GI Bill had a
15 much higher stipend, monthly stipend and it
16 started to -- it was new for education
17 benefits and that it was paying tuition and
18 books, a certain amount of tuition and a
19 certain amount of books.

20 So, as veterans were looking at
21 the two options, I've got the Montgomery GI
22 Bill here that pays me more per month and pays

1 most of my tuition and books, and I've got the
2 voc rehab program over here that pays me a lot
3 less monthly and pays my tuition and books.

4 They were making that assessment,
5 and a lot of veterans were opting for the
6 higher standard of living, cost allowance.

7 So then you'll see Public Law 111-
8 377 just kicked in. It just became effective
9 August 1st of this year, and what this does
10 is, it allows a veteran who is eligible for
11 both programs to go into the voc rehab program
12 and elect the higher subsistence allowance
13 rate.

14 So now they don't have to choose.
15 And what's more, not only do they not have to
16 choose based on the higher rate, but they now
17 also get a hundred percent of their tuition
18 and books and fees and licenses and everything
19 paid for if they are in our voc rehab program.

20 So, we've very thankful for that
21 law that was passed. You can see our workload
22 is already starting to bump up as these

1 veterans are realizing the benefits of being
2 in our program.

3 Another difference to our program
4 is that our case managers, our voc rehab
5 counselors, case-manage these veterans in our
6 program until they are successful. They have
7 face-to-face interaction with them, typically
8 about once per quarter, and frequent phone and
9 email interactions.

10 They have one go-to person that
11 they can go to for any problems that come up.
12 Whereas, in the Montgomery GI Bill, that's not
13 part of the program. Next slide.

14 Okay. This just -- again, this is
15 fiscal year '10. As we get our fiscal year
16 '11 year closed out, we will update our
17 slides. This speaks to what types of
18 occupations.

19 I mentioned earlier our program is
20 about careers, so you'll see that 76 percent
21 of our jobs in 2010 were in the professional,
22 technical and managerial.

1 And then we have other smaller
2 percentages in clerical services, machine
3 trades and structural or building trades. So,
4 you can see a lot of our veterans, of course,
5 are coming to us with a lot of experience and
6 knowledge and managerial skills.

7 And then once we give them the
8 components they need to be competitive in the
9 civilian market -- usually it's higher
10 education -- then they can compete for those
11 higher-level jobs. So we are looking at
12 careers for our veterans.

13 This slide speaks to the types of
14 employers that are hiring our veterans. So,
15 in 2010 the majority were private sector
16 employers, but you can also see that a third
17 of our employers were Federal Government, and
18 then we have a pretty significant amount that
19 were in state and local government, and then
20 a smaller section that were faith-based and
21 community organizations. So, we do track them
22 by those types. Next slide.

1 Okay. Now I'm going to start
2 talking about our initiatives that we have
3 going on right now. We have three initiatives
4 that are around self-employment.

5 The reason we are doing that is
6 because we have typically underutilized that
7 self-employment track for veterans. And
8 there's a combination of reasons for that.

9 One is because the sort of full
10 benefit is limited to those individuals that
11 are so severe that traditional employment is
12 not an option.

13 The other is that, for those
14 individuals who might pursue self-employment,
15 but who don't qualify for that track, it's
16 hard to navigate starting your own business,
17 and our voc rehab counselors, while they are
18 very trained in vocational rehabilitation,
19 counseling, and those types of things, are not
20 very well-trained in doing the business of
21 self-employment.

22 So what we've done is, we've gone

1 out to industry and got these three
2 initiatives started. These are pilot tests of
3 three ways to help veterans start up their
4 programs.

5 One is sort of a -- the Business
6 Incubator helps the veteran with that actual
7 start-up phase, and then the Business
8 Accelerator is more of a tool to guide them,
9 and then the EAdvantage is actual training,
10 how to -- how to set up your business. Is
11 self-employment right for me?

12 We just started -- the first few
13 are just in the very beginning phases and the
14 EAdvantage were just -- we've just kicked off.
15 So, we're really excited about these
16 initiatives and seeing how it helps us to put
17 more veterans for whom self-employment is a
18 good option into the self-employment track.
19 Next slide.

20 The Self-Management Industry
21 Innovation Competition, we're actually
22 currently reviewing those submissions and the

1 purpose of this innovation was to help us get
2 in touch with industry opportunities to help
3 our very severely disabled veterans get into
4 the work force and be successful, both in
5 their training and in their employment.

6 Looking at assistive technology
7 devices that, you know, we know that in
8 government, unless we reach out sometimes, at
9 least for VBA, unless we reach out to private
10 sectors, sometimes we don't know what all is
11 out there.

12 So, we're hoping that through
13 these submissions we're going to find some
14 that are really great for pilot testing to
15 help veterans with severe disabilities become
16 successful.

17 The Transition Assistance Program
18 and Disabled Transition Assistance Program,
19 our little piece of that is the DTAP. We --
20 and I do want to point out, there was an error
21 in the slide deck.

22 On slide seven there are different

1 numbers under DTAP than on slide 13, and the
2 correct number are the higher set of numbers.
3 So the set on slide seven, I believe, is the
4 higher set of numbers.

5 And I apologize for that. When we
6 did it originally, we used August numbers and
7 we updated it to September numbers on one of
8 the slides and failed to do that on the other
9 one. So I apologize for that error. Next
10 slide, please.

11 We are in the process of
12 redesigning DTAP to make it more user-
13 friendly. Right now it kind of is like what
14 I'm doing here, sort of death by PowerPoint.

15 So what we're doing is, we're
16 doing a promotional video that's a really
17 short, really grab-your-attention type of
18 video that sort of gives the service member
19 the "What's in it for me? Why should I go to
20 DTAP? What's in it for me? Why do I need to
21 know this information?"

22 And then we're redesigning the

1 DTAP presentation to make it more interactive,
2 more in-line with the current attention span
3 of us, you know, people, in general, with the
4 current -- everything that -- the sound bites
5 that come to us really quickly and having a
6 web-based tool for them also so that if they
7 miss it or they want to come back and revisit
8 it, that they can.

9 And allowing -- and this is really
10 important for Guard and Reserve, that the web
11 conferencing ability so that if they're not
12 coming through a location that has a DTAP
13 group, that they can still get the same
14 information. Next slide.

15 Business process reengineering.
16 Our program, the Voc Rehab and Employment
17 Program, is a really excellent program, but
18 even with an excellent program there's always
19 room for improvement and opportunities.

20 So, what we're doing is, we're
21 doing a huge business process reengineering
22 and really looking at how can we streamline

1 the process for veterans, how can we reduce
2 the bureaucracy and redundancy for our
3 counselors so that they can provide more face-
4 to-face services to veterans and better
5 services.

6 How do we simplify and speed up
7 the process while maintaining the integrity of
8 the amount, the quality of services that we
9 provide to our veterans, so we are working on
10 that.

11 And the next slide kind of shows
12 the buckets that we're -- that we're sort of
13 in, in terms of the improvements we've
14 identified.

15 So, really, the form improvement
16 and QA standards really speaks to reducing
17 paperwork. The roles, analysis and
18 performance management really speaks to, do we
19 have the right people in the right places
20 doing the right things.

21 Caseload and staffing analysis
22 really looks at, is our workload where it

1 needs to be, do we need more people, do we
2 need people doing different things. And then,
3 business requirements is about developing the
4 right IT tools to support our staff so that
5 they can support their veterans more
6 effectively, and then the knowledge management
7 portal is about taking all of the regulations,
8 procedural directives, policies, not only just
9 about our program, but about every other
10 program that could possibly affect a veteran
11 and putting it into one place so that they
12 have -- the counselors have access to it in
13 an easy-to-use manner. Next slide.

14 Okay. This is an initiative that
15 I'm really, really excited about, which is the
16 -- our part of the IDES initiative, which is
17 where we will be putting a voc rehab
18 counselor, a VR&E voc rehab counselor on-site
19 at some of the IDES installations so that when
20 the service member is going through IDES,
21 there will be a requirement for one mandatory
22 meeting with the voc rehab counselor.

1 We have gotten the MOU signed.
2 DoD and VA have worked together on that, and
3 we've gotten the first instructional document
4 signed and approved to do the first three
5 sites and I'm not sure if those three sites
6 are in the slide deck because that just
7 happened. It's really hot-off-the-press.

8 So, what we're going to do is,
9 when the service member is going through DES,
10 they will be referred to the voc rehab
11 counselor, and that first meeting will be
12 mandatory.

13 And that's the meeting where they
14 will sit down face-to-face with the counselor
15 and the counselor will say, "Here's what this
16 program can do for you. Let's briefly talk
17 about where you are now, where you think
18 you're going to be. Do you think you're going
19 to be getting out of the military? Do you
20 think you're going to be trying to stay in?
21 Here are the options for you from our
22 perspective, from a voc rehab counselor's

1 perspective."

2 And because it's at the point that
3 they are referred to the PEB, what our
4 understanding is, is that at that point we're
5 pretty certain they probably be coming out
6 with a disability condition.

7 But even if they're not, we will
8 help them just to navigate that process in
9 terms of thinking it through. If I do get
10 out, what are my options? If I do stay in,
11 can this program help me and how?

12 MR. DRACH: Margarita, let me just
13 go back a little bit. I see here where you're
14 talking about the mandatory meeting with the
15 PEB, when it gets referred to the PEB.

16 Do you know typically when a memo
17 rating is -- is provided? Is it before the
18 MEB? Is it after the MEB? Do you know what
19 stage, generally?

20 MS. COCKER: I believe it's
21 typically at the PEB or after the PEB, but
22 it's in that -- in that part of the process,

1 which is why that's where we're inserting
2 ourselves, not earlier than that, because we
3 want to make sure we're really only getting to
4 those service members that are really sort of
5 moving on that track.

6 As far as the memorandum rating,
7 of course, we can use the IDES rating, which
8 is being developed at that point. But even
9 before we have that we can start working with
10 them under the authority of Chapter 36.

11 So that's the beauty of our
12 program is, we don't even have to have that
13 rating to start working with them.

14 So, at that mandatory meeting, the
15 service member can say, "Sign me up. I want
16 to go through the whole evaluation and see
17 what I -- you know, how this program can help
18 me," or, "I'm not interested."

19 If they're not interested, they're
20 done, but at least hopefully we've placed the
21 seed of information into their mind so that
22 whether they come back in a couple of weeks or

1 six years or ten years, they'll remember that
2 our program is there and what it can do for
3 them if they need it.

4 At the point that they decide they
5 want to go through with the evaluation, we'll
6 do their assessment of the interests,
7 aptitudes and abilities and we'll help them to
8 develop a transition plan to employment that
9 includes the education that they need to get
10 to competitive employment, and we can start
11 providing the services if it's approved by
12 their commander while they're still there, or
13 if they're moving -- if they're transitioning
14 out and because it happens, it should be
15 happening fairly quickly, they are going back
16 to hometown USA. There will be a warm hand-
17 off between that counselor that's at the IDES
18 installation and the counselor at hometown USA
19 that they're going to be moving to.

20 So the plan can be developed,
21 transitioned home, and then they can either
22 start their retraining while they're on-site

1 or after they transition home.

2 So we currently, based on the
3 numbers that we've shared with DoD, we've
4 identified that we're currently touching
5 approximately 25 percent of transitioning
6 service members going through IDES, so this
7 will give us a hundred percent touch point.

8 We're only going to be at three
9 sites initially, and then we have 110 FTE
10 approved for fiscal year '12, if the
11 President's budget goes forward as it was
12 originally presented. So, we're excited about
13 that. Next slide.

14 I think I went through all of
15 this. Originally we were supposed to do four
16 sites in 2011, but we ended up with three.

17 Okay. Remote counseling is
18 another initiative where we're looking at --
19 again, I mentioned earlier that we do face-to-
20 face counseling with our veterans, and so this
21 allows us to reach those remote individuals
22 that, because of just geography, they are in

1 rural areas. They are not as close to one of
2 our offices and they need us, that we could
3 reach them remotely through video
4 teleconferencing.

5 We have piloted this in several
6 stations, and we have found it to be
7 successful. The veterans like it. The
8 counselors like it. So now we're in the
9 process of figuring out how to roll that out
10 nationally. So we're working on those plans
11 now.

12 MG STONE: And where does the
13 veteran need to be in order to access this?

14 MS. COCKER: That's a really good
15 question. We are looking at a couple of
16 different avenues. The way our program is
17 structured, we can purchase the equipment for
18 the veteran for him -- for him or her to have
19 in their home, and we have, under the
20 mandatory budget, the authority to do that.

21 Where we're going to have to also
22 partner with other entities is if the veteran

1 is not already in our program and they want to
2 meet with a counselor to discuss any benefits
3 or anything like that.

4 We're going to talk to VHA and
5 we're already starting those conversations
6 about partnering at the -- having them go to
7 the CBOC or wherever the equipment already
8 exists so that they can come there to their
9 nearest location and talk to us.

10 But once they're in our program we
11 can actually purchase the equipment for them,
12 so they would be communicating from their home
13 to our counselor. Next slide.

14 This really just talks about more
15 of the pilot, how we implemented the pilot and
16 the success, but the success rate -- the way
17 we gauge it, really, is more from the
18 veterans' satisfaction rate, and they were
19 very satisfied with it.

20 We also provided a lot of hand-
21 tailored support to those individuals. So,
22 one of the things we're working on is what

1 kind of support can we provide to these
2 individuals from a technical standpoint once
3 we roll out nationally. Next slide.

4 Troops to Counselors is another
5 initiative I'm very excited about. One of the
6 things that VBA prides itself on is hiring as
7 many veterans as we can.

8 One of the challenges for the voc
9 rehab counselor occupation is that we don't
10 have a lot of veterans pursuing that as an
11 occupation from the educational standpoint.

12 So, our voc rehab counselors have
13 Master's degrees in rehabilitation counseling
14 or a closely-related degree. In order for us
15 to hire a veteran as a voc rehab counselor,
16 they also have to have that educational
17 accomplishment but a lot of times, again, they
18 don't know about that track, that educational
19 track, so they don't go there.

20 A lot of our veterans who are
21 interested in social services will go to
22 social work or to clinical psychology or other

1 tracks.

2 So, we're trying to educate
3 veteran students who are even at the
4 undergraduate level about a career in VA as a
5 voc rehab counselor so that we can attract
6 more veterans to that educational track so
7 that we can hire them.

8 And then, even better, once we
9 pique their interest and they say, "Oh, I want
10 to do that. I want to help veterans get into
11 careers. I want to become a voc rehab
12 counselor," through the Student Career
13 Experience Program, we can hire them while
14 they are still students as a GS-5 and keep
15 them on board and then, as they progress
16 through their training they get promoted up to
17 a GS-7 when they start their internship in
18 their graduate program, and then to the
19 9/11/12 career track once they graduate, and
20 that's a noncompetitive process.

21 MR. DRACH: That's a great
22 initiative. Thank you. Are you collaborating

1 at all with the Student Veterans of America in
2 this initiative in reaching out to students?

3 MS. COCKER: Yes. And we're also
4 collaborating with them on the VetSuccess on
5 Campus Program. We are trying to publicize
6 this program as much as possible.

7 We've gone out to some of the
8 universities and really put it out there, and
9 we're getting a lot of phone calls from
10 individuals who are interested, so we are very
11 excited about this.

12 So, you can see there we've done a
13 lot of the -- a lot of the outreach. So,
14 very, very excited about this, and we're
15 tracking, and our goal is that all of our new
16 hires from the point at which we started this
17 initiative, that all of our new hires, when
18 you look at just the new hires, that we would
19 hire 60 percent veterans.

20 Our current statistic -- and I'm
21 sorry that it's not on this slide -- I believe
22 is in the 50 percent area of how many of our

1 employees in VBA are veterans. Next slide.

2 This is a screen shot of our
3 knowledge management portal, and I mentioned
4 it earlier. It's sort of a place where we
5 capture all of the different resources,
6 information, procedures and everything that's
7 going on in the world that could help a voc
8 rehab counselor help a veteran.

9 This was one of our initiatives
10 that we were able to complete and kick off
11 already. A lot of the rest of the business
12 process reengineering is still going on and we
13 haven't completed that yet. Next slide.

14 VetSuccess on Campus. So, to help
15 service members and veterans be more
16 successful in their educational endeavors, we
17 began in 2009 at the University of South
18 Florida, a pilot project where we stationed a
19 voc rehab counselor full time on the campus at
20 University of South Florida, and the VHA
21 contributed a vet center outreach coordinator.

22 So, we have two people on the

1 campus who are there to help the individual
2 veteran students with being successful in
3 their educational endeavors.

4 A lot of what we found is that we
5 have individual veterans come to us who don't
6 know what their benefits are. They don't know
7 about the Home Loan Guarantee Program.

8 They don't know that the medical
9 benefits apply to them. They don't know about
10 their service-connected disability rating and
11 how to get it increased or how to apply for
12 this rating or, "I don't think I'll get this."

13 The voc rehab counselors, we train
14 them fully on every VA benefit, not just the
15 VBA benefits, but every benefit that a veteran
16 or service member could be eligible for so
17 that they can help that veteran decipher what
18 are your needs, what's going on with you, and
19 let me make sure that I get you connected to
20 all of these services. And, oh, by the way,
21 are you struggling academically, let me help
22 you with that, too.

1 So, because they are voc rehab
2 counselors they can help them with things that
3 aren't always obvious to the individual like,
4 you know, my strength isn't in math and I
5 didn't really realize that until just now, and
6 I'm in an engineering track, and I really want
7 to do this as my occupation.

8 Well, there are other tracks to
9 get you there, and let's talk about the
10 different options. Or, did you know that you
11 could get a tutor and, you know, it can be
12 paid for and things like that. Next slide.

13 So, we started at USF and we
14 expanded to these seven additional sites, and
15 we are working right now on our 2012
16 expansion. We are working with Student
17 Veterans of America. We always collaborate
18 with them to ensure that there's a presence
19 there at any of the colleges that we go to.

20 We're also collaborating with VHA
21 in their VITAL Program. So, we're looking at
22 20 sites in 2012. Next slide.

1 vetsuccess.gov is our
2 comprehensive employment website. It's a site
3 designed to help veterans to find jobs and to
4 help employers find veterans to fill jobs.

5 So, what vetsuccess.gov is, it's a
6 job board specifically for veterans. We've
7 recently connected with eBenefits. So, if you
8 get an eBenefits account you automatically get
9 a vetsuccess.gov account.

10 We have access to over eight
11 million jobs in the database through both our
12 VetSuccess jobs and other databases that we
13 are linked to.

14 We have 1800 registered employers
15 who are interested in specifically hiring
16 veterans. So they contact us all the time,
17 employers, and they say, "How do I hire a
18 veteran? I want to hire a veteran."

19 We'll tell you how. We're going
20 to do two things. We are going to show you
21 how to post your job on vetsuccess.gov because
22 veterans go there looking for jobs.

1 And secondly, we're going to put
2 you in touch with an employment coordinator in
3 one of our regional offices so that they can
4 actually hand-feed you potentially some
5 resumes.

6 If you're looking for a veteran
7 that specifically has this type of skill, they
8 may have somebody that they are already trying
9 to help get a job and they can put you in
10 touch with them and give you their resume.

11 So employers can search veterans
12 who have posted their resumes by the keywords,
13 skill type, security clearance, and veterans
14 can search jobs. Next slide.

15 MG STONE: I wonder if you could
16 tell us how many veterans have actually found
17 employment under these programs.

18 MS. COCKER: You know, that is our
19 biggest challenge. And when we talk to the
20 developer of our website we said, how can we
21 do this, and it comes down to self-report.
22 And that's where our biggest challenge is in

1 trying to get statistics that show the success
2 of our program.

3 So, we do have a link on the site
4 where we encourage our veterans to come back
5 and say, "This worked for me," or, "This
6 didn't work for me," so that we can collect
7 statistics, and likewise, for employers to
8 report back.

9 But, given that we can't make it
10 mandatory, we're struggling with actually
11 getting some actual statistics.

12 MG STONE: Then how do we go back
13 to the pie chart that you showed us in slide
14 nine that has an average annual benefits
15 report from your 2010 placements?

16 Can you tell us how many jobs are
17 described in that 2010 placements that are
18 self-reported?

19 MS. COCKER: Oh, the placements
20 that you see on the pie charts are -- they are
21 all self-reported, but those are actual -- and
22 that's a good distinction. Those are actual

1 voc rehab participants that graduated through
2 our program.

3 So, the vetsuccess.gov is open to
4 all veterans, even veterans who are not in the
5 voc rehab program. So, while we have a little
6 bit of control, if they are in our program,
7 because we have benefits to pay them, so they
8 tend to want to talk to us because they want
9 their benefits.

10 But, for the general veteran
11 community who is not in our program, the
12 challenge is trying to get them to report back
13 that the system worked for them.

14 DR. PHILLIPS: I'm not sure what
15 your rules might be, but that information
16 should be available either through IRS or
17 Census reports.

18 MS. COCKER: So, getting the
19 information through other programs, DOL has
20 information that they can share with us, but
21 if they get a Government job there's no -- you
22 know, those wage reports don't include

1 Government jobs, so we would be limited to
2 those private sector jobs where reporting is
3 available.

4 So these are some of the
5 enhancements that we recently put into
6 vetsuccess.gov show there's actually -- and I
7 believe if you can go on -- go on ahead to the
8 next screen.

9 Okay. I thought the next one was
10 the screen shot. I think it's another one up.
11 But -- so, this is what the main website home
12 page looks like, in the middle there's a
13 little video clip that talks about how this
14 site can help them and about job searching.

15 We've got on the left-hand side
16 little news blurbs that we put up there that
17 we update periodically. You can see at the
18 bottom there are job application tips, and
19 then there's member log-in.

20 Now, a veteran can go onto this
21 website and browse and look for jobs and
22 everything without creating an account. But

1 if they want to apply for a job that is
2 specifically posted on this site, specifically
3 for veterans, they have to create an account,
4 because we don't want -- we want to protect
5 that those employers want to hire a veteran
6 and only veterans are logging onto the website
7 and applying for those jobs.

8 So, on the right you can see
9 there's an employer log-in and a veteran log-
10 in. If an employer wants to create a site and
11 post jobs, we do verify that they are, in
12 fact, a legitimate employer and not a
13 recruiter or something like that that doesn't
14 have an actual job posting, and we verify that
15 they are actually posting a real, legitimate
16 job.

17 And our employment coordinators in
18 D.C. do that. Next slide.

19 MR. CONSTANTINE: Ms. Cocker, when
20 you said that they have access to eight
21 million jobs, it seems really high. Where
22 does that number come from?

1 MS. COCKER: We collaborate with
2 the National Association of State Workforce
3 Agencies, which is the DOL VETS's connection
4 to job, so their DVOPs and LVERs are creating
5 jobs at the local level, and we are -- we have
6 a direct connection to all of those jobs
7 nationally.

8 MR. CONSTANTINE: So you -- at any
9 given time there's eight million jobs out
10 there that are available?

11 MS. COCKER: That's correct.

12 MG STONE: So how do you explain
13 the unemployment rate amongst veterans?

14 MS. COCKER: That's a good
15 question, and I can't -- I can't give you the
16 answer to the unemployment rate.

17 MG STONE: So how do we evaluate
18 the success of this type of program? It seems
19 so extraordinarily well-developed, which
20 reaches out so effectively, which is so well-
21 articulated, how do we explain the
22 unemployment rate?

1 MS. COCKER: If I had the answer
2 to that -- I can tell you that through our DoD
3 DVA task force we are working on trying to
4 identify some of the core issues around the
5 unemployment.

6 And one of the things we're trying
7 to do is get our hands around data that can
8 show us, so we know in the 18 to 24 age range
9 we've got a higher unemployment rate.

10 What are the root causes of that,
11 and where are these individuals? Are they
12 clustered in certain areas? Is there certain
13 geographic -- are there certain geographical
14 reasons that they are not employed? Is it a
15 skill set limitation? Is it that they don't
16 know how to use, or don't have access to,
17 eligible for benefits such as education?

18 Another thing we don't know is
19 whether there's -- apparently, in some states
20 they can receive unemployment while they are
21 pursuing their education benefits, so we're
22 trying to really identify what is the pocket

1 of individuals that really need the help, and
2 what -- which pocket of individuals are
3 actually pursuing a benefit.

4 Like, for example, if they are
5 pursuing voc rehab and they are in our program
6 and receiving a benefit, they may be
7 unemployed, but they are receiving the
8 services that they need to become employed
9 when they finish our program.

10 So what we're really focusing on
11 is trying to understand, what are the root
12 causes. And to understand that, of the
13 veteran unemployment, you have to know who --
14 who is it, what are the issues, what are the
15 root causes, and then how do we fix that.

16 Now, I know that one of the issues
17 around vetsuccess.gov is getting the word out,
18 making sure that veterans know about it and
19 that employers know about it.

20 We have a marketing campaign that
21 we're hoping to kick off this coming year in
22 2012 to really get the word out to both

1 veterans, service members and employers
2 because you can have all the benefits out
3 there in the world, but if they don't know
4 about it --

5 MR. CONSTANTINE: Yes. I wanted
6 to ask you about it because I think from your
7 statistics earlier it said, before a number of
8 presentations you gave and a number of
9 applicants, there's one to ten, it seemed
10 like, and frankly, most of you all don't even
11 have to go to these briefings, anyway.

12 MS. COCKER: Right.

13 MR. CONSTANTINE: So there's
14 probably a whole lot who don't go. So, how do
15 you feel, after working in this for quite a
16 while, that may make service members aware
17 about voc rehab?

18 MS. COCKER: One of the things
19 that we're doing is the IDES Initiative, so
20 actually putting the voc rehab counselor on
21 site and making it a mandatory session.

22 Because you're right, they don't

1 have to go to the DTAP briefing. With the TAP
2 renovation, and that's -- that's not -- we're
3 not doing the TAP renovation, but we are
4 working with DOL on that.

5 And one of the pieces of that is
6 making sure that, in the TAP presentation they
7 get the "what's in it for me" on the DTAP so
8 that they will actually go to DTAP.

9 It's a combination of things. I
10 don't want to be associated with having a
11 disability, so maybe I don't want to go
12 because of that. I'm done. I'm done with
13 briefings. I don't want another PowerPoint,
14 so I'm not going to go because of that.

15 So, we're working on trying to
16 make it more -- again, I have to keep coming
17 back to the "what's in it for me." You know,
18 they don't always know what they don't know
19 and why it's important for them to know it.

20 So, we're trying to do that, and I
21 think putting the counselors on site and
22 making that a mandatory session is going to be

1 really important.

2 And then there's the Guard and
3 Reserves challenge. You know, how do we reach
4 them? So, that's why that webinar piece is so
5 important with being able to reach them where
6 they are.

7 CSM DeJONG: Ma'am, that was my
8 next question was, when you talked about the
9 early intervention, you talked about the DoD,
10 the Yellow Ribbon Programs for the Guard and
11 Reserves.

12 How is that being, I guess,
13 introduced to them? Are you being invited by
14 the states or are you trying to play catch-up
15 and find out when they are being -- how are --
16 how are the states and these Yellow Ribbon
17 Programs in your office interacting, I guess,
18 is my question?

19 MS. COCKER: We are reaching out
20 to them, and making sure we find out who --
21 who is coordinating the events and when the
22 events are occurring so that we can be there.

1 CSM DeJONG: Okay. And with that,
2 with the changes in the post-9/11 GI Bill that
3 have just come down, is that going to --
4 looking at that, is that going to also help
5 build with -- I'm not an expert on it. I kind
6 of know the little bits and pieces of how it
7 kind of goes into, not just -- it kind of goes
8 into the voc rehab and some of the
9 specialties.

10 Are you guys going to be able to
11 tie that together with your system more?

12 MS. COCKER: Tie the -- are you
13 referring to the individual -- the veterans
14 that are pursuing the GI Bill and making sure
15 that they tie into --

16 CSM DeJONG: Correct.

17 MS. COCKER: -- vetsuccess.gov?

18 CSM DeJONG: There's a new change
19 that just came down in the last month or so,
20 which is now kind of going to more licensing
21 and other type. Have you guys also worked
22 with tying that together?

1 MS. COCKER: We already provided
2 those types of benefits under our program, so
3 that part doesn't change the benefit that we
4 administer because our veterans were already
5 able to pursue the OJT and the apprenticeship
6 and the licensure and all those kinds of
7 things.

8 I think the main piece, if you're
9 talking about collaboration between the
10 education services and the voc rehab benefits,
11 our main piece is the VetSuccess on Campus,
12 and putting a counselor on there, on the
13 campus at the colleges.

14 We're not doing that with the
15 voc/tech schools and the OJTs and
16 apprenticeships because, if you think about
17 it, you've got a large number of veterans at
18 a college campus and you can reach a large
19 number of veterans by putting a counselor
20 there, but the OJTs, apprenticeships and
21 licensures are kind of all over the place.

22 Is that -- am I answering your

1 question? Am I understanding your question?

2 CSM DeJONG: Absolutely, yes.

3 MS. COCKER: Okay.

4 CO-CHAIR CROCKETT-JONES: I have a
5 question for you on the vetsuccess.gov. Are
6 you capturing demographic information on who
7 is registering, what -- whether it's veterans
8 -- veterans who have been -- like the age when
9 they've separated? Is it available to people
10 who are currently active duty and I'm
11 wondering if you have some information over
12 the rate of registrants over time, and if you
13 could get that to us.

14 MS. COCKER: We do. I can get
15 that to you. It's not in this PowerPoint
16 deck, but I do have a chart that shows, over
17 time, how many veterans have registered.

18 And demographic information,
19 because -- one of the things about this
20 website that makes it easy from a user's
21 perspective is that it doesn't have a whole
22 lot of barriers to get again.

1 It doesn't have any PII on it. No
2 privacy-protected information. We post a
3 warning when they're logging in, because we
4 wanted to be able to host it outside of the
5 server and the firewall, so that employers can
6 get to it.

7 And so, we don't collect privacy-
8 protected information.

9 CO-CHAIR CROCKETT-JONES: But if
10 you are screening to know that they are
11 eligible --

12 MS. COCKER: And for this program,
13 every veteran is eligible. And we do not --
14 so, is your question around are we verifying
15 that they are actually a veteran?

16 CO-CHAIR CROCKETT-JONES: It's
17 more about are we differentiating between
18 their statuses, but if you're not --

19 MS. COCKER: We're not.

20 CO-CHAIR CROCKETT-JONES: Okay.

21 CSM DeJONG: A quick note on that,
22 the Yellow Ribbon and DoD and the

1 postemployment health reassessments. Is there
2 -- do you have anyone tracking the percentages
3 of states that are actually utilizing this
4 benefit and getting in and interacting with
5 your office?

6 MS. COCKER: No. I don't have
7 statistics on that.

8 CSM DeJONG: Because, over the
9 next few years we're going to be hitting a lot
10 of the Joint Forces Headquarters and stuff
11 like that. That may be a metric that might be
12 helpful in both advertising what you have and
13 giving some feedback to the different states.

14 It's a difficult -- it's a
15 difficult road to travel with the Guard and
16 Reserves and trying to hit every yellow
17 ribbon, but if the question is out there and
18 it's asked of us, of how much is being used
19 and if there's a percentage somewhere, whether
20 it's the East Coast, West Coast, Midwest that
21 are actually using it, we might be able to, at
22 least show the metrics that are being used out

1 there, if the Guard Bureau would ask.

2 MS. COCKER: We can collect that.
3 We do manage that at the regional office
4 level, but I can reach out to the regional
5 offices and get some data.

6 CSM DeJONG: Okay. Thank you.

7 MS. COCKER: Be happy to do that,
8 and I'm -- hopefully there's going to be
9 somebody I can coordinate getting this
10 information back to. Okay.

11 MR. CONSTANTINE: I'm interested
12 in the for-profit colleges which have gotten
13 a lot of publicity right now with the GI Bill.

14 Voc rehab, you have the quote-
15 unquote "luxury" of telling a service member
16 or veteran, "We're not going to approve you to
17 go to this school." That's my understanding,
18 at least, or are not -- they don't -- the
19 service member doesn't get to say, "I want to
20 go to this school, and it's going to happen."

21 Do you -- what do you see
22 regarding these for-profit schools and voc

1 rehab support of service members going there
2 or are you trying to guide them to more
3 traditional community college or vocational
4 school or four-year university?

5 MS. COCKER: We do have specific
6 policy about that, and it's -- it's -- the
7 policy is more written around cost. And so,
8 what the policy says in our procedural manual
9 is that the voc rehab counselor, working with
10 the veteran, first establishes the career
11 goal, right?

12 So, you work your way backwards
13 from that. It's like, you know, if you're
14 taking a road trip you know what your
15 destination is first before you determine your
16 route.

17 And then, once you know the career
18 that we're going to try and work this veteran
19 into, then you determine what educational
20 requirements are needed. And then you look at
21 the schools in the area and what can best
22 prepare that veteran for employment.

1 So, what our counselors will do
2 is, they will say to the veteran, "Here are,
3 you know, those six schools in the area that
4 are reputable and are known to produce the
5 credentials that you need so that you can
6 compete for employment."

7 Typically, the high cost, private,
8 for-profit schools are not our first choice
9 because our manual says, "Go with the state
10 schools as much as possible."

11 However, there are instances where
12 the private colleges have smaller classroom
13 settings and different classroom supports than
14 the public colleges that will help that
15 veteran be more successful.

16 So, there is a stipulation that we
17 can approve it in certain circumstances. It's
18 really not that limiting in the sense that we
19 don't -- you don't have to jump through a lot
20 of hurdles to approve it.

21 What, I think, one of our biggest
22 challenges, at least it was when I was a

1 counselor, was that the veterans get a lot of
2 media, sort of information overload about the
3 private, for-profit colleges.

4 So, they come to their counselor
5 with a preconceived notion about which college
6 they want to attend, and we take what's called
7 an informed choice perspective on helping the
8 veteran develop their rehab plan.

9 So, we're not going to say no
10 before we've given them the opportunity to
11 research all of the options, and then, once
12 we've researched all of the options, we make
13 a decision on what's the best for them in
14 conjunction with them.

15 So, it's a two-way street working
16 with the veteran and the counselor. If it is
17 a high-cost school and it exceeds a certain
18 cost threshold, it does have to go to the VR&E
19 manager for approval of the high cost.

20 MR. CONSTANTINE: All right.

21 Thank you.

22 MS. COCKER: You're welcome.

1 Okay.

2 Okay. Next slide. This is the
3 map for veterans in transition, and we have
4 one for veterans in the home, veterans at
5 work, veterans at school, and what you do with
6 this map, if you're on the website, is you
7 click on the state that you're in and then you
8 can look at VA benefits specific to that
9 state, what's available, where's my local VA
10 regional office.

11 And also state benefits that, one
12 of the things that I think a lot of veterans
13 don't know is all the state benefits that are
14 available to them. And then other nonstate,
15 non-Federal benefits that are available to
16 them.

17 For example, a lot of community-
18 based organizations that provide benefits to
19 veterans. So, when you -- I always talk about
20 the safety net. You know, if you've got a
21 safety net for your veterans and if they have
22 a service-connected disability, they can go

1 into voc rehab.

2 If they have educational benefits
3 they can go into the post-9/11 Montgomery GI
4 Bill. What if they don't have either of
5 those? What's there to help them?

6 Well, we've got vetsuccess.gov,
7 which is for any veteran that -- it will help
8 them with finding a job and connecting to
9 employers but then, if they click on their
10 state, if there are any other state-specific
11 or region-specific benefits that are available
12 to them, it will give them that.

13 So, this is just an example, if
14 they hover over Montana, you've got VA
15 resources, State of Montana resources, and
16 then you drill down from there.

17 So that's the overview. I
18 appreciate all of your questions. Do you have
19 any other questions? And I will get you the
20 items that you've requested.

21 DR. PHILLIPS: Just one question.
22 Gauging the success or failure of any program

1 is critical. I mean, we spend a lot of time,
2 effort and money into doing that.

3 And obviously this is not isolated
4 to the VA or any other -- to most Government
5 organizations. We have difficulty evaluating
6 success because of certain restrictions.

7 Could you possibly identify the
8 constraints that you're under in evaluating
9 the success of a particular program? I mean,
10 we've heard talk about personal identifiable
11 information and things like that.

12 I mean, that might be helpful for
13 us in our recommendations.

14 MS. COCKER: Are you referring
15 specifically to the vetsuccess.gov program as
16 opposed to our program as a whole?

17 DR. PHILLIPS: All the programs.
18 We went through, for example, the first ones
19 you described, the very first one we talked
20 about, I think it's the -- the performance
21 programs and the participation in some of the
22 rehab programs and so forth.

1 I mean, these things are difficult
2 to get a handle on. You know, how successful
3 are you in helping someone achieve their goal
4 --

5 MS. COCKER: Well, I can tell you
6 --

7 DR. PHILLIPS: -- and what is the
8 failure rate and so forth?

9 MS. COCKER: -- and I don't think
10 we have our performance statistics up here,
11 but our key measure is the rehabilitation
12 rate.

13 And what that measures is the
14 success rate of our veterans who actually
15 enter into a plan of services. So, because
16 our program is a benefit program, it's by
17 choice, so a veteran chooses to apply, but a
18 veteran also can choose to attend or not
19 attend the counseling appointment.

20 And because we do so much
21 outreach, a lot of times veterans will fill
22 out the application but, you know, in the two

1 weeks it take us to process their application
2 and get them their first letter saying, "Guess
3 what, you're eligible, we're scheduling you
4 for an appointment," things change, they got
5 a job, they no longer feel they need us.

6 It could be a whole host of
7 reasons why they don't come to that first
8 appointment. Or, they come to the first
9 appointment and then they decide, you know,
10 I'm going to use my GI Bill instead.

11 So what we do is, we measure the
12 veterans who actually go through our
13 evaluation and start a plan of services, what
14 percentage of those actually complete
15 successfully.

16 And our target is 77 percent and
17 we are at 77 percent. So, we're meeting our
18 target in that.

19 DR. PHILLIPS: And your outreach
20 and early intervention programs?

21 MS. COCKER: The way we measure
22 the success of that -- and that is a difficult

1 one, is the degree of, is the number of
2 applications that we receive.

3 So, what we do is, we target
4 increase in applications, based on our
5 increased outreach.

6 DR. PHILLIPS: This is sort of a
7 tough situation. Is there -- have you been
8 able to identify situations, or is this an
9 issue where not having a job, that someone
10 would benefit more from staying in the program
11 than trying to get a job?

12 MS. COCKER: Yes. For an
13 individual who is going through one of our
14 tracks to employment, who is going to school,
15 say, for example, full time, it may be too
16 much for them to have a job and go to school
17 full time.

18 So, with the stipend, especially
19 now that we have the higher post-9/11 GI Bill
20 type rate, they hopefully have enough that
21 they can financially -- focus on going to
22 school so that they can get through faster and

1 be successful and not have too many
2 responsibilities that would detract them from
3 their educational success.

4 However, having said that, family
5 responsibilities come into play and a lot of
6 times they do -- our veterans do hold down,
7 even if it's a part-time job or a work study,
8 because the work study program, they can tap
9 into as well, which is only a few hours a
10 week. It's minimum wage, but it's a little
11 bit of extra money.

12 So, yes, there are times where we
13 really encourage our veterans not to get
14 another job if they can afford not to.

15 CO-CHAIR CROCKETT-JONES: I have
16 some more questions about this time line.
17 Anecdotally, I'm hearing a really different
18 experience from people who have applied to
19 VR&E.

20 You're saying 45 days between
21 getting eligibility confirmation and that
22 first appointment. What's the time line

1 between applying and getting the eligibility
2 confirmed?

3 MS. COCKER: The 45 days is
4 actually from the date we received their
5 application to the date they are before a
6 counselor face-to-face, getting a decision.

7 So, in that 45 days includes the
8 eligibility decision, which -- the eligibility
9 decision, if it's positive, the output of
10 that, that the veteran sees, is a letter
11 saying you're being scheduled to meet with a
12 voc rehab counselor.

13 CO-CHAIR CROCKETT-JONES: Okay.
14 I've just heard some really different numbers
15 from service members who have applied and
16 waited many months to get an appointment.

17 MS. COCKER: And the 45 days is an
18 average.

19 CO-CHAIR CROCKETT-JONES: Right.

20 MS. COCKER: And we have had
21 problems in some cases, especially if the
22 character of discharge is not -- if that issue

1 is not resolved yet because we can't issue a
2 memorandum rating if we don't know if the
3 character of discharge is honorable or other
4 than dishonorable.

5 So, sometimes when that's being
6 developed for, that does cause a delay. Or,
7 sometimes -- and we are working on this, but
8 getting the memorandum rating, if they are in
9 transition and they are actually moving, their
10 file has to move with them.

11 But, on average, we are averaging
12 45 days, and that includes those individual
13 service members that are coming out and
14 receiving a memorandum rating to get into our
15 program.

16 So, because it's an average,
17 you'll have some individual veterans who are
18 going through the process in ten days, five
19 days, 14 days and so on, and then you will
20 have some who it's taking longer for, but we
21 do strive for that average of 45 days.

22 CO-CHAIR CROCKETT-JONES: Can we

1 get some of the data that was used to find
2 that average? Can we?

3 MS. COCKER: The raw data?

4 CO-CHAIR CROCKETT-JONES: Yes,
5 some of the range at least of those dates.

6 MS. COCKER: Yes. I can look at
7 that and see how we would do that. I'm not
8 sure. Maybe for fiscal year '10 we can do
9 something.

10 CO-CHAIR CROCKETT-JONES: I'm just
11 wondering if there's some disconnect between
12 the experience and what you're having
13 reported.

14 MS. COCKER: Yes. Our data is --
15 it's not self-report. It's data based on when
16 the voc rehab counselor meets with the veteran
17 and makes the decision.

18 They have to go into the system
19 and send a letter to the veteran, even if
20 they're telling the veteran face-to-face,
21 you're entitled, they have to send a letter to
22 the veteran, and that triggers the closing off

1 of the clock on that days to entitlement
2 decision.

3 And then there's -- we also have
4 another timing measure that we track which is
5 the number of days from that first appointment
6 to when the veteran enters into a
7 rehabilitation plan and actually begins that
8 process of, "I've got a plan. It's signed.
9 It's approved. I know what I'm doing. I'm
10 going to this school. I'm doing this." And
11 that, our average is about 105 days.

12 MG STONE: Ms. Cocker, thank you
13 very much. As the Department of Defense have
14 18,000 of our service members in the Army
15 alone in the IDES program, we appreciate the
16 efforts of your department to reach out to
17 support them.

18 Please do not infer in any of our
19 questions any more than frustration in trying
20 to get to how to help these service members
21 effectively, and make sure we prepare them
22 well for that hand-off.

1 But we thank you very much, and
2 I'm sure that your director will be very
3 pleased that your performance went so well
4 today. Thank you.

5 MS. COCKER: Thank you. Thank you
6 for having us.

7 MG STONE: I think at this point
8 then, we will break for lunch and we'll
9 reconvene at 1300. Thank you.

10 (Whereupon, the above-entitled
11 matter went off the record at 12:13 p.m. and
12 resumed at 1:04 p.m.)

13 CO-CHAIR CROCKETT-JONES: We're
14 back from lunch and we will now be hearing
15 from Captain Sharon Ludwig, senior
16 epidemiologist in the Epidemiology and
17 Analysis Division of the Armed Forces Health
18 Surveillance Center, and a contributing editor
19 for the Medical Surveillance Monthly Report.

20 We can find her work on Tab E.

21 CAPT LUDWIG: Hello. I'm Captain
22 Sharon Ludwig, as you mentioned. Actually,

1 I'm the Chief of Epidemiology and Analysis at
2 the Armed Forces Health Surveillance Center.

3 The person whose bio you just
4 mentioned is the other person who is on her
5 way, Dr. Clark. I am going to give the first
6 part of the presentation, which is an
7 introduction to our organization. And then, -
8 - well, and then she will give the next part,
9 which I'll mention in a minute.

10 I want to clarify who I am, just
11 for those of you who are confused. I'm in the
12 US Coast Guard. I'm actually detailed from
13 the US Public Health Service, and I am further
14 detailed from the Coast Guard to the Armed
15 Forces Health Surveillance Center.

16 I also have nine years in the Army
17 under my belt before I came to Coast Guard,
18 and I've been at Coast Guard for 13 years.

19 So, that's who I am. That's our
20 building where our -- and I've got a
21 disclaimer here. What I say is my material
22 only.

1 Our outline is -- I'll give you an
2 overview of the AFHSC. I'll discuss a little
3 bit, I don't know what everybody's background
4 is, but in case you need a little review of
5 what epidemiology and surveillance are all
6 about, I'm going to do that.

7 So, the AFHSC was organized in
8 2008 by combining three different
9 organizations.

10 Dr. Clark, you can come on up
11 here. This is my -- not very. We just
12 started.

13 So the three organizations that
14 combined are the DoD Global Emerging
15 Infectious Surveillance and Response System.
16 Whoopsie. Wrong one. Nobody says "Whoopsie."

17 Okay. And that's DoD GEIS. Some
18 of you may have heard of them. The Army
19 Medical Surveillance Activity, which included
20 most of the resources that I'm going to really
21 go into any detail on today, and the -- part
22 of the DASD for Health Affairs, Force Health

1 Protection and Readiness. So, called Global
2 Health Surveillance.

3 So they still have a cell called
4 Global Health Surveillance. It's just one
5 person and all of their resources came to
6 AFHSC.

7 Those really fall in the very
8 broad wiring diagram. Just so you know, we do
9 have Army Executive Agent, but we fall under
10 ASD Health Affairs and the Force Health
11 Protection Council.

12 I show this slide just so that you
13 realize or see how we fall compared to in the
14 national system. We are the CDC for the DoD.
15 I'm sorry. This will keep you moving here.
16 Let me stand this way.

17 And the state health departments
18 would be the equivalent of the Service Public
19 Health Centers and their Surgeon General
20 staff, so two different organizations would
21 make up the state level.

22 And then what would be county or

1 metro departments of health would be the
2 military treatment facilities.

3 Here's our mission. I'll give you
4 a second to read over that. And I have in
5 italics here, to me the most important words,
6 "The work that we do is relevant, timely,
7 actionable and comprehensive for the DoD."

8 Our vision is to be the central
9 epidemiologic resource for the US Armed Forces
10 and the Military Health System.

11 A couple of things to point out
12 here. Just in some venues I need to go into
13 detail here, but I'll just mention that we do
14 not do direct installation surveillance
15 support. We do strategic level, DoD level
16 surveillance.

17 So, epidemiology, for those who
18 need a reminder or a refresh is the study of
19 the distribution and determinants of health-
20 related states or events in specified
21 populations and the application of this study
22 to control diseases and other health problems.

1 Public health surveillance is a
2 part of, or is sort of a subgroup under
3 epidemiology. It's the ongoing, systematic
4 collection, analysis, interpretation and
5 reporting of health-related data. I'll
6 emphasize again, it's a defined population.
7 And then timely dissemination and public
8 health action to prevent, treat or control
9 disease and injury.

10 There's a difference between --
11 even though a lot of what we do looks like
12 research, the big "R," there is a difference
13 between public health practice and research.
14 What we do is primarily public health
15 practice, where the primary intent is to
16 prevent or control disease or injury and
17 improve health.

18 Okay. The benefit is to the
19 population from which the data are collected.
20 It's a little different from research whose
21 primary intent is to generate or contribute to
22 generalizable knowledge.

1 The reason this is important in
2 our setting is because if it is specifically
3 public health practice, we have a lot -- we
4 can respond a lot more quickly than if it's a
5 research project where we need to go through
6 a different process.

7 So here's our structure. You may
8 have been told that Captain Russell was
9 coming. He is the Director of the AFHSC,
10 unable to come today, but really the person
11 who needs to be here the most is Dr. Clark,
12 who is sitting right here, and I think she's
13 going to be touching on the topic that's
14 probably most of interest to you.

15 These are the four divisions.
16 Right here is my division. So, I'm going to
17 touch on each of the divisions very briefly.

18 The Communications Standards and
19 Training Division puts up our website and
20 keeps it current, and I encourage everybody to
21 take a look at it. There's lots of good
22 information there as well as links.

1 We put out the Medical
2 Surveillance Monthly Report, of which Dr.
3 Clark is the contributing editor. She is a
4 senior epidemiologist. This is what it looks
5 like. It's available online and only this
6 current version, which I was going to bring
7 and neglected to, is a beautiful, glossy,
8 color journal.

9 It is now listed in ProMED -- or
10 in MEDLINE, indexed in MEDLINE. It's peer-
11 reviewed, and that's a relatively new thing,
12 too. So, I encourage you to take a look at
13 that. Again, that's on our website.

14 We also have preventive medicine
15 and occupational medicine residents who rotate
16 through our organization to learn as much as
17 they can in one month to six weeks about
18 military epidemiology and surveillance.

19 The GEIS Operations Division
20 consists of several pillars. If you'll
21 remember from the -- what GEIS stands for,
22 it's epidemiologic -- sorry. It's infectious

1 disease-focused, and the pillars. These
2 buttons are very close to one another, so --

3 The pillars are respiratory
4 infection, gastrointestinal infection, febrile
5 and vector-borne disease, antimicrobial
6 resistance and sexually transmitted
7 infections. So they -- they have a much more
8 global focus than the rest of AFHSC, and they
9 are typically focusing on emerging or
10 reemerging infectious diseases.

11 There are some of the sites where
12 we have partners or laboratories throughout
13 the world. Those don't all belong to us, by
14 the way. Most of them are supported by us.

15 And they have quite a large budget
16 to distribute to these laboratories, which I
17 just mentioned, and all sorts of various other
18 projects.

19 The third division I'm going to
20 talk about is DMTS or Data Management. They
21 basically maintain the three main resources
22 that we use in our analyses which you'll hear

1 about in a minute. It's a longitudinal
2 database with over one and a half billion
3 records.

4 You can see where -- where they
5 are from. Some from MEPS, personnel data, HIV
6 test results, hospitalizations, ambulatory
7 data, all of these things, and they give us
8 quite a complete picture of the active force
9 and somewhat of a picture of the Reserve and
10 Guard components.

11 We also do have data on family
12 members and other dependents, but it's
13 limited. Those data are limited,
14 unfortunately.

15 So one of the things that they do
16 is maintain a web-based database that can be
17 accessed by people who have permission, and
18 most people with a .mil address can get
19 permission to do your own kind of quick looks,
20 and you can vary the population -- the
21 population and you can look at
22 hospitalizations, break out ambulatory.

1 We also have reportable events, et
2 cetera. So, that's a nice resource for people
3 who are doing epidemiology or trying to look
4 at surveillance.

5 We also maintain the largest serum
6 repository in the world, which is really the
7 envy of many different organizations who would
8 like to have access to these -- something like
9 this, because it's longitudinal.

10 That is, we have serum specimens
11 on all active duty folks from when they came
12 in, or even before they came into the military
13 at the MEP stations, all through their whole
14 military career, and we can use those sera to
15 examine many different issues where a marker
16 might appear or antibodies or whatever might
17 appear in the serum.

18 So that's a wonderful resource and
19 it's somewhat underutilized. So, we encourage
20 people to think about ways they could use that
21 resource.

22 And finally, my division.

1 Obviously, I didn't go in order because I want
2 to focus a little bit more on my division
3 before I turn it over to Dr. Clark.

4 These are the kinds of products
5 that we produce. Again, it's DoD-wide
6 operational surveillance analysis, and these
7 analyses constitute support for a variety of
8 different inquiries, and also for analyses for
9 things like the MSMR articles. That's the
10 Medical Surveillance Monthly Reports. And
11 resident projects and other such lower-level
12 analyses than these.

13 We also do some special studies,
14 which is basically using the serum repository
15 and some research support.

16 We put out over about 1500 focused
17 periodic reports. They are more or less
18 automated. Obviously, each time we put one
19 out we go over it carefully, but once they've
20 been developed, which is the hard part, they
21 go out on a periodic basis from weekly to
22 annually.

1 I think we may have one or two
2 that are -- I think annually is the most --
3 least common, least often.

4 These are our customers, some of
5 our customers. We have others as well. An
6 example of a serum study, I just put one in
7 here so you can see. This was looking for
8 antibodies to hantavirus.

9 This is rather -- this was done
10 quite a while ago, but I'd like it as an
11 example, because I could get some pretty
12 pictures. But it's very interesting. The
13 military personnel from that part of the world
14 or that part of the country that has a high
15 exposure possibility to hantavirus and to see
16 how many of them have actually been exposed,
17 as opposed to those who actually came down
18 with the disease.

19 An example of how all the parts of
20 AFHSC work together is the response to the
21 H1N1 influenza, and I'll just -- I'll just
22 touch on this because I want to get onto the

1 report that you're most interested in, I
2 think.

3 The first four cases of pandemic
4 H1N1 were detected in two of our funded
5 laboratories, and three of the DoD H1N1
6 strains were used by the World Health
7 Organization as potential seed strains, and
8 on. All these things were coordinated through
9 AFHSC.

10 There are, again, are some of the
11 international laboratory capabilities. We put
12 out regular reports during that time, and
13 actually, we put out regular reports all
14 throughout the influenza season.

15 So, those are the attributes
16 combined under one roof, laboratory network,
17 reportable medical events, conference call
18 coordination and daily and weekly reporting
19 for chain of command. Keep in mind, this is
20 just one example of many.

21 And now onto the part that Dr.
22 Clark is going to talk about, the effect of

1 repeated deployments from the MSMR, stating
2 from the MSMR.

3 DR. CLARK: Thanks, Captain
4 Ludwig.

5 I appreciate the opportunity to be
6 here and discuss this particular MSMR
7 analysis. I want to expand a little bit on
8 what Captain Ludwig said. I don't know how
9 many people in the room are familiar with the
10 MSMR or read it on a regular basis.

11 Anybody familiar with it? Okay.
12 That's good. That's good to know.

13 A little bit of background. This
14 publication has been in print, and you can
15 access 15 years of issues that have been
16 coming out on a monthly basis.

17 So, it was started by Dr. John
18 Brundage, a preventive medicine physician who
19 was with the Army. So, that gives you, I
20 think, some idea of the -- you know, there is
21 a preventive medicine component to all the
22 sorts of analyses that we undertake, the idea

1 being we want to identify problems in the
2 active component, Reserve, and Guard force and
3 hopefully, in our editorial comment, sort of
4 present the issues and challenges with
5 whatever medical issue we're looking at, and
6 some ways that we can deal with it.

7 So, our repeated deployment -- and
8 I believe you guys have gotten a copy of the
9 sort of first overview article. So, this is
10 an issue. As you all know, because of the
11 continued involvement in Iraq and Afghanistan,
12 this is the longest ground war the United
13 States military has ever been involved in.

14 There have been a number of
15 concerns that suicide risk and mental health
16 disorders, specifically, are increasing with
17 the increasing number of combat deployments.

18 There have been a number of
19 studies done in the United States. There's
20 actually also a fairly significant body of
21 literature done in Great Britain looking at
22 some of these issues.

1 Some are showing an increase in
2 PTSD, depression, and other mental health
3 issues and repeat deployers. Other studies
4 are not finding the same sort of effect.

5 One of the reasons for this is the
6 -- what we call the healthy deployer effect in
7 occupational groups. It's more generally
8 known as a healthy worker effect, the idea
9 being that when you come into the military --
10 so we're screening people, to begin with, that
11 come into the military for sort of physical
12 and mental health.

13 There are lots of conditions that
14 will exclude you from military service. And,
15 in addition, when you deploy, you again, are
16 going through a specific screening to
17 determine if you're healthy enough to deploy.

18 So, what we find, oftentimes, when
19 we look for any sort of health condition in
20 deployers, is that they seem much healthier
21 than the comparison population that we usually
22 look at, which are nondeployers that are

1 CONUS-based. And so that's the healthy
2 deployer effect.

3 So we can see this, and we've
4 actually been figuring out how to do this
5 analysis for about a year now. It's a pretty
6 large topic, and we've done quite a bit of
7 analysis, really too much to put in one
8 article.

9 So the first article and the one
10 that you guys have had access to is the
11 overview, and I'm going to kind of very
12 briefly go over the general method, so the way
13 that we looked at this issue, and sort of the
14 overall excessive conditions -- and I'll sort
15 of explain how we define "excessive
16 conditions."

17 But again, this is sort of the
18 first introduction. So, the purpose of the
19 first article was to acquaint people with the
20 methodology that we used, to look very
21 generally by gender at conditions that we were
22 seeing that were excessive in people that had

1 been repeat deployers as opposed to the first
2 deployment.

3 And that's actually an important,
4 I think that's a very important methodologic
5 issue. We didn't look a deployment itself as
6 a potential risk factor for some of these
7 outcomes.

8 We were very interested in
9 actually trying to tease out the effect of
10 repeated deployments, so people that had
11 deployed multiple times, and for that reason
12 we used people that had deployed once as the
13 comparison group. So that, I think, is
14 helpful when you are looking at our -- at our
15 results.

16 So this is just some sort of basic
17 demographics about the repeated deployments.
18 We have about -- there were about 1.35 million
19 deployers. About 40 percent had deployed at
20 least twice, and you can see the rest of the
21 percentages breakdown there.

22 Again, I won't bore you with the

1 details of going through the demographics
2 here, but these are just the demographic
3 breakdowns by military and demographic
4 characteristics after each deployment period.

5 We went out -- there are certainly
6 lots of people that have deployed even more
7 than five times, but we truncated it at five
8 and I'll kind of explain why that is, as we
9 move forward.

10 This is, again, just sort of a
11 very overall graphic that demonstrates
12 hospitalization rates and ambulatory rates,
13 any visit.

14 So, -- and I'll pause here to say,
15 and I know you guys have familiarized
16 yourselves with the analysis, but -- and I
17 think Captain Ludwig sort of briefly touched
18 on the source of our data. So, we're very
19 fortunate in our Defense Medical Surveillance
20 System to have a database that essentially
21 captures all medical care for active component
22 members.

1 And I will say that's another
2 important point here, not because we do not
3 think Reserve and Guard members are important,
4 but we don't have the same sort of capture on
5 our Reserve and Guard members as we do of
6 active component.

7 So, that's one of the reasons we
8 restricted to looking at active component.
9 And we are essentially looking at medical
10 encounters, so we are scanning the medical
11 records of deployers to see what physician has
12 diagnosed them with, and we are looking at the
13 first listed diagnosis, so the primary
14 diagnostic position. If you would move
15 forward.

16 And, in general, again, for this
17 sort of brief overview issue and the point of
18 it was to see if we could tease out what we're
19 considering excessive conditions.

20 And what we saw was that
21 essentially, in repeated deployers, their
22 medical experience in the year following a

1 return from deployment, so that was the
2 surveillance period. We would look for
3 people. We would surveil for a year after
4 they returned from deployment.

5 Many people don't have dwell times
6 of a year, so we incorporated that into the
7 analysis, but we were intrigued to find that
8 repeat and first-time deployers, overall, were
9 affected by many of the -- many similar
10 conditions.

11 There's a significant overlap
12 among conditions that were most excessive in
13 each repeat deployer cohort, and a lot of
14 things that we were seeing were related to age
15 and sort of unhealthy behaviors.

16 And so, for example, and if you --
17 I believe you guys have had access to the
18 table, things like hypertension and
19 hyperlipidemia and sleep disorders come up in
20 terms of the top 20 conditions that were
21 excessive among repeat, rather than first-time
22 deployers.

1 So, I actually -- you can go to
2 the next slide. We're making a concerted
3 effort in the MSMR and our analysis to
4 separate out gender because we feel that we
5 need to pay as much attention to the female
6 deployers' issues and female members of the
7 active component, and oftentimes the health
8 conditions that affect the genders are very
9 different.

10 But in this -- again, in the
11 overview, when we're looking for most
12 excessive conditions, they were very similar
13 and there was lots of overlap.

14 So, for men, for example, other
15 and unspecified disorders of the joint, that
16 would be sort of your standard musculoskeletal
17 issues, knee problems. Back problems are
18 something that, again, very frequently popped
19 up.

20 And for women, this disorders of
21 refraction and accommodation, that essentially
22 is standard -- you know, we're all getting

1 older, standard eye issues. You know, we're
2 starting to have myopia or needing glasses.

3 But again, you've got the overlap
4 of other and unspecified disorders of the
5 joints, and acute URIs, which again, that's
6 sort of just a common condition overall in our
7 population.

8 So before I want -- I'm going to
9 lead this slide up, but I kind of want to give
10 you a preview of sort of this second part of
11 the analysis that we've done because that --
12 that isn't in press yet but I will tell you it
13 will be available online. It should go online
14 on Wednesday.

15 That is -- so, again, we wanted to
16 present sort of the overall excessive
17 conditions, to begin with, but then we're
18 doing a lot of subanalyses, looking at
19 specific conditions and specific types of
20 diagnoses and, because mental health disorders
21 are of probably paramount concern to most
22 people, that's the next analysis that's

1 upcoming.

2 And I can't -- that's actually
3 technically embargoed, but I will give you a
4 little bit of a preview in terms of things
5 that we saw that I think are instructive and
6 in some ways may promote additional research
7 to tease out what we're seeing.

8 And I know -- I'm sure you guys
9 have a lot of questions, and I want to leave
10 time for questions. And because this is an
11 issue that I know all of you have been
12 thinking about for quite some time, I'd be
13 very interested to hear your thoughts and
14 additional analyses that you think would be of
15 use in sort of teasing out this issue.

16 So what we've found, you know,
17 very briefly, in terms of mental health
18 disorders, again, I want to be clear that
19 we're looking at diagnosed mental health
20 conditions, so that's an ICD-9 code that's
21 been assigned by a physician in a medical
22 record in the primary position.

1 In addition, we looked at some V
2 codes. There are a number of V codes that are
3 related to mental health. Suicide ideation is
4 something that we're seeing actually a fairly
5 significant increase in over the last couple
6 of years.

7 And last, we looked for sort of
8 counseling codes that were related to mental
9 health problems and conditions, but that did
10 not rise to the level of a diagnosis.

11 So, although the DoD has done a
12 great deal of work in trying to reduce stigma
13 for seeking help for mental health care, we
14 felt it was important to look at codes that
15 would be perhaps indicative of seeking sort of
16 mental health care without actually receiving
17 a mental health diagnosis.

18 Interestingly enough, as you would
19 expect, multiple deployments. You do see an
20 increase in, for example, PTSD in both
21 genders. Up until about the third deployment
22 -- and again, this is a preview, and I would

1 recommend that you guys go online and read the
2 entire article and the editorial comment, but
3 one of the most interesting things in the
4 analysis that we saw was that a number of
5 conditions we would see an increase from the
6 first to the third deployment, and then it
7 dropped pretty precipitously after that.

8 And we have a couple of theories
9 about why that is, but I'd be interested in
10 hearing what some of your thoughts about that
11 would be.

12 One, as we pointed out in our
13 original editorial comment, we do feel that a
14 lot of repeat deployers are people who
15 innately have resilience, for whatever reason
16 because, if they suffer a lot of issues after
17 a first and second deployment, either because
18 they won't be allowed to redeploy or they,
19 themselves, self-select out of the service, we
20 essentially have a selection bias for people
21 that have deployed multiple times.

22 One of the other interesting

1 findings in this upcoming analysis was we
2 looked at dwell times. We wanted to see what
3 dwell times had, what kind of impact that had
4 on increasing diagnoses after multiple
5 deployments.

6 The most interesting finding
7 there, although I -- when you think about it,
8 and I actually am -- I'm the wife of a retired
9 Navy officer, so I have, on the home front,
10 been involved with, you know, a family member
11 who's deployed multiple times.

12 We saw that actually the longer
13 the dwell time, the more likely you would have
14 a mental health disorder when you redeployed
15 in the year after your deployment.

16 That is actually in keeping with
17 some work that Charles Hoge has done, and this
18 theory has been -- well, I wouldn't say it's
19 a theory. It's an observation that's been
20 brought up by a number of people looking at
21 this issue.

22 And I think the thinking is that

1 when you have time, when you're at home and
2 you have time to sort of readjust and get back
3 into the rhythm of family life, it makes it
4 actually more difficult if you redeploy, if
5 you are sent back into theater, whereas people
6 who are on a slightly quicker rotation --
7 deployment schedule kind of never get out of
8 that battle mind, never get out of that mind
9 set that they --

10 MG STONE: Dr. Clark, are you
11 talking about the MHAT study?

12 DR. CLARK: We actually reference
13 the MHAT study and, yes.

14 MG STONE: Okay. I'm not sure
15 you're quoting Dr. Hoge's work correctly.

16 DR. CLARK: I actually am quoting
17 not his published literature, but his -- the
18 book that he's written looking at this issue.
19 So --

20 MG STONE: Actually, the
21 utilization of, in the Army, from the seven
22 MHAT studies show that the incidence of

1 utilization of behavioral health services goes
2 up quite dramatically in the second six months
3 through 24 to 27 months.

4 DR. CLARK: Right.

5 MG STONE: At 27 months it goes
6 back to garrison level in the nondeployed
7 state. How do I correlate that to what you
8 just said?

9 DR. CLARK: Well, what you have to
10 understand about Charles Hoge work is that --
11 Charles Hoge's work is that in a lot of
12 instances he's looking at a subset of this
13 population.

14 So, we, fortunately, have the
15 luxury of looking across all services and all
16 deployments. Charles Hoge generally
17 restricted to looking at the Army and
18 oftentimes combat -- combat troops.

19 MG STONE: So his work looked at
20 both Army and Marine Corps. So, to my
21 recollection --

22 DR. CLARK: Some of his work did,

1 yes. He's done lots of studies.

2 MG STONE: My recollection is
3 still ground war. That's how you started this
4 platform.

5 DR. CLARK: Right.

6 MG STONE: So, the vast majority
7 of deployments certainly relate to contact
8 experiences, combat experiences of the Army
9 and the Marine Corps.

10 DR. CLARK: Are you saying you
11 think many deployments relate to -- because
12 there's a number of people, as you know, that
13 deploy that don't see combat experience, and
14 so -- but to address your point with regard to
15 combat troops, that's another analysis we did.

16 We looked specifically at
17 occupational categories. So, -- and again,
18 the results that I was explaining to you dealt
19 with all occupational groups, all deployments,
20 all services across the entire time point.

21 You definitely do see, again,
22 increased mental health concerns in combat

1 troops as compared to logistics people or
2 intelligence people.

3 But actually, I'm glad you brought
4 that point up. Although we saw this actually
5 in a mental health survey we did over ten
6 years for all DoD without considering
7 deployment, we saw that health workers, so
8 physicians and people dealing with health care
9 also had actually very high rates of PTSD and
10 we are seeing that in this analysis as well.

11 I'm not arguing your point, and
12 I'm not saying that I disagree with Dr. Hoge's
13 work --

14 MG STONE: So, let me ask you a
15 couple of questions. First of all, are there
16 any historical models of the utilization of
17 the military on a rotational basis such as
18 American has embarked upon with its military
19 here?

20 DR. CLARK: No. We've -- and, as
21 you know, we've not ever been in a ground war
22 of this type, and we also have not had the

1 ability to survey --

2 MG STONE: So there are no models
3 by which people rotated in and out of combat
4 on an organized basis. This is a unique way
5 of using a military.

6 DR. CLARK: That's correct.

7 MG STONE: Okay.

8 DR. CLARK: I would agree.

9 MG STONE: The second question is,
10 with this research, how do you connect to make
11 this knowledge useable to the services of the
12 Department of Defense?

13 DR. CLARK: Well, it's
14 interesting, because the first point I would
15 make is that we don't see this as research.
16 We actually see this as surveillance.

17 So, from our perspective, we are
18 presenting the experience, again, across DoD-
19 wide, broken down in a number of
20 subcategories, what we're seeing in terms of
21 actual diagnoses.

22 MG STONE: Okay. So how -- once

1 this surveillance is done, how is that body of
2 knowledge transferred to the decisionmakers
3 that would allow us to make decisions on how
4 we're utilizing this force?

5 DR. CLARK: Well, although you're
6 not -- I don't know that you're familiar with
7 the MSMR. That's actually one of the primary
8 ways that we disseminate a lot of the major
9 surveillance efforts that we take.

10 In addition, we are always willing
11 to send -- and I will tell you, that what will
12 occur after this article appears in press is,
13 we will get lots of queries from policymakers
14 in DoD as well as the media, and we'll be able
15 to provide additional analysis to
16 policymakers.

17 But, what I would say from the
18 purpose of, you know, a policymaker, why would
19 this be used for information? Well, it
20 actually, in many ways, reemphasizes things
21 that smaller studies in subsets of the
22 population have seen.

1 So, I think replication is
2 important. I think it's teased out some
3 things that have not been seen because, to my
4 knowledge, no one's ever done this sort of
5 analysis where they've been able to look
6 throughout the course of the conflict at
7 conditions that people may be experiencing
8 after repeated deployments.

9 So, again, as I said, I don't know
10 that anyone, for example, has seen or
11 demonstrated that after -- after a third
12 deployment on a population-wide level you
13 actually see a decrease in mental health
14 diagnoses.

15 I don't know that there's actually
16 a full appreciation of the fact that other --
17 in addition to combat troops there are other
18 occupational groups that may be also at great
19 risk of having a postdeployment mental health
20 diagnosis.

21 So I think it gives you
22 potentially additional information on areas

1 where you might want to focus increased
2 efforts to provide care and provide
3 intervention for people in the same way that
4 the DoD is doing now.

5 CAPT LUDWIG: General, is your
6 question sort of a general one about what
7 surveillance -- what is surveillance used for?

8 MG STONE: I think the frustration
9 with the line is how long it takes us in
10 medical knowledge, in public health knowledge,
11 to transfer that knowledge into useable stuff,
12 into useable actions.

13 And what I'm most interested in is
14 when you create very good things like this, is
15 it a matter of you've approached this data the
16 same way every other academic journal does,
17 that somewhere between seven and ten years
18 from now the academics will decided to move
19 this data onto useable information?

20 How does DoD connect to you? Who
21 is the accountable agent to look at your stuff
22 and say "This is really good. Let's take some

1 action to change the way we're working."

2 CAPT LUDWIG: I would refer you
3 back -- if there were an easy way, I'd do it,
4 to -- I can't -- I'll just say to our
5 customers.

6 So, since we fall under Health
7 Affairs, they would be our first -- probably
8 our first customer, and they regularly look at
9 our results and also make many, many requests
10 of us to look at various things.

11 The MSMR, itself, is a vehicle
12 that we use much as the CDC uses their monthly
13 -- let's see, the --

14 DR. CLARK: The MMWR.

15 CAPT LUDWIG: -- MMWR, Medical
16 Surveillance Weekly Report, something like
17 that.

18 And that is just to get the
19 information out there so that the people who
20 help collect the data can see where -- what
21 we're learning from those collections of data,
22 but also so that people in policymaking

1 positions have it available to support, you
2 know, their policymaking.

3 DR. CLARK: I think your point is
4 a good one, and I think that it's something
5 that I hear from -- again, you know, I think
6 the operational perspective, I think it is
7 very frustrating sometimes because you don't
8 get the information you feel is useful to you.

9 And I would say that you can be
10 the customer. You know, so, again, oftentimes
11 what happens is, an analysis like this comes
12 out, and we get a number of queries from, you
13 know, from Health Affairs, from sometimes
14 congressional staffers, sometimes -- you know,
15 a specific, the Army OTSG or the Surgeon
16 General of another service, because they want
17 to look at it with a little bit of a tweak, or
18 they want additional analysis, or they want
19 the numbers behind a graph that we didn't
20 provide.

21 The MSMR is one of the principal
22 ways that we -- because no one asked for this.

1 So, as Captain Ludwig pointed out, you know,
2 the AFHSC, as a general institution is --
3 provides surveillance for DoD, and so we do
4 actually respond to numerous, in some cases,
5 you know, over 600 queries a year from people
6 in the field, a lot of them are operational,
7 questions like this.

8 But I will say that, on the
9 operational side, you know, we usually don't
10 get that sort of highly or refined question in
11 terms of, you know, the study that we're
12 doing.

13 So what we try to do in the MSMR
14 is look at things that are militarily relevant
15 and timely and to us, again, we're sort of --
16 this is the first way to push this analysis
17 out, but it doesn't mean that you can't
18 contact AFHSC or a member of your staff can't
19 contact AFHSC and ask for an additional brief
20 or --

21 And, honestly, that's one of the
22 ways that a lot of our work gets -- gets

1 disseminated to sort of higher-level
2 policymakers, or we -- we do a lot of briefs,
3 and we do a lot of ad hoc analyses.

4 CAPT LUDWIG: I would also refer
5 you to the slide that shows our scope of
6 responsibility. You probably don't want to
7 hear this, but our job is to get the
8 information out there so that others who are
9 in a position to effect policy change and
10 change the way things are done will have
11 information to use to support those decisions.

12 So, we're not really -- I mean,
13 we're not at all an operational -- in actual
14 operational entity, in that -- I have to be
15 careful about how I say that because we focus
16 on operational concerns, but we don't
17 operationalize them.

18 MG STONE: So, is there a
19 formalized venue by which you communicate to
20 the Public Health Commands of the services?

21 CAPT LUDWIG: There are several,
22 actually. We fall under the Force Health

1 Protection and Implementation Council. They
2 just added the "I," so I think that's what it
3 is, Implementation Council.

4 And that's made up of the Deputy
5 Surgeons General. We also report to --
6 regularly to Health Affairs, Dr. Taylor and
7 Dr. Woodson, and -- let's see, what else.

8 We provide regular -- some of
9 those regular reports that I mentioned goes
10 straight to Health Affairs and to the
11 services. Many of those 1500 regular periodic
12 reports go to various people in various
13 organizations, including the Surgeons General
14 or the Public Health Commands of each service
15 and so on.

16 DR. CLARK: Do you have a
17 suggestion about -- like, I would love to hear
18 if you have some ideas about how we might
19 disseminate this in a more widespread manner.

20 MG STONE: I think you have Public
21 Health Commands that are the tactical arm of
22 the research work that you do.

1 DR. CLARK: Yes.

2 MG STONE: I think a formalized
3 method by which you communicate directly with
4 them, not in a committee meeting with a bunch
5 of people like me, but with people doing real
6 work is how you get to this.

7 I'm interested that we've had our
8 first death from rabies in a 10-year war, but
9 yet that didn't make the list up here. Okay.
10 So, when I say that, I know the public health
11 response that has occurred as part of that
12 that's gotten very substantial interest.

13 And I'd just like to know that
14 we're all talking to each other in an
15 effective manner.

16 DR. CLARK: Yes, we do -- we
17 actually interact with the Public Health
18 Command very frequently on an individual
19 bases, and I will say that, for example, we've
20 been very involved in the rabies response and
21 I'm sure you know that -- that that has
22 engendered quite a lot of concern.

1 The reason that a rabies death
2 doesn't show up in this analysis is because
3 it's one -- it's one case. And so, again, on
4 an individual basis, that's tremendously
5 important, and any death is important.

6 But when you're looking at
7 something populationwide, that -- that's just
8 not -- that's not going to make the top 20
9 list. So --

10 MG STONE: So the 7,000 soldiers
11 and marines at risk did not make the list with
12 bites that we didn't surveil for properly?
13 I'm not sure that -- I don't want you to
14 concentrate on the death, as extraordinary a
15 tragedy as that was, but it brings up a public
16 health issue.

17 The question is: How do we, as a
18 DoD, get after public health issues and are we
19 effectively communicating with each other?

20 CAPT LUDWIG: We -- as I -- as I
21 mentioned in the example using influenza, we
22 coordinate telephone calls and conference

1 calls and also actual face-to-face meetings
2 with interested -- you know, various
3 interested parties.

4 We don't always -- and sometimes
5 we don't coordinate them, but we take part in
6 them, and the rabies is a very good example.
7 We were involved in that very early on. And
8 the other thing to remember is that this list,
9 all of this was done before the rabies case
10 even came to our attention.

11 So, you know, an outbreak, if you
12 will, an epidemic, is defined as something
13 that -- an illness or something, injury or
14 illness that occurs at a greater than expected
15 rate among a certain population.

16 So, in a sense, that rabies case
17 is an epidemic and definitely spurs public
18 health activity. And we have -- we have been
19 involved where we can -- your point, though,
20 is perfect, is that the service public health
21 hubs are the operational arm of public health
22 surveillance and they do their own

1 surveillance in slightly different focuses,
2 mostly service-specific, where ours is DoD-
3 wide, but we do work with them on that.

4 I wish we -- I could say that we
5 could go out and make it all happen.

6 DR. CLARK: But I think, you know,
7 if we want to go back to the rabies, one of
8 the ways we cooperate with the Public Health
9 Commands, especially with that particular
10 issue is that, as you may or may not be aware,
11 one of the -- from the Public Health Command
12 perspective they were very interested, once
13 this case occurred, in doing sort of active
14 case finding.

15 People who potentially had an
16 exposure that they wanted to sort of double
17 check and make sure the appropriate medical
18 treatment was provided or if there was any
19 risk to those people, so to that end, they
20 contacted us to survey -- because we do have
21 ability -- so in addition to medical
22 encounters we also are the DoD central

1 repository for postdeployment forms.

2 And so, as you know, one of the
3 questions on the postdeployment forms is
4 specifically related to animal bites. So, we
5 provided both to Health Affairs of the DoD
6 level, but also to Army Public Health Command,
7 people who had recently redeployed who had
8 reported an exposure, an animal bite exposure
9 so that they could basically go out and do
10 active case finding, and that's sort of the
11 process that's ongoing right now.

12 So, maybe that gives you a little
13 bit better sense of how we cooperate with the
14 public health hubs.

15 MR. CONSTANTINE: Dr. Clark, you
16 were talking a little bit about deployments
17 and differences in deployments. The Marine
18 Corps on the chart has a lot less deploying
19 service members.

20 Obviously, we're seeing a lot more
21 kinetic action. But even within the Marine
22 Corps there are differences if you're on, say,

1 Fallujah as opposed to being out -- pushed out
2 there at the Iraq.

3 And it's no surprise to me that
4 medical personnel are having a lot of PCSes,
5 they are seeing all these -- these injuries.

6 How do you account for that in
7 your deductions and your analyses of how -- in
8 the background when you send the logistics
9 personnel, they don't see action, but in fact,
10 they can be running convoys and be exposed to
11 stuff, too.

12 So, how do you -- when you get
13 down to the nitty-gritty, how do you account
14 for those?

15 DR. CLARK: Yes. That's a good
16 point, and actually that's something we know
17 about -- so anytime we look at occupational
18 group, we're relying on DoD POC, and we know
19 that people -- so, for example, there are --
20 that's an occupational code, and people in
21 combat professions and armor and transport and
22 intel, they all have a specific DoD POC.

1 The problem is you put -- put very
2 well is that, once you get into theater, kind
3 of all bets are off. So, by subgrouping the
4 analysis by DoD POC is not going to get at
5 that issue.

6 There's just no way to find out
7 what people do on a daily basis, and that's
8 really what we would need to do, is have some
9 sort of sense of what each individual exposure
10 was in theater with regard to combat
11 exposures.

12 But one -- so we didn't do that in
13 this analysis. We have looked at it in the
14 way we do try to incorporate it again -- and
15 again, to reference Dr. Hoge, because I think
16 he's done quite a bit of work in this area, we
17 rely on the forms.

18 And so, regardless of your
19 occupation, there are a number of questions on
20 the form that talk about engagement with the
21 enemy. "Have you seen battle? Did someone
22 die? Did you see civilians killed?"

1 And so, we use that oftentimes as
2 sort of an exposure for combat or -- or
3 traumatic events that you may have experienced
4 in theater.

5 Dr. Hoge has the luxury, when you
6 do things with a little bit of a smaller
7 population, or a very defined population, he's
8 had the ability also to administer additional
9 tools, because he does a lot of prospective
10 research, he's not -- you know, we are sort of
11 relying on data that's collected, not even
12 really for surveillance purposes. So, he's
13 allowed to ask a lot more detail and get a lot
14 more detail on that.

15 So, I hope that addresses your
16 issue a little bit. It's --

17 MR. CONSTANTINE: It does. It's
18 just -- you know, decisions are going to be
19 made by, okay, well, this group went on three
20 or four -- they've done three deployments and
21 here's where the level of mental health is,
22 when they could have gone to a nice, safe

1 place in Iraq or Afghanistan or a horrible
2 place.

3 DR. CLARK: Right.

4 MR. CONSTANTINE: And we don't
5 know that. And so, I guess -- I don't have a
6 point. It's a frustrating part of the
7 research that --

8 DR. CLARK: You're pointing out
9 something that I think, oftentimes with
10 medical research, population research versus
11 like individual providers, is we can't -- so,
12 again, we're doing surveillance on a
13 population level here and, you're right.
14 There's a lot of nuances at the individual
15 level that we're -- we can tease out.

16 And so, as Captain Ludwig pointed
17 out, one of the -- actually, one of the things
18 we try to do -- again, we do things on a
19 population level and hopefully someone out in
20 the community, whether it's at a hub or
21 someone that has the ability to really dive
22 in, they may have other data resources that we

1 don't have available to us, can further our
2 work.

3 I mean, that's -- that's a lot of
4 what we do is, we sort of take the first stab
5 at things on a population level, hopefully
6 bring up things that may be of interest or may
7 generate some hypotheses or ideas, and someone
8 else, well, will kind of take that further
9 because -- and oftentimes it is at the public
10 health hub or Navy Health Research Center out
11 in San Diego. They have a deployment health
12 center out there.

13 MR. CONSTANTINE: Thank you.

14 MG STONE: Any other questions?

15 Dr. Clark, Captain Ludwig, let me
16 just say one thing. Captain Ludwig, I'm the
17 senior medical person for Personnel Policy for
18 the Army Medical Department.

19 Every once in a while I get a
20 request to transfer people out of the Army
21 into the Public Health Service. I often
22 wonder, as I'm signing those, what happens to

1 those people. It's nice to know that they end
2 up assigned back to the Department of Defense
3 doing great work.

4 And, as tough as I've been on you
5 today, please understand you're doing great
6 work.

7 CAPT LUDWIG: Thank you.

8 MG STONE: Our concern, as a
9 committee, is are we connecting this to
10 actionable stuff. And so, I appreciate the
11 fact that you took this barrage in a very
12 professional manner. Thank you.

13 CAPT LUDWIG: Oh, you're welcome.
14 I hope that we've piqued some interest and
15 that we are able to collaborate and contribute
16 what we can to this effort in the future.

17 I know that we will, but if we can
18 hear from some of you folks, if you have
19 thoughts, ideas, whatever, please communicate
20 them.

21 MG STONE: With that, we'll take a
22 15-minute break.

1 (Whereupon, the above-entitled
2 matter went off the record at 1:57 p.m. and
3 resumed at 2:14 p.m.)

4 MS. DAILEY: We're missing one of
5 our members. Lieutenant Colonel Keane is --
6 he's here. He hasn't -- we need to get him
7 back here. He's got -- we've got like two
8 minutes, but we can start off.

9 But I do want to preface a couple
10 of these next two briefings, ladies and
11 gentlemen. What we hoped to achieve by
12 bringing in organizations that are addressing
13 soldier, sailor, airmen, marines, and a lot of
14 the things we hoped to find with these
15 organizations is what's happening after the
16 DD-214?

17 This is kind of -- helps us with
18 the outcomes and the effectiveness of our
19 programs. Congress wants us to assess the
20 effectiveness. Our ability to reach across
21 the DD-214 is somewhat limited, although we're
22 trying.

1 These organizations can talk to us
2 about what they're seeing in service members
3 and family members after they've left the
4 military.

5 That helps you assess the
6 effectiveness of programs preparing them to
7 leave the military, and it helps you look at
8 what's working and what's not working before
9 the DD-214.

10 So, these types of organizations
11 are giving us an insight into post-DD-214
12 integration transition issues that we can kind
13 of back step to our own policies and improving
14 those so that they are better prepared to
15 cross the DD-214.

16 MG STONE: And with that
17 introduction we're now going to hear from Mrs.
18 Kimberly Munoz, Executive Director of the
19 Quality of Life Foundation and her
20 presentation is behind Tab F.

21 Welcome.

22 MS. MUNOZ: Thank you. I think

1 I'm going to have to use this for my voice to
2 project, but than you very much. I'm so
3 excited to be here.

4 Thank you to Suzanne and Denise
5 for taking the time to speak with me earlier
6 this quarter about what you're doing and thank
7 you to the Task Force for the work that you
8 all are doing. I'm sure that it's not always
9 the easiest thing to do, but very, very
10 important and a lot of hard work. So, thank
11 you for that. I have like 5,000 things here
12 to hold at once.

13 I am Kimberly Munoz with the
14 Quality of Life Foundation. A little bit of
15 background about me. My husband is a retired
16 Army guy. He served, I don't know, I think
17 like 28 years.

18 It was before I met him that he
19 was even -- began to serve, but we've been
20 married for 16 years and I've followed him
21 around for about ten of those while he was
22 active duty.

1 And so, I got to experience a lot
2 of that whole commander's wife, family
3 support, kind of a role, and I really, really
4 enjoyed it.

5 And when he retired, I wasn't
6 quite ready to be done working with military
7 families. So, I went to work for the Quality
8 of Life Foundation to continue working with
9 military families. But, in this particular
10 situation, military families whose service
11 member had been catastrophically wounded, ill
12 or injured.

13 The Quality of Life Foundation was
14 created, was incorporated in November of 2007
15 with a very broad mission, and that mission
16 was to increase the quality of life of those
17 folks who had been struck by misfortune or
18 were overcoming limiting barriers through no
19 fault of their own.

20 So, it's got a very broad mission,
21 but it was a very new organization in November
22 of 2007.

1 Their first initiative came about
2 at that time in February of 2008, and it was
3 the Wounded Warrior Family Care Project. So,
4 again, the Quality of Life Foundation has a
5 very broad mission. Our first initiative, and
6 so far our only initiative is the Wounded
7 Warrior Family Care Project.

8 And in that project, the catalyst
9 for that project was a chance meeting between
10 our founder, Mike Zeiders and the spouse of a
11 severely-injured Marine.

12 Mike Zeiders is also the president
13 of Zeiders Enterprises, which is a for-profit
14 company that runs a lot of military family
15 support. They do the staffing for Fleet and
16 Family Support Service Centers, Army Community
17 Centers, family support all across the nation,
18 all across the services.

19 So he was at a Fleet and Family
20 Support Center when he met this Marine's
21 spouse. And she was explaining to him the
22 challenges that she was facing after she had

1 spent many months at Walter Reed with her
2 husband who had been injured and had been left
3 with a traumatic brain injury.

4 She told the story of being at
5 Walter Reed for many months, leaving her
6 school-aged children behind with grandparents,
7 leaving her job behind, kind of leaving that
8 whole network of support to be there at her
9 husband's side, and then returning home to her
10 husband having to be discharged from the
11 military, having to move off of a military
12 installation and find accessible housing, and
13 just regroup their home life all fell on her
14 shoulders, getting her kids back to where they
15 needed to be academically, and just rebuilding
16 that life away from a military installation
17 for the first time -- I think they'd been
18 married 17 years.

19 So, for the first time in a long
20 time they had lived on the economy and not on
21 a military installation surrounded by their
22 comrades.

1 So, she shared with him the
2 challenges that she was facing, and that is
3 what became his -- his goal was, I want to
4 find out if this is just one person's
5 challenge or if this is similar across
6 families across the services and across the
7 country who are facing caregiving challenges.

8 So again, our population was very
9 narrow. It was those families who are going
10 to be doing a sustained level of care-giving
11 for a very long time.

12 So he laid out several goals, and
13 the first goal was we need to find out what
14 are the unique challenges that these families
15 face, what are the resources that they rely
16 upon to face those challenges and how well do
17 they help face those challenges, if there are
18 gaps between the resources and the needs for
19 this particular population of family, what are
20 those gaps, and if there are gaps, what are
21 the solutions to those gaps.

22 So, those were my goals. And I

1 spent about eight to nine months interviewing
2 family caregivers across the country, both via
3 anonymous surveys and word-of-mouth, through
4 referrals, through other case managers and
5 nonprofits, like Ruthie back there.

6 I spent the next several months
7 doing internet research on the kinds of
8 things, the studies that had already been
9 done, because there was a lot of attention
10 going on in 2008. It was after the Walter
11 Reed issue broke and, you know, the media was
12 all over it. There was the Dole-Shalala
13 Commission.

14 So, we reviewed all of the current
15 research that I could find on the internet.
16 At the time, many of you may recall, there was
17 a website called "America Supports You." This
18 was back in 2008, and it listed alphabetically
19 all of the nonprofits or many of the
20 nonprofits that existed to help with Wounded
21 Warrior families.

22 This was before the National

1 Resource Directory and before the Warrior
2 Gateway. It was clearly just an alphabetical
3 listing.

4 We researched every single
5 nonprofit that we could find that serviced
6 Wounded Warriors and their families to find
7 out who -- which -- what services do you
8 provide to what clientele and in what area.

9 Many of them were very specific.
10 "We only serve Army families," or "We only
11 serve explosive ordinance device families."
12 We had to find out who all is out there in
13 this world that is currently helping these
14 families.

15 We talked to every single military
16 service Wounded Warrior program. At the time
17 it was Air Force Palace HART. It's now called
18 Air Force Wounded Warrior Program.

19 There's the Army Wounded Warrior
20 Program, the Special Ops Care Coalition, the
21 Navy Safe Harbor and the US Marine Corps
22 Wounded Warrior Regiment.

1 We talked with all of them on the
2 military service side and found out what kinds
3 of things you do to help these families. We
4 talked to the VA Federal Recovery Coordinator
5 Program Director.

6 We talked to the VA OIF/OEF Care
7 Managers, everyone that we could think of that
8 had a hand in it. We wanted to know from them
9 what do you do and where do you see the gaps.
10 We didn't want to just assume from this one
11 exposure that we had had to this military
12 spouse that we knew the answer right away that
13 we needed to do.

14 Once we finished speaking to all
15 of these folks, we've had quite a few things
16 show up on our research. And one of it was
17 that, across the journey of recovery, from the
18 moment you get that phone call that your loved
19 one has been injured, to after you transition
20 home.

21 There was room for improvement
22 across that journey. There was a lot of

1 support, however, at the front end when
2 families were at the hospital. That's where
3 the system of support was the most robust.

4 And again, remember, this was in
5 2008, 2009 that we were conducting our
6 research. But there were literally hundreds
7 of organizations that came to the Walter Reed
8 at the time and now Bethesda and the other
9 military hospitals and VA hospitals across the
10 country, and they were there to provide their
11 support to the families.

12 The Government resources came in
13 with chaplain support and mental health
14 support, child care for the children who were
15 there with their other parent.

16 So there was a lot of family
17 support at the hospital. But what happened
18 was, when that family moved away from the
19 hospital, either to a Fisher House and they
20 continued with their outpatient treatment
21 nearby, or all the way home.

22 But, once that family left the

1 inpatient status, and it didn't matter whether
2 they were on one side or the other of the DD-
3 214, but when they left inpatient status,
4 that's when the responsibilities for that
5 family caregiver became the most and where the
6 system of support was the least robust.

7 So we put all of our findings in a
8 report that we published in April of 2009, and
9 it's on our website, and it's called The
10 Wounded Warrior Family Care Report.

11 And in that report we established
12 a model of support and we took the journey of
13 recovery from the moment that you're notified
14 until after you move home, and we split it
15 into five different phases; notification,
16 travel to bedside, inpatient, transitioned
17 outpatient, and then when you're transitioned
18 home.

19 In that model of support, for each
20 of those five stages, we would tell the story
21 of this Mrs. Jones who was a mother caregiver,
22 and we would explain, "Here's what happened

1 with Mr. and Mrs. Jones when they received the
2 phone call. Here are the supports that came
3 in to support this family during this stage
4 and, if we were kings for the day, here are
5 the supports that we would have had in place
6 for Mr. and Mrs. Jones." And we did that
7 through each five steps of that journey of
8 recovery.

9 Then, we didn't take it upon
10 ourselves to say and, "You know, Government
11 Wounded Warrior Programs, you should do this
12 and Nonprofit A, B and C, you should do that.
13 We just laid out "Here's what should be done."

14 And when we distributed the report
15 we asked those to whom we distributed it to,
16 when you are working to support families of
17 catastrophically-injured, wounded or ill
18 service members, please consider this model of
19 support in whatever area that you're working,
20 and think about if you could incorporate this
21 model into what you're already doing.

22 We distributed that report to

1 everyone in the Department of Defense that we
2 had met during our research, as well as many
3 that we hadn't met. We went directly to the
4 Surgeon Generals. We went to General Cheek at
5 the time who was the -- I can't remember --
6 please forgive me, wherever you are, General
7 Cheek.

8 I forgot what his position was at
9 Warrior Transition Unit Brigade Commander, I
10 think.

11 We went to the Department of
12 Veterans Affairs to the Secretary of Veterans
13 Affairs, as well as his under secretaries. We
14 delivered our report to the Veterans Affairs
15 Committees on both the House and Senate sides
16 of Congress, and we sent our report out to all
17 the nonprofits that we had contacted
18 throughout our research.

19 There were hundreds of them. And
20 again, with the whole idea of saying "We've
21 looked at this for this particular set of
22 families. Please consider what we've found as

1 you deliver support to these families."

2 It was very well-received, and
3 probably the people that received it the best
4 that made the most impact on me was the family
5 caregivers who read it. Of course, we took
6 their input all along the way and they helped
7 us review it all along the way.

8 But, people who hadn't -- family
9 caregivers who hadn't been part of it that
10 then got ahold of it, you know, said to us,
11 "You told our story. You were our voice. You
12 know, you validated the experience that I went
13 through. Thank you so much." And that just
14 meant the world to us.

15 Other things that were important,
16 too, is we were invited to testify before a
17 subcommittee on disability compensation. We
18 were invited to testify or to give a brief to
19 the VA Advisory Committee on Disability
20 Compensation.

21 We were invited to provide a
22 presentation at a big March 2010 event with

1 the -- Challenge American put on. Again, an
2 other big forum where many, many holders,
3 many, many stakeholders in the Wounded Warrior
4 arena came together to talk about "Here's our
5 best practices. Here's how we can move
6 forward with these families."

7 Probably the most important thing,
8 though, that came out of our report is we
9 developed a program of support for these
10 families after they move home.

11 We developed that program with the
12 help of many people over two days in May of
13 2010. NMFA, Barb and Kathy were there at that
14 two days. Ruthie was there at that two days.
15 Some of her Visiting Nurses were there.
16 Operation Homefront, Wounded Warrior Project.
17 We had MOAA.

18 We had a representative from every
19 single military service Wounded Warrior
20 Program there. We had representation from the
21 Federal Recovery Coordinator Program there
22 and, of course, we had family caregivers

1 there.

2 And we took that two days to work
3 off-site near Quantico, Virginia, and said,
4 "We need to pick everyone's collective brain
5 here to figure out the best way to support
6 these families who are providing full-time
7 care to their veteran at home. What needs to
8 be in that program and how do we deliver it?"

9 And, over those two days we
10 developed a program that we now call The
11 Wounded Warrior Family Care Program.

12 And we rolled that out in May of
13 2010. So, again, just to reiterate, the
14 program is for those families who have moved
15 home and their veteran has been so
16 catastrophically-wounded or injured or become
17 ill that he or she will require a caregiver
18 for the rest of their life.

19 So, as you know, from what I've
20 already said is, from the moment these
21 families get this phone call, their whole
22 focus shifts to all about that veteran and

1 helping that veteran recover.

2 A lot of times they leave a lot of
3 things undone at home, especially families
4 with small children. After spending many,
5 many months at a bedside, at an inpatient
6 facility, they return home to take on a 24/7
7 care-giving role at home without the 24/7
8 backup of medical personnel at the hospital.

9 In addition to just the -- just
10 the emotional challenge of recognizing that,
11 gosh, all of our lives have been changed
12 forever, and this is what we are going to,
13 together, rebuild a new life with, there's
14 some very practical and logistical challenges
15 they face.

16 And that's where we're going to go
17 with this next. Certainly the first one is
18 when family caregivers give months, if not
19 years, at a bedside, at an inpatient facility.
20 They're going to lose their job.

21 For parent caregivers, while their
22 service member is still active duty, they are

1 also going to lose their health insurance and
2 other employer-sponsored benefits.

3 Spouse caregivers aren't going to
4 lose that because they have it through
5 TRICARE, but parent caregivers do lose their
6 health insurance when they lose their jobs.

7 Yes, sir.

8 MR. DRACH: And I was wondering,
9 in your research and in your experience, what
10 impact, if any, has the Family Medical Leave
11 Act had on these kinds of issues?

12 MS. MUNOZ: I'm sorry, the Family
13 --

14 MR. DRACH: The Family Medical
15 Leave Act, FMLA.

16 MS. MUNOZ: Yes. Well, you know,
17 I didn't have any specific family talk to me
18 about the Family Medical Leave Act, but
19 certainly they would have been able to go back
20 to their job if they didn't have the
21 caregiving responsibilities at home that would
22 keep them from doing that. I'm -- that's the

1 best answer I have for you. I apologize.

2 So, the next challenge that I have
3 here is just, again, once you spend -- you
4 know, many of you may be from dual-income
5 families yourself. If you thought about
6 spending 12 months, 24 months with one of you
7 not earning an income, whether it was the
8 larger or the lesser income doesn't matter,
9 but if you went that long without having that
10 income, you can imagine what kind of financial
11 condition you might wind up in.

12 So, sometimes these families wind
13 up draining their savings accounts, draining
14 their retirement accounts, again with parent
15 caregivers, to just meet existing financial
16 obligations that they had before the injury or
17 wound or illness occurred.

18 Certainly most of the families
19 that we help in our program, their veteran is
20 going to require home modifications. Many of
21 them will require home modifications that
22 exceed the cost that is allowed under the VA

1 Housing Modification Grant.

2 There are some times when homes
3 will be modified to meet the veteran's need,
4 and actually another family member's living
5 room and space will be taken away for that.

6 An example of that is, we had a
7 family of a Navy Corpsman with a traumatic
8 brain injury. He was one of three children
9 for this family. The two younger siblings of
10 this Navy Corpsman were still living at home.

11 They were in the junior and senior
12 levels of high school, and when they enlarged
13 his room and his bathroom to be large enough
14 to meet his needs, it took the siblings' room
15 away and the girls wound up living in the
16 garage for a while.

17 They were in Florida, so it was --
18 the climate was okay for that, but it still
19 wasn't ideal. And then, when the oldest
20 daughter went into college, mom and dad wound
21 up getting an apartment for their two -- so
22 their senior in high school and their freshman

1 in college to live in because there just
2 wasn't enough room in the home.

3 So oftentimes while the veteran's
4 needs may be met with this grant, the whole
5 family's needs are not considered for that
6 grant.

7 You know, of the families that we
8 help, most of them, their veteran requires
9 some level of skilled nursing care in the
10 home. And I would say 80 percent of the
11 families that we've had exposure to have not
12 been satisfied with the quality or the
13 quantity of home health care providers that
14 they've been able to get in their area.

15 Sometimes people just don't show
16 up. You know, veterans, especially who live
17 in a rural area, and it takes those home
18 health care providers a lot of time and gas to
19 even get to their house, and maybe for a
20 skilled nurse the prescription has only been
21 written for three hours a day.

22 That's a long -- that's a lot of

1 things for that home health care provider to
2 consider before they accept that job or they
3 do a long-term commitment to helping that
4 veteran's family.

5 Others have just been not the
6 right quality. You know, we've had families
7 who have told us that during the bathing, a
8 feeding tube has been pulled out because the
9 wrong quality of home health care provider has
10 been there.

11 I've had veterans tell me they had
12 home health care providers who stole from
13 them. Clearly, I don't want to paint a
14 horrible stereotypical picture of home health
15 care providers. I think there are some that
16 are very wonderful.

17 But I think that when you look at
18 the challenges that these families face,
19 something that we must be committed to
20 providing to them is quality and reliable home
21 health providers.

22 And I don't know exactly what the

1 answer is to that. I don't know how we
2 increase the supply of those providers or
3 increase the quality.

4 I have been told by the families
5 themselves that the providers tell them, "We
6 just don't earn a lot of money." So, it's
7 really -- unless they are just doing it
8 because they care -- and there are some of
9 them that do -- they're just not paid a very
10 high level that makes them want to stay with
11 sometimes very difficult jobs.

12 Continuing maintenance and rehab
13 therapy for the veteran at home. Just as in
14 any other insurance industry, there comes a
15 point where rehabilitative therapy is not
16 provided any longer.

17 If you're not going to continue to
18 make progress or improvement in your
19 condition, many insurance plans do not provide
20 rehab or maintenance rehab, or maybe it would
21 be called physical therapy at that point
22 instead of rehab, but they don't keep coming.

1 Here's an example. We have a
2 quadriplegic veteran in Richmond who worked
3 very hard to kind of regain as much movement
4 as he could in his upper body and then,
5 because he wasn't making any further
6 improvement, the VA stopped providing rehab
7 therapy for him.

8 He could do that in his home, but
9 he didn't really have any -- any equipment or
10 training to do that. So we helped that
11 veteran find a way to work with local
12 providers and get some rehab therapy in the
13 home.

14 He didn't -- he wanted to maintain
15 the tone that he had gained back through his
16 very regimented and intense exercise therapy
17 at -- while he was inpatient at the VA. He
18 didn't want to lose that. He didn't want that
19 to atrophy.

20 It was a neat story because he had
21 said -- he had tried this thing called an FES
22 cycle. I don't know if any of you have heard

1 of it, but it's an amazing piece of equipment
2 that uses electrical stimulation to make your
3 muscles contract and move your limbs when you
4 can no longer move them yourself.

5 And he had used this at the VA
6 hospital and he felt like it did a lot for
7 keeping his tone, keeping his cardiovascular
8 fitness up, keeping him limber, but it wasn't
9 something that was approved.

10 And we called the manufacturer.
11 We did a lot of research to figure out is this
12 something that's really good for the veteran,
13 because if it isn't really good for him, do we
14 really want to go to provide it for him.

15 So when we concluded that, yes, it
16 looks like it is good, and we're not medical
17 professionals, but all the research pointed us
18 in that direction, we got the name of his
19 spinal cord doctor at the VA Polytrauma in
20 Richmond and we sent him an email through
21 someone at the Army Wounded Warrior Program
22 who was working out of Richmond, gave us his

1 email.

2 So we sent him an email, "Dear Dr.
3 Gater, you know, here's who we are and here's
4 what this veteran is saying that he would
5 like. Could you work with us and, you know,
6 it needs -- we need a prescription. If it's
7 good for him, would you be willing to write a
8 prescription and help us try and push it
9 through."

10 That doctor, within two hours, got
11 back with us and enrolled that veteran in a --
12 enrolled him in a pilot study that provided
13 that equipment in his home, and he is now
14 using it in his home thanks to that very
15 responsive doctor within the VA hospital.

16 So, -- but that's one person. You
17 know, we need to be able to do these kinds of
18 things, provide these types of tools and
19 resources to veterans at home so they can
20 maintain the physical strength they've
21 regained through their hard work at the
22 hospital.

1 Families have a hard time
2 understanding VA disability compensation.
3 What makes this amount? What am I allowed to
4 use this for? Especially families who have
5 been assigned as a guardian for a veteran and
6 they're taking care of their affairs.

7 They are very concerned that they
8 don't misspend and that they don't -- have a
9 violation with the fiduciary that's assigned
10 to that veteran.

11 So, I think one of the challenges
12 that they have is just understanding what am
13 I allowed to do with this income and what
14 shouldn't I do with it. What kinds of amounts
15 are included in here, for example, for aid and
16 attendants.

17 If there's, you know, a thousand
18 dollars in this monthly disability
19 compensation that's for aid and attendants,
20 you know, then I know the rest of it can be
21 budgeted for something else. And they can
22 kind of -- they just need that knowledge.

1 We've had about a half a dozen
2 families in our program that, when their
3 veteran wound up signing papers to be
4 discharged, was not aware of, or maybe they
5 forgot that it's at this point, Buster, that
6 you need to assign who's going to get your GI
7 Bill benefits.

8 And if you don't do it now, you're
9 not going to have an opportunity to transfer
10 that to a spouse or a child later.

11 I know that that is something that
12 the Federal case managers go through with
13 them. I know it's on the list of things that
14 they are supposed to go through, these
15 families, but we've had enough people say, "I
16 didn't know. No one told me," that I think
17 that that's something we really have to
18 reinforce with our Federal case managers.

19 You know, just the lack of time
20 and energy to do things that you and I may see
21 as a little bit of an annoyance, like grocery
22 shopping or taking our clothes to the dry

1 cleaner, things like that that are really not
2 hard at all to do, and something that a
3 community resource could help a family with
4 very easily.

5 That's a huge thing that these
6 families face, especially these families who
7 feel very tied to the home and they feel very,
8 one hundred percent responsible for their
9 veteran who doesn't have their own voice,
10 folks who cannot speak or think for
11 themselves, and they are a very vulnerable
12 population.

13 Caregivers are often very, very
14 unlikely to want to leave, unless they go back
15 to that one challenge I talked about with home
16 health care providers. They are -- very, very
17 hard for them to leave their home and take
18 care of these kinds of things.

19 Certainly spa days and date nights
20 and going on many vacations become low on the
21 priority list for these families, so we try to
22 work very hard to see if we can find some

1 respite providers for them that they are
2 comfortable with and just, you know, give them
3 a few days to just go kick back and relax a
4 little bit.

5 Every family that we've talked to
6 who has that 24/7 responsibility for their
7 veteran, whether it's been a spouse or a
8 parent caregiver, has been very concerned
9 about what's going to happen in the event that
10 I will no longer be able to care for my
11 veteran. Who is going to provide the kind of
12 care to this young man or young woman that I
13 provide.

14 You know, we have a family in
15 Manassas Park. Their son was shot in the back
16 of the neck. He -- his spinal cord was
17 shattered and then he had a stroke, so he has
18 anoxic brain injury as well.

19 He was injured in 2003, for almost
20 eight years, because he's been home a little
21 bit, almost eight years now. They've been --
22 his mom and dad have been providing 24/7 care

1 for him and he's in their dining room.

2 That young man does not have a
3 single bed sore, never has, because his mom and
4 dad are constant -- constant, attentive
5 caregivers. And they want to make sure, if
6 something horrible happens to us, we want that
7 same level of care to be given to our son.

8 So there's some special
9 considerations with the population that we
10 deal with. There's a lot of support, both at
11 the Government level and at the nonprofit
12 level for combat-wounded service members. And
13 that's fantastic and that's as it should be.

14 On the nonprofit side there's not
15 as much support for noncombat-injured service
16 members. One of the families in our program,
17 the man's been in the Marine Corps, I believe,
18 for 17 years. He had deployed six times in
19 that 17-year career.

20 He was slotted to deploy again
21 last November to Afghanistan, ran an errand
22 for his wife before he was leaving, and he

1 rode his motorcycle and was in a no-fault
2 accident on his motorcycle, wound up a C-3
3 quadriplegic. And he's at the VA in Tampa
4 right now.

5 He's not a combat-injured veteran,
6 however, his injuries are every much as severe
7 as someone who was wounded in combat.

8 There's a program where you can --
9 they're from North Carolina. They are going
10 to have to sell their house and they are going
11 to move to Tampa to be near the VA Polytrauma
12 Center there.

13 There's a program, I believe it's
14 called HAP, that allows Wounded Warriors, they
15 can sell their -- they can get assistance to
16 sell their home when they have to move because
17 of their injuries.

18 Because he's not combat-wounded,
19 he cannot access that program. So, there is
20 -- there is some difference between combat-
21 wounded and noncombat-wounded. And clearly,
22 across the nonprofit organization it -- you

1 know, there's many, many organizations that
2 will say we only help, you know, combat-
3 wounded.

4 Reserve or Guard service members,
5 the biggest issue that we have seen with
6 Reserve and Guard members is that they just
7 start out with a lower level of knowledge of
8 what's out there to begin with because they're
9 not living in that culture 24/7, 365 days a
10 year, so they don't have all the access to all
11 the outreach that happens all year long to our
12 active duty component about the different
13 programs.

14 So they just kind of begin without
15 that ready knowledge of all of the resources
16 that are out there. And then -- but the one
17 thing that they have going for them that maybe
18 the active duty doesn't have as much is when
19 they move back home, they are usually moving
20 home to a community that they are well-
21 established in, so they have much more
22 community support than people moving off the

1 military installation.

2 Unseen wounds, there's a lot of
3 times when families will need support, but
4 their service member isn't obviously injured.
5 They may be -- have a traumatic brain injury
6 that's not a penetrating injury, and so they
7 have a lot of cognitive deficits or emotional
8 deficits.

9 They may have PTSD and require a
10 lot of oversight. These veterans still
11 require a full-time caregiver in many
12 instances, still require someone to not be
13 working and be that full-time safety net for
14 them. But there's not as many -- there's not
15 as many readily viable supports for them.

16 And I just got the sign that we're
17 15 minutes, so I'm going to stop right here
18 and give you all a chance to ask me questions
19 because briefings can get kind of boring after
20 they go this long.

21 CSM DeJONG: Ma'am, you all seem
22 to have done a ton of research and a ton of --

1 to build what you started with in talking to
2 these not-for-profit organizations.

3 Do you have anything, or have you
4 guys thought about taking all that research
5 that you've used and building data bases of
6 people willing to do assistance by area,
7 perhaps, in different areas?

8 Do you have anything like that
9 that you could give the families, so if they
10 live in an area and they need house and lawn
11 care, whatever, finding -- reaching out to
12 that community and getting some feedback as to
13 who is willing, based off of certain criteria,
14 to help this family out? Have you guys done
15 that?

16 MS. MUNOZ: We have not created a
17 database to -- for a self-help tool like that
18 for families, but we -- we do it one family at
19 a time, and depending on where they are
20 currently located.

21 We also have peer networks so we
22 have veterans who are willing to reach out to

1 other veterans with similar injuries or
2 caregivers who are willing to reach out to
3 other caregivers.

4 I do know that the Wounded Warrior
5 Project has a tool on its website that has a
6 care team like that, where people can go out
7 and sign up to do particular things for a
8 particular family.

9 MR. CONSTANTINE: Yes, ma'am.
10 When I worked on the Hill in 2009, I remember
11 a company, I think it was called e-con Systems
12 or something like that came, and they gave a -
13 - briefed us in the VA about quality of life
14 and what it would cost if the VA were to
15 restructure disability compensation tables
16 with a true quality of life factor in there.

17 And no one -- no one really knows
18 how to do that, because what does that mean,
19 and how complicated is that. Is that
20 something that you all engage on in any way?

21 MS. MUNOZ: No, sir, it isn't. We
22 focus solely on what kind of supports can we

1 bring to bear for that family in the community
2 in which they are living right now, but we
3 don't do, you know, that Ph.D.-level research
4 that kind of quantifies those types of -- the
5 values associated with that.

6 CO-CHAIR CROCKETT-JONES: How do
7 you find your families?

8 MS. MUNOZ: We have worked with
9 the Federal Recovery Coordinator Program.
10 We've actually briefed their FRCs and they
11 refer families to us.

12 We will not work with a family
13 unless we are working with their Federal case
14 manager. That does two things. Probably the
15 most important is that we know that the people
16 we're working with are plugged into the right
17 Government resources and the right people who
18 can get those Government resources for them.

19 But it also makes sure that we're
20 not being redundant in what we provide. Now,
21 sometimes we'll get a family come to us
22 directly, and we will just say, "Can you give

1 us the name of your Federal Recovery
2 Coordinator," and if they don't have one,
3 "Who's the VA OIF/OEF care manager that you
4 work with?"

5 You know, so we keep going down
6 and eventually sometimes we even get to the
7 military service Wounded Warrior Program
8 contact and we work with that person.

9 But, at some level we have a
10 Federal case manager involved in their care.
11 And then Ruthie sometimes refers people to us.
12 Operation Homefront, other nonprofits refer
13 people to us, and then people who are in our
14 program will refer people to us.

15 But the way we want it to work,
16 the strategy is to do it through the Federal
17 Recovery Coordinator Program.

18 MR. DRACH: Do you actually -- the
19 foundation, do you actually provide services,
20 or provide the linkages to the services in the
21 community?

22 MS. MUNOZ: We have the three

1 tiers of response. The first response is, we
2 will find a local community resource that will
3 help a family.

4 For example, we had a family who
5 had a family member that needed orthodontics
6 and they just simply couldn't afford it. We
7 made phone calls to two orthodontics in their
8 area and the second one said, "I want to
9 provide pro bono orthodontics to that family."

10 The second tier response is we
11 look at our national nonprofit folks that we
12 know and if we know that they provide a
13 service that that family needs for that
14 particular branch of service and that location
15 and what their need is, then we contact that
16 nonprofit.

17 "Hey, the Jones family in Arkansas
18 needs a foster home for their pet for a week,"
19 and believe me, there is an organization that
20 does that. And we will match it -- you know,
21 "Can you help them? Are you still providing
22 services? What do you need from them to do

1 it?" And if we get a confirmation yes, then
2 we connect them that way.

3 The third response is, when we
4 can't find an existing resource that will help
5 them, we will buy a product or service for
6 that family, but we don't actually do the
7 services ourself.

8 CO-CHAIR CROCKETT-JONES: Well,
9 thank you, Ms. Munoz. This has been very
10 helpful, some great ideas. Thank you very
11 much for your presentation.

12 MS. MUNOZ: Thank you. And I was
13 happy to be here. You guys have the slides
14 from -- that I didn't get to go through. I
15 had a few just recommendations.

16 You all can read those on your
17 own, but those four guiding principles that we
18 laid out in the report, number one, lean
19 forward on these families and, you know,
20 provide that veteran the most -- the best
21 health care that you can to make sure that
22 that veteran's recovery is as good as it can

1 be.

2 Second is, be proactive and keep
3 these families from becoming emotionally and
4 financially and physically bankrupt where we
5 can.

6 Third is get -- help them get
7 ready to move home. Don't put them in a
8 crisis situation when they are moving home.
9 Help them get that home environment ready for
10 themselves so that that transition home is
11 smooth.

12 And four, when they're home, give
13 them the tools they need to thrive when
14 they're home. Thank you very much for letting
15 me come today.

16 CO-CHAIR CROCKETT-JONES: Thank
17 you very much.

18 We will now hear from Dr. Barbara
19 Cohoon, Deputy Director of Government
20 Relations for the National Military Family
21 Association.

22 DR. COHOON: Hi. I'm Dr. Barbara

1 Cohoon, and I work for the National Military
2 Family Association, and I really appreciate
3 having the opportunity to come today to talk
4 to you about our passion, which is the voice
5 of military families.

6 I'm going to talk to you about our
7 association so you'll have a better
8 understanding as far as who we are and what we
9 do and why we're considered the voice for
10 military families.

11 I'm going to give you some
12 demographic information, just as far as to
13 give you an idea of the scope of the issue
14 that lies ahead, which I'm sure you all are
15 very aware of, considering you've been doing
16 some focus groups.

17 Also, I'm going to talk to you
18 about risk factors as far as within our
19 military families, and there's kind of a
20 layering effect that our families are going
21 through prior to the injury that all needs to
22 be taken into consideration as you're looking

1 at things.

2 I'm going to talk about issues
3 that are facing our Wounded Warriors and their
4 families, and also some recommendations.

5 Our organization has been around
6 for 41 years now. We started off with a group
7 of five women sitting around a kitchen table
8 about survivor benefits.

9 Believe it or not, they did not
10 exist back then, and so our organization
11 founded and that's how we got started and
12 still work on survivor issues.

13 But we are an all-volunteer-led
14 force. We have spouses and those that are
15 interested in working on military family
16 issues that are global, and they are our eyes
17 and ears for us.

18 We are a 501(c)(3) nonprofit. We
19 do not take any Federal funding, nor do we
20 want any. We serve all seven uniformed
21 services and all components, and we are the
22 only organization that does that.

1 We gather information lots of
2 different ways. Our volunteers that are out
3 there, out in the field, they attend meetings
4 on a regular basis on areas that they,
5 themselves, either an expert or areas that
6 they are interested in, and they feed that
7 information back to our organization once a
8 month.

9 And from that we take a look as
10 far as to identify common themes that are
11 happening with our military families.

12 Also, too, we might get asked by
13 someone as far as what we're hearing about
14 military families, and so then we can turn
15 around and ask our volunteers that are out
16 there as far as what are you hearing and
17 seeing out there, and then we wait as far as
18 waiting for the information to come back to us
19 as far as what they're seeing.

20 And I'll give you an example.
21 When I first started working for the
22 organization, I was asked by a staffer who

1 worked on the Senate Appropriations what we
2 were hearing regarding the impact of children
3 in the war.

4 He said that, outside Camp
5 Pendleton they'd been hearing quite a bit from
6 constituents as far as having difficulty, and
7 wanted to know what we were hearing.

8 So, I came back to the office
9 because I'm not the one that does the looking
10 at what the volunteers are bringing back,
11 asked if we were seeing this and if there was
12 a common theme.

13 And some pieces had been coming
14 in, but not a lot. Also, too, and I'll talk
15 about this a little bit later. Our Operation
16 Purple Camps, we started hearing from
17 counselors at the camps that the kids that
18 were showing up for our camps were needing
19 more medication than those that were the
20 civilian cohorts that were coming to their
21 particular camp.

22 Then we asked our volunteers, as

1 far as what they were seeing and hearing and
2 within six months we started getting a lot
3 back. So that was just a way as far as how we
4 used our volunteers.

5 We work an awful lot with DoD and
6 VA and members of Congress as far as driving
7 change. Not everything takes a legislative
8 change.

9 For our -- we want to make sure
10 that our military families have the right
11 information at the right times so they can
12 make the right decisions.

13 We also want to make sure they
14 understand their benefits. If they are
15 looking at health care, because that's an area
16 that I work on, then we want to make sure that
17 they understand the TRICARE benefit as far as
18 when to access it and how to access it, and
19 when they're moving from one TRICARE region to
20 another, how that works.

21 We also want to meet the needs of
22 military families. We have a scholarship. As

1 I said, we are -- we run on donations. We had
2 a donor that came forward, as far as putting
3 together, and we have a specific scholarship
4 just for spouses of the wounded. We also have
5 for the fallen and also for regular spouses as
6 well.

7 But we have three Operation
8 Purple. We have the camp, which is a camp for
9 kids. This year we had 3500 kids that were
10 able to go to camp for a week for free. What
11 we do is, we purchase actually the weeks of
12 the camp runs as it normally does, but then we
13 layer in a piece of the military culture, so
14 they have a hero's wall and every morning and
15 evening they raise and lower the flag. They
16 write letters, those types of things.

17 We've been doing this since 2004.
18 This year we had 41 weeks of camp in 25 states
19 and they're Purple, so all services and
20 components can apply to go.

21 We also are doing Operation Purple
22 Family Retreats. And the reason why we

1 started doing those -- we're in our second
2 year -- is because, as we were picking -- as
3 the parents were picking the kids up at the
4 Operation Purple Camps they said, "You know,
5 we really need something for ourselves as far
6 as being together as a family," and we started
7 doing those.

8 And then four years ago we started
9 doing Operation Healing Adventure Camps. And
10 how that started was, we had a donor come
11 forward. Because we were having such great
12 success with the Operation Camps for the kids,
13 wanted to have one just for kids of the
14 wounded.

15 So we held it just outside of Camp
16 Pendleton. And initially we had great
17 response, but as we got closer to the day of
18 the camp, we had more and more basically say
19 that they weren't coming.

20 So we decided we'd hold a focus
21 group after the camp. We went down to Camp
22 Lejeune. There was three of us. I sat in on

1 the focus group for the wounded. Another
2 person with the spouses or the caregivers and
3 another one with the children.

4 And what we came up with was not a
5 camp for just the children. They all wanted
6 a camp for themselves as a family. They felt
7 they really weren't spending enough time
8 together as a family, and wanted to reconnect
9 as a family. And that's how that got started.

10 So this past year we're actually
11 going to have two. We had one in August,
12 which was in Warm Springs, Georgia. We had 12
13 families and four of those were veterans. And
14 we have another camp that's coming up starting
15 November 4th through the 6th, and that's going
16 to be in Colorado.

17 Now, before I move on, do any of
18 you have any questions about my organization,
19 our association?

20 (No response.)

21 DR. COHOON: For demographics,
22 it's interesting, because I'm using the

1 Medical Surveillance Monthly Report as far as
2 the fact that she briefed today.

3 According to them, last year in
4 2010 service members, they averaged 614.6
5 traumatic brain injuries a month. They are
6 averaging 16.4 amputations versus 7.3 in 2009.

7 For mental health evacuations,
8 they are outpacing medical evacuations
9 starting in 2007 for service members that
10 served in OIF or Operation New Dawn.

11 For married, the reason why this
12 is important is because there is a little bit
13 of difference between active duty and Reserve
14 component. But when we look at the injury we
15 then see as far as how many will actually have
16 a spouse and how many wouldn't.

17 As far as number of females, we
18 have more reserve component females than we do
19 active duty. Those that are dual with
20 children, as you can see, the percentage is
21 fairly small, but they do exist within our
22 population.

1 And single, for Reserve component
2 is higher than active duty. And again, this
3 all becomes important when you look at the
4 wound.

5 For spouses, currently there's 3.1
6 million family members. That's also active
7 duty and Reserve component together. We have
8 more active duty spouses than we do Reserve
9 component.

10 Research has shown that there's
11 been an increase in alcohol intake and/or
12 substance use when the service member is
13 deployed, by the spouse. Also, there's been
14 an increase in mental health services when the
15 service member is deployed.

16 For children, there's 1.9 million
17 children, active duty and Reserve, and 73
18 percent are under the age of 11. Do you know
19 why that that's important, under the age of
20 11? First of all, it's the majority, but they
21 don't know a world at peace.

22 We've been at war for ten years.

1 So, 73 percent of our military children only
2 know a world at war. 41,000, approximately,
3 have a wounded, injured or ill or deployed
4 parent.

5 Our organization utilized in the
6 Operation Purple Camps, asked teens and
7 children as far as what they thought others
8 should know about them, and we made up a list
9 for top ten things that they thought you
10 should know.

11 For military teens, they know war.
12 They see it on TV, they read about it. They
13 see it from this, where they live.
14 Transition, they thought it was important for
15 you to know that they move every 2.9 years.

16 Also, too, they will attend nine
17 different schools in their entire lifetime.
18 They say good-bye to more significant others
19 than the rest of us do by the time they turn
20 age 18.

21 And they say that the most
22 constant thing in their life is their

1 furniture and their family. But my kids
2 probably would say no, because being a
3 military spouse and them being military
4 dependents, we did two tours in Hawaii, and
5 furniture wasn't something we had. We just
6 had family. That was it.

7 Also, too, community, 85 percent
8 of the military live -- I mean, attend public
9 schools and 65 percent live in the community.
10 So, the majority of us live out in the
11 community, not on a base or not on an
12 installation.

13 Also, too, for the kids, they
14 basically had similar to the teens, but they
15 worry. They worry about the injury, but also
16 they worry about the loss, not the loss of the
17 parent, but the fact that the parent missed
18 out on important events in their lives, the
19 first day that they walked, the first day they
20 went to school, or maybe even when they
21 graduated from high school.

22 Our military families have a lot

1 of risk factors. One is an individual
2 augmentee. Are you all familiar with what
3 that means?

4 (No response.)

5 DR. COHOON: An individual
6 augmentee is the service member, themselves,
7 either Guard or Reservists, also, gets called
8 up and they get sent as a onesie to do
9 something they weren't necessarily trained to
10 do, or were trained to do, but not with their
11 unit.

12 And the reason why this is
13 important, because spouses now and families
14 can relocate. They don't have to stay where
15 they are. And so now they could find
16 themselves in a community that's not where an
17 installation is.

18 The community is not used to them
19 because they don't know that they are
20 military, and so they -- even though they've
21 moved closer to family for support, they have
22 really left the military behind.

1 Our special needs families are
2 another risk factor, especially with our Guard
3 and Reserve, because a lot of times they are
4 using both of them as far as to help maintain
5 the family and all of a sudden one is gone and
6 that makes it a little bit harder and a little
7 more challenging for them.

8 Or, the spouse, the nondeployed
9 person may be the one that is a special needs.
10 They may have MS. Dual service, as I
11 mentioned before, that is a small percentage,
12 but it does occur.

13 And the reason why this is
14 important, because they can choose to either
15 deploy together or they can deploy separately.
16 And if they deploy separately, that means that
17 the children are without parent or a parent
18 for a longer period of time than they would
19 before.

20 Pregnant. That affects not only
21 the spouse who gives birth to the child, but
22 also to the service member who is deployed

1 because they are missing out on that
2 particular event.

3 Single parents, they obviously
4 have to find somebody to care for the child
5 when they are forward-deployed, but also, too,
6 if something happens to them, who is going to
7 take care of the children, and for them.

8 History of mental health. I'll
9 talk to you a little bit about that. It has
10 to do with our research that we did.

11 Financial issues. Obviously, if
12 they're having difficulty during deployment,
13 financial, it impacts the whole family.

14 And veteran status, that's
15 something that keeps me up at night, and I'll
16 talk to you a little bit about that later as
17 well.

18 Our organization kept asking for
19 DoD to do a study as far as looking at the
20 impact on the war on children and also the
21 nonemployed spouse, and we decided that we
22 should do things on our own.

1 So, we hired RAND to do a study
2 for us, and it's called "Views From the
3 Homefront." It's a longitudinal study and we
4 looked at 1500 Operation Purple Camp
5 applicants. And they really wanted to
6 participate, and RAND was very surprised on
7 how many actually stepped forward.

8 What did we find? I'm not going
9 to go too much into research, but I just
10 wanted to let you know that these are
11 additional risk factors that our families are
12 running into.

13 We're seeing a difference between
14 -- difference with military children and also
15 with the civilian sector. Military children
16 are having a higher incidence of anxiety.
17 They having more difficulty with family
18 relationships and they're having more
19 emotional difficulties than their civilian
20 cohort.

21 There's also deployment and
22 reintegration challenges. For deployment,

1 it's just getting used to the parent being
2 gone, and then how do you reconfigure or
3 redefine the family unit while the service
4 member is now deployed.

5 And then, reintegration is the
6 same thing. How do we bring them back into
7 our lives and basically reform as a family
8 unit again.

9 But we did find, for
10 reintegration, that girls were having more
11 issues than boys. Cumulative months of
12 deployment made a difference. So, it's not
13 the number of deployments, but it's the number
14 of months that you are deployed.

15 So, two deployments for the Marine
16 Corps, and I think they average about eight
17 months each time would be 16 months where, for
18 your Army, they've been going about 12 months
19 each deployment. So if they were gone for
20 two, it would be 24.

21 So, it's the 24 months versus the
22 16 that makes more of an issue than the fact

1 that they both were gone two deployments. And
2 other research has shown this as well.

3 The mental health of the caregiver
4 really is key. And anyone that understands
5 mental health would obviously understand that
6 if the person who's at home taking care of the
7 children is having issues then, obviously, the
8 family, itself, unit is not healthy.

9 In quality of family
10 communications. If nobody's communicating
11 with each other we're seeing an increase in
12 issue with the children. We're also seeing an
13 increase in issue as far as with the caregiver
14 as well.

15 Do we have any questions about
16 risk factors before I move on?

17 (No response.)

18 DR. COHOON: All right. What I
19 wanted to demonstrate to you is that our
20 families have all these risk factors before
21 the injury actually takes place.

22 So we have an active duty Army

1 family that's been in for 13 years. They have
2 been married for 13 years. They have three
3 children, an eleven-year-old, a seven-year-
4 old, and she had a child while he was gone, so
5 they have a two-month-old boy.

6 They have a special needs child
7 who is seven, and the birth during the
8 deployment. The mom has a history of mental
9 health. She is bipolar, and under medication.
10 They are having communication issues because
11 of her mental health now, with the eleven-
12 year-old and also with the seven-year-old.

13 Mom is seeking mental health
14 service, which is a good thing during this
15 current deployment. Mom works as a full-time
16 employee at a realty. They have moved four
17 times. And like I said, they move every 2.9
18 years.

19 They moved prior to this
20 deployment. She has a new retail job because
21 they just moved. They now live in a new
22 community and don't really know very many

1 people that are there.

2 The eleven-year-old has been to
3 three schools. The seven-year-old has been to
4 two schools. They are both starting a new
5 school.

6 The service member and both of
7 them -- all of them have done 24 months of
8 deployment and currently doing four months of
9 a new deployment.

10 They've had difficulties with
11 reintegration between the second and third
12 deployment, between mom and dad. They never
13 reintegrated, and the daughter is worried
14 about the dad being gone and hurt this time.
15 Now we add the wound on top of all of this,
16 and that's the family.

17 When our organization held the
18 first Healing Adventure, Operation Purple
19 Camp, I had an opportunity as far as to meet
20 with the families. And these are the issues
21 that I saw and that they talked about.

22 First of all, the caregivers do

1 not know how to deal with injury. They don't
2 understand the physical location, especially
3 the traumatic brain injury, and how that
4 relates to changes in the personality of the
5 service member, of their loved one, and the
6 children don't know this, either.

7 Also, too, they don't know how to
8 deal with the anger outbursts, and I've heard
9 this all four years. And they have this
10 little secret that they only share amongst
11 themselves, and the anger outbursts are
12 really, really intense and they don't know how
13 to deal with them.

14 Caregivers are so busy taking care
15 of everything else, taking care of the
16 children, taking care of the household, that
17 a lot of times they don't take care of
18 themselves, and I think Kim talked a little
19 bit about that as well.

20 And they are still too busy
21 fighting the system even though everything
22 else is in place, I hear this constantly.

1 Mental health issues is huge. We
2 are not doing family counseling. They started
3 at Walter Reed, the old Walter Reed. They
4 have it down at BAMC. They have it at Balboa,
5 but once you leave that particular area it
6 goes away.

7 And even then when I talk to
8 families that are in those particular
9 circumstances, they're not necessarily getting
10 family counseling for them to understand
11 what's happening.

12 The couples, they don't know how
13 to reunite with this injury and how to become
14 a couple again.

15 And I remember when I was in
16 nursing school and they actually showed us
17 videos of, you know, someone in a wheelchair,
18 and basically teaching how to communicate on
19 that particular level. They're not -- from
20 what I hear from caregivers, they're not
21 getting any of this.

22 Also, too, the caregivers,

1 themselves, they need to help on how do deal
2 with the everyday stress, strain. Not only as
3 far as dealing with the service member, but
4 how to deal with the system, but also as far
5 as just being a parent because now you're
6 really a single parent in some circumstances.

7 And the children, they really are
8 having difficulty just dealing with what
9 everyone calls the "New Normal," and sometimes
10 they are really left out.

11 In one particular focus group I
12 was in, they never brought up the children,
13 and I didn't hear that until last year when,
14 finally, two caregivers came up to me and
15 said, "I'm really concerned about my
16 children."

17 But up until then I hardly ever
18 heard anyone talk about the kids. Even Dr.
19 Kozo, who does research, one of his reports
20 talked about the lack of focus on the kids.

21 For reintegration, there are a lot
22 of programs out there for when you're just

1 about to come back from being forward deployed
2 or down ranged. And the Navy's been doing
3 this for decades. So you're all excited. You
4 know the date that they're coming back and you
5 kind of cycle through this deployment, and as
6 you get close to them coming back, you're
7 ready for them to come back.

8 But the injury doesn't allow that
9 to happen. Your day is just cruising along as
10 if everything's fine and all of a sudden it
11 changes and reintegration is never, ever dealt
12 with, and they just kind of go on.

13 And so, when the brigade comes
14 back, everyone now is cycling into the
15 reintegration, but they have never had that
16 opportunity as far as to do that.

17 Also, too, we saw that case
18 management, still none of them are aware of
19 Federal Recovery Coordinators. It doesn't
20 make any difference if they just went to an
21 AW2 summit, which one of them just did when we
22 were down there, if they are attached to Camp

1 Lejeune, if they are up at Madigan, if they
2 are at Walter Reed, it doesn't make any
3 difference. They do not know that Federal
4 Recovery Coordinators exist or they are even
5 eligible, for one.

6 They still have difficulty
7 navigating the DoD and VA health care system,
8 even though they have recovery care
9 coordinators or OIF/OEF case managers, they
10 are still bumping up into the system on a
11 regular basis.

12 Access to mental health is a real
13 issue, actually to health care. Depending
14 upon where the service member ends up, if they
15 end up in DoD and they attach to a military
16 treatment facility, if they are Guard or
17 Reserve, they are someplace else.

18 The family can come up and visit,
19 but guess who pays for the trip up? The
20 family does. If the family calls up to find
21 out what's going on, because of HIPAA issues,
22 a lot of times they won't share with them as

1 far as what's happening. And a lot of times
2 they are left out of the case management
3 business altogether, which makes it very
4 difficult for them to advocate.

5 They can move up to the base if
6 they want to, if the injury warrants, as far
7 as them being maybe permanently located there,
8 but guess who pays for the move? The family
9 does.

10 They -- I've heard that they
11 qualify for housing, but one of our families,
12 when they went up there to check into housing,
13 the woman that normally ran the program was on
14 vacation and so they were told they didn't
15 qualify. Rented out in town and, guess what,
16 they qualified for housing at Madigan.

17 As far as the Community-Based
18 Warrior in Transition Unit, for Guard and
19 Reserve they want them closer to home, and a
20 lot of them are in areas where the care is
21 there. The TRICARE network is robust or
22 there's a VA there, but their services, for

1 the large part are very reluctant to allow
2 them as far as to go back to CBWTUs, and
3 that's been an ongoing fight for a lot of that
4 population.

5 What I heard this particular time,
6 as I mentioned, we had four veterans. They
7 are actually having difficulty accessing care
8 within the VA. They have chosen to use the VA
9 but for some reason the VA either is delaying
10 as far as their ability to get in for
11 treatment or they're having to drive
12 unbelievable amounts of distance, according to
13 them.

14 So they are starting to use the
15 TRICARE benefit and having out-of-pocket
16 copayments to provide for service-connected
17 treatment.

18 For the DES, IDES -- and you all
19 brought this up in one of your reports, that
20 the families are finding out, they think, way
21 too late in the process to be able to make any
22 sort of long-term decisions on what's coming

1 their way, especially when it comes to am I
2 going to qualify for TRICARE or not, and also,
3 too, as far as where is the best place to
4 live. And I'll talk about that as well.

5 One of the things I wanted to ask
6 this particular Healing Adventure Camp was why
7 did they decide to live or move to where they
8 wanted to go to. And since four of them were
9 veterans I could ask them that particular
10 question.

11 And one of them, they have four
12 little children. Life goes on, even though
13 there's an injury and they moved to Indiana
14 where her family located, and he wanted to
15 make sure that I knew that it wasn't all that
16 close, but close enough for him.

17 And then another one said, "Well,
18 I couldn't move because I couldn't afford to
19 sell my house." But he's also still active
20 duty and getting great care as far as through
21 the DoD.

22 The other ones basically were

1 happy where they were. Everything was running
2 smoothly. They were getting care through the
3 -- either the Warrior Transition Unit, or
4 through the Marine Corps. Their kids were
5 happy with school. The wife was working.
6 Everything now is balanced out and things were
7 running smoothly.

8 So I just wanted to find out from
9 them why they kind of chose to go and live
10 where they did. Gaps still remain. There are
11 a lot of programs out there, especially
12 through the Department of Defense, but
13 families, for the most part, don't know that
14 they exist.

15 It's one of those, "I don't know
16 what I don't know." So they don't know how to
17 ask sometimes, or they're just overwhelmed,
18 completely.

19 A lot of the programs are geared
20 towards acute and preventive, but there's, as
21 you know, little outcomes that have been done
22 on existing programs, and there are so many

1 websites.

2 There's little research that's out
3 there as far as the timing of the injury and
4 the well-being of the family. Also, too, we
5 haven't looked at a longitudinal study as far
6 as the impact on the wounded and the family
7 unit. And what about the transition as far as
8 what's happening to family members when you
9 move from active duty to veteran status?

10 There's inconsistency across the
11 recovery phases. Basically if you are a
12 spouse or on invitational travel orders,
13 dictated -- if you're inpatient or outpatient
14 dictates, as you know, what services or
15 programs you're available to.

16 DoD versus VA. DoD allows you, if
17 there's space available, to give you health
18 care even though you don't have health care
19 and you don't qualify within the system, but
20 they'll allow -- the NDA allowed that.

21 The VA is supposed to provide the
22 same services, but they have not stood their

1 program up. There's inconsistency from active
2 duty to veteran status. The key here is if
3 the service member is medically-separated or
4 medically-retired as far as impact on the
5 military family.

6 If they are medically-retired, the
7 family gets TRICARE. If they are medically-
8 separated, the family does not get TRICARE.

9 If the family has TRICARE and they
10 are medically-separated -- medically-retired,
11 if they are enrolled in a military treatment
12 facility, they have to disenroll once they are
13 retired, and then the commander of the
14 installation determines, then, if you can re-
15 enroll or not if they have space available
16 within the facility. There's no priority.

17 For CHAMPVA, again, if the service
18 member is medically separated and the family
19 doesn't qualify for TRICARE, the veteran now
20 has to reach a hundred percent for the
21 families to qualify for CHAMPVA.

22 So, if you are less than a hundred

1 percent medically-separated, families don't
2 qualify for health care.

3 For DoD programs and services, if
4 they are medically-retired they are treated as
5 retired, so they qualify for housing. They
6 qualify -- for retired housing. They qualify
7 for the commissary and the exchange and access
8 on and off the base.

9 Honorable versus dishonorable
10 discharge. I haven't heard very many people
11 talk about this, but when a dishonorable
12 discharge happens, the families also are left
13 out in the cold as well. It's not just the
14 service member or the veteran.

15 Military OneSource -- Denise
16 wanted me to make sure that I let you guys
17 know that once you retire you don't qualify
18 for Military OneSource anymore. It goes away.

19 And for TRICARE special needs,
20 which is called the Extended Care Health
21 Option -- remember, I had mentioned to you
22 about risk factor, about special needs? If

1 your child is autistic or has Asperger's
2 syndrome or other types that qualify for you
3 for the extended care health option, this goes
4 away the moment you retire from the military.

5 And again, since you haven't had
6 opportunity as far as to plan for this, this
7 can be a huge financial hit. And also, as far
8 as access to care really is impeded.

9 What keeps me up at night, we've
10 been at war for ten years. Access to mental
11 health, there's a shortage out there and
12 within the military it's a shortage within a
13 shortage.

14 Our children, as I said, 73
15 percent are under the age of eleven. Who is
16 going to care for them when they are adults
17 and they have their own children and they are
18 having issues as far as what happened to them
19 as far as children? Who is responsible for
20 that?

21 Are we going to overwhelm the
22 community-based mental health centers or is

1 their civilian employer going to pick up this
2 issue?

3 Our parents, as far as their
4 retirement plans and everything that they had
5 hoped for, if you have a child who has a
6 special needs when the child is born you can
7 plan for it for your life. And when you go to
8 retire you can have systems in place as far as
9 the take care of your child.

10 But when it happens, at this
11 particular juncture in your life, which I'm at
12 that age. I have children that could be that
13 age. I haven't planned for that. I -- maybe
14 you've bought a house that isn't accessible as
15 far as for someone in a wheelchair.

16 Or, I may have downsized to a
17 condo in New York City. Anyway -- how about
18 divorce of separated spouses and their
19 children? I heard recently but I couldn't
20 find the actual quote. Fifty percent of our
21 wounded are ending in divorce. Who is going
22 to take care of them?

1 We are not assessing military
2 families and their well-being before the
3 service member leaves the military. Admiral
4 Mullen has said on a regular basis, "Let's
5 assess the service member to make sure they're
6 ready to discharge," but we're not looking at
7 the families.

8 So, when the service member leaves
9 the military, a lot of times access to health
10 care and programs for families also go away,
11 but we're not looking at how they are doing.

12 For caregiver burn-out, the first
13 time I went to our Healing Adventure, I heard
14 their stories and I came back to work and
15 said, "We need to be working on this." They
16 are at the breaking point, and if they leave
17 we're looking at a lose-lose.

18 The caregiver basically goes off
19 on their own and, as you know, when families
20 split up financially, everybody takes a hit.
21 But now the service member who's been -- who
22 has benefitted from this caregiver and the

1 family unit also goes away, and so now you
2 look at a lose-lose for both.

3 So, our association, along with
4 three others worked really hard on making sure
5 that we built in some caregiver benefits. So
6 we have the DoD caregiver compensation and the
7 VA caregiver benefit, and they don't align.

8 The DoD caregiver compensation has
9 a different definition than the VA. DoD is
10 catastrophic. VA is severely. They don't
11 align.

12 DoD's arsenal includes illness.
13 VA does not include illness. And so what I've
14 been hearing through the VA is that a lot of
15 people are being disqualified because they
16 cannot include the illness and that rating is
17 enough basically to keep them from being able
18 to benefit from this benefit.

19 Also, too, the DoD caregiver
20 compensation does not include all the other
21 benefits. It's just a compensation -- well,
22 I shouldn't say "just," because it's a lot,

1 but they don't include any training. They
2 don't offer any mental health services, health
3 care, none of that.

4 And that only comes once the VA
5 caregiver benefit kicks in. The application
6 process for the VA caregiver benefit doesn't
7 start until the wounded service member and
8 injured -- member illness doesn't count -- has
9 received a date of separate.

10 According to the Army, once they
11 hit a date of separation, once they receive
12 their 30 days and they're out. So, 30 days
13 later now they're veteran status and this
14 benefit hasn't even started yet.

15 What do we need to do? Well, the
16 benefit starts, as I said, too late in the
17 process. It needs to start when the medical
18 evaluation board process beings. And you
19 don't have to start all the benefits at the
20 same time. Basically you need to start
21 training when it's appropriate to start
22 training.

1 And the VA needs to be in charge
2 of the training mechanism because, if you
3 leave it up to DoD and VA, they are not going
4 to align because DoD is not going to do it.
5 It's going to be the Army, Air Force, Marine
6 Corps, Navy.

7 And they are not going to set up
8 the same training -- most likely not going to
9 set up the same training program as the VA
10 would.

11 So now you've got caregivers going
12 through a training program that satisfies DoD
13 or the services, but does it align with VA,
14 and if it doesn't, now they've got to go
15 through another training process when the
16 service member becomes veteran status.

17 For mental health services, the VA
18 does not provide medication. So, if the
19 caregiver needs any sort of medication on top
20 of the mental health services, the VA is not
21 going to provide it or to make sure there's a
22 coordination of services at all.

1 What about the sandwich
2 generation? We had a family that was this.
3 She had a dad that was World War II, and he
4 had moderate dementia. Her husband had a
5 hundred percent posttraumatic stress disorder.
6 He was in charge of taking care of removing
7 the service members after they had passed away
8 in theater back to the States. That was his
9 role for the time that he was in theater and
10 had a very difficulty handling the mortuary
11 affairs.

12 And so she qualified for certain
13 benefits because of her husband being OIF/OEF,
14 but did not qualify for the same benefits
15 because her dad was World War II. Also, too,
16 they had a seven-year-old son who was the
17 cutest little thing but, again, she was a
18 sandwich generation.

19 Do you all have any questions on
20 issues before I move to recommendations?

21 LTC KEANE: Yes, ma'am. The
22 Marine Corps does have a one-week training for

1 the DoD caregiver program. It's covered in
2 the Skedaddle, which was presented the
3 beginning of September.

4 The reason for the three-month
5 extension for the service program is to cover
6 that time when the member is now post-DD-214
7 until the VA caregiver program kicks in. That
8 was an active thought, to have that three
9 months covered into a veterans status.

10 DR. COHOON: Yes. I'm aware of
11 that because I worked on that, making sure
12 that there was a bridge. And originally,
13 because there were two different versions.
14 One was it ended the moment that you became
15 veteran status, and the second was the
16 extension for the three months, and our
17 organization advocated for the three for just
18 what you're talking about.

19 But again, the way that they're
20 set up, they're -- it's not a -- it's not a
21 seamless transition because there's too many
22 disparities between the two programs. One

1 doesn't include illness. Once is
2 catastrophic. One is severe.

3 So, you're going to find some
4 groups that qualify under DoD, but don't
5 qualify under DoD. I mean, under VA, and vice
6 versa. But, there are some pieces -- I'm not
7 saying it's a bad piece of legislation.

8 And I'm not talking about that as
9 far as the recommendation. Our association
10 would rather see it really link up with VA's
11 Aid and Attendants. Use DoD's compensation,
12 hook it up to VA's Aide and Attendants, and
13 therefore, you're already starting the program
14 at this particular point and it crosses right
15 over.

16 So, instead of waiting for Aid and
17 Attendants to come from this particular point
18 that it's -- DoD's already done the vetting
19 for all of that and it moves straight over.

20 So don't use it as a caregiver
21 compensation, use it more as far as the Aid
22 and Attendants.

1 Any other questions before I move
2 on?

3 (No response.)

4 DR. COHOON: We need to have a
5 holistic approach as far as benefits and
6 services, and we're getting there. But, for
7 the most part, a lot of times families are
8 thought of as last -- as far as when they're
9 making plans.

10 And I'll use that as an example
11 for the relocation options. If the service
12 member is married, they then -- or even as a
13 single, they have an opportunity for their
14 last move within DoD to go, really, wherever
15 they want within CONUS.

16 Now, if they started from Hawaii,
17 they will move them back to Hawaii. But if
18 you started in Connecticut and ask to go to
19 Hawaii, I don't think they are going to let
20 you do that.

21 But what we're asking for is that
22 talk about the relocation and talk about as

1 far as the non-spouse, as far as the mom or
2 dad that's caring for the child, let them have
3 an opportunity to actually move.

4 And so, instead of trying to
5 create care where it needs to be created, that
6 they all move to where the care already
7 exists. We're looking for an extension for
8 TRICARE as an active duty benefit similar to
9 what we do with the survivors, where they are
10 considered active duty, so therefore it's not
11 a big financial impact on them and they have
12 access to benefits that they wouldn't have
13 when they were retirees, i.e., the ECHO
14 program.

15 Start the VA caregiver benefit a
16 lot earlier in the program. And caregivers
17 need more support, especially posttraumatic
18 stress disorder training and dealing with
19 anger management.

20 We need to bring care closer to
21 home, which I think you all have recommended.
22 As far as bringing them back where they can be

1 cared for by their families and their families
2 are already there to take care of them.

3 And we need to look at telemental
4 health as an option as far as looking at non-
5 medical/medical services, and also to remove
6 state licensing barriers so we can use
7 telemedicine across barriers.

8 And also, too, a lot of our mental
9 health providers do not understand military
10 culture, and so to embed a curriculum
11 requirement into behavioral, but also into
12 health care providers because we are more
13 likely, as a family member, to engage with our
14 health care provider, our PCM than we are with
15 a mental health provider, and it's important
16 for them to pick up.

17 Military treatment facilities are
18 embedding mental health in their medical
19 homes, which is going a long way as far as
20 providing all of that.

21 And if I could leave you with one
22 thing, basically a healthy family equals a

1 healthy wounded family. And, as I had shown
2 you here, there's a lot of layering here
3 that's going on with risk factors.

4 And this is not -- each family is
5 an individual as far as how you're dealing
6 with it, but we need to look at preventative
7 programs because, if we can cut down on the
8 number of what the layering effect is, then
9 they can handle what's ever thrown at them,
10 and that's the most important thing, is making
11 sure we treat it before it becomes a point of
12 an emergency.

13 And I'm going to stop here and see
14 if you all have any questions.

15 MG STONE: Dr. Cohoon, are you
16 familiar with our recommendations from our
17 report?

18 DR. COHOON: I am.

19 MG STONE: Recommendation 14 and
20 15 deal with a number of issues or attempt to,
21 that you have approached. If it's beyond your
22 comment at this point I would appreciate --

1 the Task Force would appreciate your written
2 comments of how close we got to some of these
3 recommendations, in Recommendation 14, 15 from
4 last year's report.

5 DR. COHOON: Well, I have the book
6 that's in the back room where my chair is, but
7 I went through them again as far as today, and
8 if you read them I could probably tell you as
9 far as where we are with that.

10 MG STONE: Okay. Let me suggest
11 that you take these and then come back to us
12 so that we can refine those recommendations in
13 our next report to really accomplish a number
14 of these things.

15 Representative Thompson from the
16 State of Pennsylvania has introduced
17 legislation to support state licensing -

18 DR. COHOON: Yes. And our
19 organization has supported that. And so I
20 understand that Senator Collins is going to
21 introduce it on the Senate side as well.

22 MG STONE: And we would ask for

1 your support.

2 DR. COHOON: Yes. And we would --
3 you know, we've -- our organization is an
4 advocacy group. We are not a lobbyist group,
5 so they have to predominantly reach out to us,
6 but we have been approached, and we are very
7 excited because this is huge, to have an
8 opportunity to provide.

9 I mean, it's a force multiplier
10 for mental health if we can remove that
11 barrier.

12 MG STONE: And based on the
13 uniform I'm wearing, I'm not lobbying, either.
14 We would just like your support.

15 DR. COHOON: It's there already,
16 sir, and there is a few others.

17 MR. CONSTANTINE: What kind of
18 feedback have you received from the VA when
19 you talked to them about expanding the usage
20 of mental health?

21 DR. COHOON: The VA -- the vet
22 centers are set up, as you know, as far as to

1 provide mental health counseling. But a lot
2 of times they don't provide what families
3 need. It's -- they're not equally staffed
4 across the United States for vet centers.

5 The other is, they're still
6 dealing with the brick and mortar, the face-
7 to-face. And they have not expanded to
8 basically going online as far as Chat or Skype
9 or doing something that is what we would
10 consider telemental health.

11 And military families, along with
12 service members are getting used to doing
13 that. One, because of theater, talking back
14 and forth. But, TRICARE actually offers an
15 online chat or Skype called TRIApp, and it's
16 a free service for families.

17 And they are using it, not to the
18 extent that everyone thought they would, but
19 they do use it. There's also a medical
20 version of that, but I have to go to a
21 doctor's office rather than being in home, and
22 I go into a private room and I actually talk

1 back and forth to a provider, and they give me
2 counseling at that particular point in time.

3 But no, the VA is -- is not -- use
4 of vet centers aren't expanding in that
5 particular realm, but have the capability of
6 doing that.

7 MR. CONSTANTINE: I remember being
8 briefed for TRICARE for years going in their
9 good idea, you know, consistent with the
10 technology we are using in other aspects of
11 life.

12 Recently I was somewhat stymied by
13 the vet center, a personal issue, and when I
14 couldn't meet the counseling hours that they
15 kind of stick to. I know they try to be
16 flexible.

17 And so, I'm interested in the
18 telemental health. It seems like a no-
19 brainer. I know there's HIPAA considerations.
20 I know there's some privacy considerations,
21 but I just wondered, have you talked with them
22 and have they said if they intend to push

1 forward on that also, or --

2 DR. COHOON: Senator Akaka
3 actually introduced a bill, I want to say a
4 year ago now, and it actually got passed, and
5 there's a piece of it in the caregiver law --
6 what do you call it, PL 111-163 on mental
7 health, and he was very forward about
8 telemental health.

9 Because, the Indian Care System
10 uses telehealth and is also using telemental
11 health and wanted to expand that particular
12 piece.

13 But there were a couple veteran
14 service organizations that pushed back because
15 of the lack of evidence base on that
16 particular -- using research using telemental
17 health but, since then, has softened their
18 look on all that and are accepting.

19 Again, it was General Corelli is
20 why we moved towards try-out. He just wanted
21 something set up, and told the contracts to
22 set it up. We're going for it, even without

1 the evidence base, and it is making a
2 difference in our families.

3 As I said, it's the preventative
4 piece. If we can get to, "Okay, I'm having
5 some communication issues with my loved one in
6 theater, can you help me as far as how do I
7 communicate how I'm feeling Skype, and that
8 helps me get over all of that."

9 Then, when they come back from
10 theater, we've been able to resolve all those
11 issues and our communication is much better.
12 And that's what they're finding that they're
13 using. It's really a non-medical approach.

14 Also, too, the other way for the
15 telemental health not -- that's within the
16 same boundaries, but one of the contractors is
17 using, at the University of Syracuse, a bunch
18 of psychiatrist that are teaching at the
19 university.

20 And they are using their time
21 using Skype to connect back to Fort Drum, and
22 families basically use the Skype within the

1 counselor's office and are able to provide
2 that medical support.

3 So where, now, a therapist office
4 that couldn't provide medical intervention now
5 can because they've hooked up to Syracuse
6 University.

7 So, just a way of using telemental
8 health to improve access for -- in rural areas
9 and also for vulnerable population.

10 MG STONE: Dr. Cohoon, thank you
11 so much, and we appreciate your willingness to
12 take a homework assignment. So, thank you.

13 DR. COHOON: No problem. Thank
14 you again. I really appreciate it.

15 MG STONE: At this point we are a
16 few minutes ahead. We're going to take a ten-
17 minute break and then come back and Suzanne
18 will start to go over our research work that's
19 coming in our site visit.

20 So we'll take ten minutes.

21 (Whereupon, the above-entitled
22 matter went off the record at 3:42 p.m. and

1 resumed at 3:55 p.m.)

2 MG STONE: Suzanne, thank you so
3 much for allowing the group to take a break,
4 and we'll now turn it over to you to talk
5 about the installation site visits.

6 DR. LEDERER: Am I on? I guess
7 I'm on.

8 So, the briefings that you all
9 have been listening to today are a primary
10 method, as you know, of gathering data on the
11 topics that you are supposed to be assessing.

12 A second primary method of
13 gathering data on these topics is, of course,
14 the site visits and the focus groups and the
15 site level briefings that occur while on-site,
16 so that's what we are here to talk about
17 today.

18 As you know, these site visits
19 provide a unique perspective, a customer
20 prospective, an on-the-ground perspective that
21 counterbalances what you hear in more
22 headquarters-level briefings which is what

1 makes these site visits so valuable.

2 It's been actually five months
3 since your last site visit, since the
4 California JFHQ and CBWTU site visit. A lot
5 of water under the bridge. A report in the
6 interim, new membership.

7 So the purpose of the next 45
8 minutes is to do a top-line reorientation of
9 what lies ahead, site visit-wise, and I guess
10 for some it's not a reorientation, but a
11 first-time orientation.

12 There's other topics that we will
13 be talking about, and my understanding from
14 Denise is that we shouldn't rush, that if we
15 don't finish we will continue at some juncture
16 tomorrow.

17 This is Tab H, and while it looks
18 thick, there really are only 14 slides here.
19 The remainder of the material at that tab
20 consists of the instruments.

21 So let's start with a macro look,
22 and then we will drill down to what -- where

1 we're going, what we're going to do there and
2 then finally how we're going to do it.

3 I know you all are well aware of
4 the destinations this year, in year two of
5 your research. I don't know if you've seen
6 this particular chart. You have 15 sites or
7 destinations, as Denise mentioned earlier
8 today.

9 Last year you had 11. You have
10 four and a half months to do these site
11 visits. Last year you had two months. You
12 will be on the ground for 30 days. Last year
13 you were on the ground for, I think, 15.
14 About 15, 16 days.

15 So it really is a much more
16 ambitious site visit schedule. Each site
17 visit will be two days on the ground and that
18 includes the JFHQs and the CBWTUs. Each will
19 have two days, whereas last year you will
20 remember that those visits were rolled into
21 one, one day at the JFHQ and then the next day
22 at the CBWTU.

1 Another difference this year is
2 that the -- last year each of the two JFHQ
3 visits was followed immediately by a visit to
4 the CBWTU in that state, Florida and
5 California, respectively.

6 This year you have three JHFQ
7 visits, but each one is not necessarily
8 followed immediately by a CBWTU visit in that
9 same state.

10 So, for example, site number four,
11 you're going to, Command Sergeant Major
12 DeJong's home, JFHQ, but that is not followed
13 immediately by a CBWTU visit. And similarly,
14 later on, you'll be going to the IOWA JFHW,
15 but not to an Iowa CBWTU. Instead, you'll be
16 going to Illinois's CBWTU.

17 With few exceptions there are --
18 you see here three types of sites, the JFHQs
19 as we've been talking about. There are three
20 of those. The CBWTUs, there are two, and then
21 the garden variety installations you have ten
22 of those.

1 Each one of these three basic
2 types of sites has a slightly different
3 template for the itinerary. And the way these
4 templates differ is that there is some
5 variation in the topics that are being briefed
6 and in the questions for each topic that the
7 briefers are being asked to address.

8 Even for the same type of site,
9 for example, for all of the installations,
10 there are still variations having to do with
11 the unique characteristics of each site.

12 By "unique characteristics," I'm
13 referring, for example, to the organizations
14 that are houses on a particular installation
15 or to proponents that are around in the
16 vicinity of an organization.

17 I'll give you an example. At Fort
18 Knox, which is site number two, is the home of
19 the Army Accessions Command and the home of
20 Army G-1 civilian personnel. That presents a
21 rare opportunity to get certain briefings on
22 certain topics that you will not be seeking

1 elsewhere.

2 Similarly, at another Army
3 installation, Fort Stewart, it is in the
4 vicinity of the Augusta Warrior Project, which
5 is an initiative run by Mr. Jim Lorraine, the
6 former director of the SOCOM Care Coalition,
7 so that presents a rare opportunity to hear
8 from somebody in that area, and these are
9 examples of the ways in which some of these
10 site visits will vary, based on the unique
11 characteristics of each installation.

12 There's another way that they'll
13 vary. I mentioned the -- Mr. Lorraine is a --
14 he's an external proponent. Well, there are
15 a lot of other external proponents who we did
16 not tap last year, folks like the Marine
17 Corps's District Injured Support Cells, some
18 FRCs, Federal Recovery Coordinators, Army
19 Wounded Warrior advocates who may not be
20 located on-site, a bunch of different VA
21 assets, VA facilities.

22 Vet centers came up a moment ago.

1 VA OEF/OIF case managers, VA Polytrauma case
2 managers, the VA Liaisons for Health Care.
3 All of these types of proponents are touch
4 points for how -- how recovery Warriors and
5 families are adjusting, faring post DD-214.

6 Much as Kim Munoz and Barbara
7 Cohoon are touch points for what's going on
8 post-DD-214, so are these external proponents
9 around the sites that you'll be visiting and
10 they -- and where they are accessible and near
11 by they are being invited to come in and speak
12 to the Task Force members.

13 If there's a disk here but not a
14 disk there, that's an example of why these two
15 site visit itineraries will differ somewhat.

16 Okay. Questions so far?

17 (No response.)

18 DR. LEDERER: I'd like to talk
19 with you about the basic site visit templates,
20 what's similar and what's different in them.

21 All of these site visit
22 itineraries, all of these site visit

1 itineraries will include an introductory brief
2 by you all to the host organization. They
3 will all include a brief by the host
4 organization to you all.

5 For example, the Warrior
6 Transition Brigade, and they will all include
7 subject-specific briefings which you all --
8 most of you are very, very well-aware of.

9 All of the itineraries will
10 literally have on them when they are sent to
11 the sites, very specific questions that we are
12 asking them to respond to, and we're -- they
13 are encouraged, and Denise has already been in
14 contact with them.

15 They are being encouraged to
16 prepare their slide decks very specifically in
17 response to these questions.

18 Most, but not all, will have focus
19 groups. Just like last time. Three focus
20 groups per site. The exception is the JFHQ.
21 No focus groups there, and the other exception
22 is the Landstuhl visit. Because of the acute

1 care environment, there is only one focus
2 group scheduled for Landstuhl, and that will
3 be one with family members.

4 What's new this year, unlike last
5 year, is these briefings by these external
6 proponents that I mentioned, these touch
7 points.

8 And we're ready to move on to take
9 a look at what's new in the instruments.

10 Just like last year, you have four
11 instruments. You have two focus group
12 protocols and two mini-surveys, one each for
13 recovering Warriors and for the family
14 members.

15 These are tools, basically, for
16 systematically capturing the customer, the
17 recovering warrior, the family member
18 perspective, on a wide array of matters.

19 Again, these tools are
20 contributing that balance, that perspective
21 that we can only get from the customers. And
22 I think we saw at the end of the last cycle

1 that these tools generated results that were
2 very helpful in substantiating the
3 recommendations that you all wanted to make
4 the focus group results and the main survey
5 results are cited fairly consistently
6 throughout the findings of the report.

7 What do you all consider to be the
8 purpose of the protocol? Don't look at that.
9 To your mind, what is the purpose of a focus
10 group protocol?

11 MR. CONSTANTINE: I think a
12 protocol is to make sure that no matter who's
13 going in there, who's asking the questions,
14 wherever we are, we're going to ask the same
15 things and as close as we can, the same manner
16 to ensure some consistency across the board,
17 knowing for a while there's going to be some
18 differences.

19 DR. LEDERER: Yes.

20 CO-CHAIR CROCKETT-JONES: Maybe
21 also to make sure we cover all of our target
22 areas.

1 DR. LEDERER: Exactly. Yes. I
2 agree with you both, that it's to try to
3 foster consistency in the questioning, to try
4 to foster thoroughness in the questioning and
5 to try to elicit the types of responses that
6 can be compared -- that can be -- General
7 Green talked about one being in sorting.

8 At the last meeting the types of
9 responses that can be lumped together and that
10 will allow you to discern themes if there are
11 any there.

12 And, yes, Justin, we certainly did
13 see that members vary in how closely they
14 follow the protocol and it seemed to work,
15 nevertheless, despite those individual
16 differences.

17 The purpose of the mini-survey --
18 again, don't look. What is the purpose of the
19 mini-survey as far as you all are concerned?
20 Same? Okay. You're not as excited about the
21 mini-survey.

22 It's a twofold purpose. One is to

1 allow you, as a Task Force, to describe the
2 study participants, the sources of the
3 findings that you are citing in your report
4 and, in fact, in your report in Appendix E,
5 there's a section on the study methodology,
6 and within that write-up there is a reporting,
7 a rather top-line superficial reporting of the
8 characteristics of your study participants and
9 those figures came from the mini-surveys.

10 But, in addition to describing the
11 study sample, the mini-survey actually
12 augments and extends the focus group findings.

13 As you see here, the changes to
14 this year's instruments are minimal, and the
15 reason for that is that Denise, rightfully so,
16 wants to preserve the potential to combine and
17 compare from year to year as possible.

18 So, in order to preserve that
19 possibility, you can't -- you can't mess with
20 the original instrument too much. But there
21 are some changes that I would like to bring to
22 your attention.

1 You will remember that there are
2 some new research questions, some new areas of
3 inquiry that are listed in Chapter 3 of the
4 report. One of them, for example, is these
5 transition outcomes, these touch points for
6 how this community is faring post-DD-214.
7 That's an example of one of the new research
8 questions.

9 But there are many. And, in order
10 to accommodate those new research questions
11 and ask some questions targeting those on the
12 protocol, we had to cut other questions,
13 otherwise it would be an unduly long protocol.

14 It was hard enough last year to
15 get through it. Any longer would really be
16 impossible. So the way we went about cutting
17 in order to accommodate the new questions, was
18 we eliminated those that were less productive
19 or that were redundant, maybe splitting hair
20 type questions, or that seemed to be overly
21 detailed. We retained what seemed to work the
22 best.

1 Similarly, there were some minimal
2 changes to the mini-survey. Mostly the
3 changes to the mini-survey reflected new
4 information. For example, there's a question
5 about how helpful are the case managers.

6 The original mini-survey offered
7 four response options, rate a -- maybe rate
8 the Federal recovery coordinate, the rate the
9 recovery care coordinator, rate the transition
10 unit chain of command. What was the fourth
11 one -- and the Army Wounded Warrior Advocate,
12 because we didn't know any more than that.

13 Well, over the intervening months
14 we learned a lot about case managers, so in
15 the Year 2 mini-survey, rather than asking
16 them to rate four, now they're being asked to
17 rate nine. And that's just an example of how
18 the mini-survey has been tweaked.

19 We didn't expand all of the
20 questions. The other major change to the
21 mini-survey is the very first question. You
22 may remember, it's one about where they are in

1 the recovery and rehabilitation process.

2 And you may remember that it
3 wasn't a very effective question. People were
4 kind of confused by it, and that's not the
5 type of question you want to keep in a survey.
6 We replaced it.

7 And later in this meeting,
8 probably tomorrow, Jess will walk you through
9 the changes to all of these instruments so
10 that you will become intimately aware of
11 what's new and different.

12 These are lifted from your report
13 from Chapter 3 of the report. These are the
14 new -- new research questions. These new
15 topics, areas of inquiry.

16 I should point out to you that not
17 all of these are reflected in the focus
18 groups. I mean, not all of them are answered
19 via the focus group methodology. Some of them
20 are being answered in headquarters-level
21 briefings. Some of them will be answered in
22 site level briefings.

1 If you look at the third one from
2 the bottom, awareness and perception of the
3 armed forces as a whole, regarding Recovering
4 Warrior Units and programs, that's one that
5 we're trying to address through the Defense
6 Manpower Data Center, DMDC, status of forces
7 surveys. We've already been in touch with
8 those folks and contributed a number of items,
9 several of which get at that research
10 question.

11 The bottom one, relationship of
12 recruiting standards to Recovering Warrior
13 resilience, that's one that we're going to
14 hopefully begin to chip away at during the
15 visit to the briefing from Accessions Command
16 at Fort Knox, and I believe during the Air
17 Force equivalent visit at Lackland Air Force
18 Base, the Air Force Personnel Center.

19 So now we'll turn to what's going
20 to happen on-site. I need to remind you. I
21 think you're very well aware already, that
22 site visit practices and particularly focus

1 group practices are guided by Federal policy
2 on human subjects research.

3 There's the National Research Act
4 of 1974 that established the guidelines for
5 the composition and practices of institutional
6 review boards which agencies are required to
7 establish if they're going to conduct human
8 subject studies.

9 Just like last year, this year we
10 submitted the instruments and the process to
11 the ICF Institutional Review Board and they
12 were approved, and we are -- what's the word --
13 - all required, collectively required to
14 comply with the requirements of the IRB in
15 order to keep this approval.

16 We'll apply it to basically abide
17 by these three key principles that are
18 embedded in the Federal policy. And let me
19 just walk you through them briefly.

20 Respect for persons is basically
21 addressed through the informed consent
22 process, so during the focus group kickoff,

1 and you all will remember, maybe remember
2 unhappily, the rather lengthy bullets that
3 precede the focus group questions.

4 This is, unfortunately, a
5 necessary evil. And in these bullets which
6 you are obligated to -- not necessarily to
7 read verbatim, of course, but to paraphrase in
8 a way that is comfortable for you, you are
9 supposed to talk to ensure that you're
10 disclosing to your study participants enough
11 information about the study in a way that they
12 can clearly understand, so that they can make
13 an informed decision about whether or not they
14 want to participate and sign the informed
15 consent form.

16 Now, of course, in the military
17 environment, they had been directed there and
18 we all understand that. But once they are
19 there in the confines of the group that you're
20 running, you can explain that they are free to
21 participate as much or as little as they
22 choose without any consequences.

1 They are free to excuse themselves
2 right now without any consequences and so
3 forth. So that's about respect for persons.

4 LTC KEANE: Ma'am, can I
5 interrupt?

6 DR. LEDERER: Yes, please.

7 LTC KEANE: Can I apologize first?

8 Sir, and ma'am, if I'm out of
9 line, please tell me where to go. It seems
10 that this is important stuff. We have less
11 than half of our body here.

12 I assume that you have to go over
13 this again when everybody's here, right? I
14 wonder if this might be better when we have
15 more of a forum.

16 DR. LEDERER: Whatever -- Denise,
17 whatever you suggest.

18 MS. DAILEY: Everyone has this in
19 their briefing books, and I would like to
20 continue. But I will -- you know, it's one of
21 those things, I'll defer to the chairs.
22 There's -- you know --

1 MG STONE: I don't think we'll all
2 subject everybody to this again, but clearly
3 understanding the Federal policy is essential,
4 and so there will be a remedial session for
5 those people that are not present today. I
6 think everyone should share the joy of this
7 presentation.

8 LTC KEANE: Thank you.

9 DR. LEDERER: Okay. Carrying on.
10 Beneficence. Do no harm. We developed the
11 protocol questions in a very deliberate way
12 that we hope will not make people
13 uncomfortable, that will not cause people to
14 reveal more than they choose.

15 We probe in a way that we try to
16 engage them without putting them into
17 uncomfortable situations. We're always
18 mindful of the effect of participating on
19 their sense of well-being.

20 We also, if we notice that there's
21 some badgering going on or if these guys are
22 kind of ganging up on this one guy -- it does

1 happen now and again -- it's our place as a
2 moderator, our obligation to intervene and
3 just not let that happen.

4 Beneficence, do no harm also
5 extends to preserving their privacy. We are
6 very vigilant safeguards of the participants'
7 privacy.

8 And finally, justice. We try to
9 provide equal opportunity to attend and to
10 participate in these data-gathering sessions.
11 Once they are in there, we don't -- we don't
12 have favorites.

13 We are neutral. We don't
14 reinforce Joe up-and-down, up-and-down, north-
15 south, north-south and just ignore or give no
16 eye contact to Mary. We try to be very
17 neutral and even-handed.

18 As I mentioned, these principles
19 are addressed in the introductory script, and
20 I hope you'll refamiliarize yourselves with --
21 with the verbiage, and then communicate them
22 in a way that is comfortable for you.

1 So it's not my place to talk to
2 you about your role as a task force member,
3 but it's my place and even my obligation to
4 spend a little bit of time talking about your
5 role as a focus group moderator.

6 In a research capacity you,
7 ideally, are an unbiased and nonjudgmental
8 receiver of information as opposed to a giver
9 of information. Realistically, we all know
10 that you are not blank slates. You are here
11 on this Task Force because of your expertise,
12 and your connections and your influence.

13 I'm saying simply that the best
14 time to exercise that expertise, to use that
15 expertise and that influence, if possible, is
16 offline, after the focus group is over,
17 perhaps in the in-brief. But best not during
18 the focus group simply because the emphasis
19 during the focus group is on gathering as
20 opposed to sharing.

21 On the subject of the outbrief, we
22 would like to encourage you to be very mindful

1 about what you share with your host
2 organization. You, as individuals, you as a
3 team and as a task force, have not had an
4 opportunity to systematically assimilate
5 everything you've heard in the focus groups,
6 during the last two days and in the briefings.

7 You are likely to be influenced by
8 the recency effect, what you heard most
9 recently, as well as by the squeaky wheel, the
10 person who was most vociferous in your focus
11 groups may well be the person who you -- who's
12 top of mind for you, but that person will not
13 necessarily speak for the team, speak for the
14 majority in your group.

15 And until you go back in the light
16 of day you don't necessarily have a good
17 impression of what has transpired on that
18 site. So, we encourage you to be mindful of
19 that when you prepare your outbrief remarks
20 and to consider couching your remarks as
21 preliminary impressions.

22 I mentioned earlier, very

1 important to safeguard the focus group
2 participants' privacy vigilantly, paranoidly.
3 We don't mention names. We don't mention who
4 attended the group, much less who said that.

5 And in the outbrief, and actually
6 you're the one who recently reminded me of
7 this, Jess -- Jess will have a big speaking
8 part tomorrow.

9 Watch out for potentially
10 identifiable information. In your effort to
11 protect them, don't refer to Sergeant Jones as
12 -- as the guy with the triplets. There
13 probably aren't that many of them in the WTB,
14 or the woman who just arrived from Bethesda
15 with her mother. They can piece these stories
16 together, and there goes that individual's
17 privacy.

18 Not on the slide is another role
19 that you fill on site, which is during your
20 briefings. You are -- I mean, you have a lot
21 of briefings. Maybe more this year than last
22 year, in addition to the three focus groups.

1 And on your itinerary you will
2 have in front of you the exhaustive questions
3 that the briefers have been asked to address.
4 Your role, should you choose to accept it, and
5 I hope you will, is to help those briefers
6 stay on track. Help them focus on the
7 questions that we collectively need for them
8 to address for analysis purposes, for
9 reporting purposes. Probe, redirect, what
10 have you.

11 Okay. We're going to spend just a
12 little bit of time talking about the mechanics
13 of the focus group: a carefully planned
14 discussion designed to obtain perceptions on
15 a defined area of interest in a permissive,
16 nonthreatening environment.

17 What are the most important
18 aspects, words, in this definition for you?
19 For you, Jess?

20 DR. JAGGER: Well, I think we
21 start right from the top, carefully planned.
22 Obviously, we go into this with our -- you've

1 been through our frameworks before. You've
2 seen the research questions. You've had input
3 into the research questions.

4 You know that everything that's on
5 this piece of paper is there for a reason,
6 right, so we start with "carefully planned."

7 And we do need to acknowledge that
8 we're focusing on perceptions. These are
9 individual experiences, and there is some
10 discussion going on, so it's the interaction
11 of the different group members.

12 Does that get some ideas
13 percolating? Do you guys want to chime in
14 now, your thoughts?

15 DR. LEDERER: That's okay. That's
16 okay. You can do the permissive part and then
17 we'll go -- move on. Do you want to do the
18 permissive part?

19 DR. JAGGER: Sure. We want to
20 make sure this is a permissive and
21 nonthreatening environment. We want people to
22 feel like they can talk freely, or choose not

1 to talk freely.

2 If they don't want to contribute
3 to the conversation, they don't have to, and
4 if they want to contribute, they can
5 contribute in whatever means they feel
6 comfortable. So we're not trying to gear the
7 discussion in a positive or negative light.

8 We're not fishing for the bad.
9 We're not fishing for the good. We're letting
10 them bring up what they want to bring up.

11 DR. LEDERER: And at the same
12 time, we're letting them know that we're
13 interested in the good, the bad and the ugly,
14 that anything goes, and that we respect
15 differences of opinion.

16 It's very easy, when the majority
17 is kind of confirming and corroborating a
18 certain position, it's very easy to go with
19 the flow. But what is actually more valuable
20 from a research standpoint is to ascertain is
21 there some -- is there disagreement, is there
22 another perspective, and if they feel that

1 this is a nonthreatening and permissive
2 environment in which you will stand up for
3 them if they have a different point of view,
4 they are more likely to share that.

5 Okay. So at each site -- at most
6 sites where there will be focus groups, you'll
7 do -- as last year, you'll do two Recovering
8 Warrior focus groups and one family member
9 focus group.

10 Hopefully, 10 to 12 participants,
11 although you saw that that varies. There have
12 been one. There have been two, five, six. I
13 don't know that the numbers exceeded 12.
14 Once. One time. Okay.

15 And the attendees, other than the
16 participants are, of course, the members.
17 There may be one, two. I have seen three
18 members. Have there been four, Suzanne?

19 Okay. So there will be members
20 there, typically a lead moderator. Sometimes
21 there's co-moderating going on. You will have
22 your ICF scribe there. On occasion, you may

1 have another member of the research team
2 there.

3 What about any other observers?
4 What is the rule regarding other observers?
5 No. No way. That's another human subjects
6 privacy issue. No matter how well-meaning an
7 extraneous person might be, somebody may be a
8 member of the cadre or an AW2 advocate.

9 External people of no stripe --
10 and I don't mean a stripe in a military sense,
11 do not belong in the focus group.

12 Members of the staff, from what I
13 understand, there have been times when they
14 have come in and out, as necessary, just for
15 logistical reasons. That should be kept to a
16 minimum, but it's not the end of the world.
17 We all will sign a confidentiality statement,
18 by the way.

19 Okay. So the process, as you
20 know, is fairly straightforward. There is the
21 beginning. That kick-off that we have been
22 referring to, which is very important, not

1 just in terms of ensuring that informed
2 consent, but also in terms of setting the
3 stage and setting the ground rules. It's very
4 important to kick this session off the right
5 way with the right atmosphere and to explain
6 expectations and roles.

7 And then following the kick-off,
8 you have the actual questioning which follows
9 the protocol and then you have the conclusion.
10 But what I'd like to talk with you about now
11 is those first four bullets at the very
12 beginning to include the materials that you
13 will be distributing.

14 Those materials include the
15 consent form. That's the form which they sign
16 and you collect, which means that they have
17 officially consented to participate after
18 clearly understanding what you're asking them
19 to do.

20 The resource form, that's the form
21 that identifies local mental health resources,
22 in the unlikely event should they feel

1 uncomfortable as a result of participating in
2 a focus group and be seeking an outlet, it's
3 important that they have this available
4 immediately.

5 And both of those forms, the
6 consent form and the resource form are
7 required by IRB. It's very important to
8 introduce these forms before you distribute
9 them.

10 Tell them what they are about
11 before you distribute them, and there is very
12 clear language in your introductory script
13 about how to do that.

14 It's particularly important to
15 tell them about the minisurvey and be done
16 talking about the minisurvey before they start
17 filling it out. You really don't want to
18 distract them because, if you're saying
19 something important to them while they are
20 filling out the minisurvey they won't hear
21 you, plus they may not fill out the minisurvey
22 accurately because they will be distracted.

1 And, being asked to multitask like
2 that can be stressful, particularly for
3 somebody who might have some combat stress
4 issues. So, it's just not a good idea, in
5 general, to be talking to them while you're
6 asking them to complete the minisurvey.
7 Nothing else should be happening while they
8 are completing the minisurvey.

9 Remember that your scribe is more
10 than happy to help you by gathering -- by
11 distributing the minisurvey to them and
12 collecting it for you. Your scribe is happy
13 to distribute the other forms as well.

14 We do ask, though, that you not
15 begin your questioning, launch into your
16 protocol questions until your scribe has
17 returned to his or her laptop and is ready to
18 scribe.

19 I heard that that did not always
20 work that way last year, and the scribe's
21 number one job is to be at the laptop and to
22 be capturing as much of what is said in the

1 discussion as possible. Please try to
2 remember that.

3 There's another form that I want
4 to bring to your attention. It's another one
5 required by IRB. I'm not sure whether you're
6 familiar with it. It's called the adverse
7 event form. Do you remember it from last
8 year?

9 It's one that, luckily, you did
10 not need to complete. It's not something you
11 distribute to your participants. Jess is
12 going to talk to you very briefly about it.

13 DR. JAGGER: Okay. So I have the
14 job of telling you what to do if something
15 goes wrong. Well, one of the first things
16 that you need to do if something goes wrong is
17 let Denise know about it.

18 So her responsibility is to then
19 let authorities know if there is a risk of
20 injury to self or others, a risk of injury to
21 a dependent child or to a dependent adult.
22 Those types of things need to be reported

1 immediately to Ms. Dailey so that she can take
2 it up the chain and make sure that that person
3 is given the assistance that they need.

4 We are legally required to do
5 that. If something like that happens or
6 something else that makes you uncomfortable
7 and concerned about the participant's welfare,
8 we also need you to document that on this
9 form.

10 So, after you've had the
11 conversation with Ms. Dailey, you would fill
12 out one of these forms, and it just asks you
13 for what focus group it was. You know, so if
14 you were at Fort Stewart and it was focus
15 group number two with the enlisted officers --
16 or the enlisted, then you would fill this out.

17 You would put your name on it.
18 You would have the scribe's name also on it in
19 case they needed to provide some statement
20 later on down the road if somebody was looking
21 into the event, so we'd have a record of who
22 the scribe was.

1 Sign it and date it and then
2 describe the event and you'd check some
3 blocks. And the blocks down here are about
4 did they say they were going to harm
5 themselves? Did they say they were going to
6 harm someone else? Did they indicate abuse or
7 neglect of children? Did they indicate abuse
8 or neglect of a dependent adult?

9 If you checked yes for any of the
10 above, did you report it to Ms. Dailey so that
11 she can then report it, and then if you
12 checked no for all of the above, did you refer
13 the participant to some available services and
14 support?

15 So, you'd refer back to that sheet
16 that Suzanne described where there's available
17 resources, mental health resources and things
18 like that, but you just want to document that
19 you've done something to assist that person
20 that made you concerned about their welfare.

21 Okay?

22 DR. LEDERER: Should we use those

1 in case of the one-on-one interviews as well?
2 I -- you know, several times people wanted to
3 speak to one of us individually, not in the
4 focus group.

5 And some pretty intense
6 information was sometimes shared one-on-one.
7 We had questions not just about how to bring
8 that information anonymously and safely back
9 to the Task Force, but if something -- should
10 those be filled out if there is something of
11 serious concern, is that the way we should
12 document it in those cases, or is that a
13 different protocol?

14 DR. JAGGER: I would say that the
15 IRB is most concerned about focus group
16 participants, but anyone who comes to talk to
17 you because you are there, you could broadly
18 define them as being a participant in the
19 study as long as they are providing consent.

20 If they are not providing consent,
21 you would still go through the same protocols.
22 If they are talking about suicide or harming

1 someone else, then that would need to go to
2 Ms. Dailey so she could report it up the
3 chain.

4 We lose anonymity at that point.
5 We explain that. You have to explain that as
6 part of your focus group kick-off, that if a
7 person talks about such subjects that we will
8 have to tell someone else about that and they
9 will lose that anonymity at that point.

10 I would err on the side of caution
11 and just say if risk of injury to self or
12 others, report it to Ms. Dailey. If it
13 doesn't get to that level, you're still going
14 to refer them for services.

15 You can ask the scribe at any
16 point to give you one of those sheets with
17 resources available to the person, hand that
18 off. Whether or not you choose to document --
19 because it's not technically part of the focus
20 group and they haven't signed a consent form,
21 as a focus group participant, I don't think we
22 would collect the form that documents all of

1 that, but you would still do it.

2 DR. LEDERER: You're asking a
3 question that we actually hadn't thought
4 about. I like the idea -- certainly you would
5 want to report it to Denise to ensure that --
6 that the appropriate action, if any, were
7 taken.

8 I like the idea of your filling
9 out the form. We might just keep it locally.
10 I mean, within the Task Force. It might not
11 go to the IRB, for example.

12 If it happened during a focus
13 group we would actually be forwarding the form
14 to the IRB, but in this instance, at least we
15 would have the documentation and it might --
16 it might stay there.

17 Denise, do you have an opinion?

18 MS. DAILEY: I want to keep this
19 pretty narrowly focused for the use of this
20 form, which is those four categories, harm to
21 self, harm to others, harm to children, harm
22 to a dependent parent.

1 Now, we've encountered other
2 situations which are not -- we are not
3 addressing in this forum, such as the
4 discussion of mishandling of the events at
5 Twenty-nine Palms. This is not the
6 appropriate way to handle any of that.

7 We are talking about those four
8 discreet categories and how to handle those
9 four discreet categories.

10 CO-CHAIR CROCKETT-JONES: Can we,
11 perhaps, have some sort of form for
12 documenting the one-on-one conversations that
13 have come up. Not just at Twenty-nine Palms,
14 but --

15 MS. DAILEY: Yes.

16 CO-CHAIR CROCKETT-JONES: They've
17 come up in other places as well, and sometimes
18 they've brought up some significant issues.
19 So, we need some way to record it, even if
20 it's not at the level of this.

21 MS. DAILEY: Yes. Thank you.

22 MG STONE: And the utilization of

1 this form is determined under what DoDI? Is
2 it unique to this Task Force, or is it part of
3 what determines your responsibilities, Denise?

4 MS. DAILEY: Sir, it is a -- it is
5 a practice that the IRB that I utilize, which
6 is -- so it is the practice of the IRB that I
7 utilize, and they, as a part of reviewing our
8 protocols then, in turn, request that we use
9 these procedures in safeguarding the privacy
10 of the individuals involved.

11 So, I am required under -- I have
12 -- and I say required -- I have IRB
13 responsibilities. I do not use all of the IRB
14 responsibilities that DoD proscribes, but I
15 use an IRB process in order to ensure that we
16 are taking care of the privacy and
17 safeguarding the people who are participating
18 with us.

19 MG STONE: Clearly, the protection
20 and safety for those of us in uniform, we have
21 responsibilities when we are in individual
22 areas.

1 Could you please provide those
2 documents to us so that we can review to make
3 sure it covers everything we need to have
4 covered?

5 MS. DAILEY: Okay, sir.

6 MG STONE: Thank you.

7 DR. LEDERER: Suzanne, I think you
8 -- am I on? I think you also briefly alluded
9 a few moments ago to the desire for a way to
10 incorporate what you're hearing in the one-on-
11 one's into the larger data set, and I just
12 want to acknowledge that we have heard your
13 request, and then we'll talk about it at a
14 later time.

15 Okay. Moving on. Let's talk
16 briefly -- how are we doing on the time, by
17 the way? What time are we going until?

18 MG STONE: You still have --

19 DR. LEDERER: Five minutes.

20 MG STONE: -- 15 minutes.

21 DR. LEDERER: Okay. Facilitator
22 roles. I want to point out to you that the

1 first four bullets have to do with managing
2 the content, right, managing what you're
3 hearing.

4 You're gathering information from
5 them. You are hopefully sticking more or less
6 to the -- to the protocol wording. You are
7 listening carefully -- very importantly,
8 evaluating what you're hearing, processing
9 what you're hearing.

10 Are you understanding it? Is it
11 specific enough to be useful? Do you know
12 whether other people in the group stand by
13 that? Are there -- or is everyone nodding or
14 is it possible that there's more information
15 in the group that you have not yet tapped.
16 That's managing the content.

17 And then, the last four has more
18 to do with managing the process. And the sad
19 fact of it is you're expected to manage all of
20 that simultaneously. And, no, it's not easy.

21 Having co-moderators there can
22 help. You might want to talk explicitly about

1 who's doing what. Are there parts that you
2 think you're particularly -- you as a group
3 were particularly successful at, or
4 particularly unsuccessful at? Let's say "less
5 successful."

6 I know you're just thinking to
7 yourselves, so I'll move on.

8 These are the actual things we do
9 to facilitate and I encourage you, for the
10 effective behaviors, to be conscious of what
11 works, what you're trying to do and try to
12 cultivate these skills, if possible.

13 I'm not going to read them to you.
14 I think you understand them very well. The
15 one that perhaps is less obvious is the
16 sophisticated naivete. You are all are not
17 naive to anything that you are hearing.

18 You have probably heard most of it
19 before, but in order to encourage them to talk
20 to you about their perspective, you -- you are
21 a blank slate. You do not disclose just how
22 well you understand what they're saying. You

1 are on "receive."

2 I'll point out to you that the
3 last two bullets encouraging and checking for
4 contrasting opinions and checking for
5 congruent opinions are very important
6 behaviors for US moderators because they help
7 us go from an in-of-one, one person's
8 observation or perspective to the majority of
9 the group, or everyone in the group, or half-
10 and-half.

11 And that really strengthens the
12 findings that can be discerned within a
13 session, and when you aggregate across
14 sessions.

15 You want to ask things like, "Does
16 he speak for everyone? Is there another point
17 of view? Can I see a show of hands? I'm
18 seeing a lot of nods. Do you all agree?" this
19 type of thing.

20 The less effective behaviors are,
21 quite obviously, in many instances they are
22 simply the converse of the effective

1 behaviors.

2 I would like to point out that the
3 first one and the last one are particularly
4 important to be mindful of as a moderator. Be
5 mindful if you think you might be taking up
6 too much of the air-time in the group, if you
7 might be getting into a mentoring or
8 information-sharing mode, rather than an
9 information-gathering mode.

10 Kind of monitor yourself if you
11 can. Similarly, that very bottom bullet,
12 failing to probe or follow up when necessary.
13 Sometimes, particularly when we're feeling
14 rushed, and oftentimes we are because we have
15 90 minutes and a long protocol, but sometimes
16 we ask a question. We get no answer and we
17 move on.

18 Sometimes we need to give a
19 pregnant pause or prod them or probe.
20 Sometimes we get just a very light-weight one-
21 word answer from one person or even three.
22 Well, have you heard enough? Do you have

1 enough clarity? Do you have enough
2 specificity to really consider it an answer?

3 Is it useable information? If
4 it's not, consider dwelling on that question
5 a bit longer, but it's not easy because you're
6 constantly balancing, trying to finish the
7 protocol, getting a quantity of information
8 with eliciting quality information.

9 And nobody is saying it's easy,
10 but if you can try to be mindful of both, I
11 think it will serve you in good stead.

12 I'm almost done, folks. I do want
13 to remind you that your scribe and you are a
14 team. They are very eager to support you, and
15 I think -- I think our scribes do a very good
16 job.

17 I did hear, General Stone, your
18 comment about the emotion that you think
19 perhaps was not reflected in some of the
20 sessions, and we'll talk about how we can
21 address that. It's hard, but we -- but I
22 heard you and we'll see what we can do about

1 that.

2 There are ways that you can
3 support our scribes, just as they will support
4 you. During your kick-off you will be asking
5 the participants to speak clearly and to avoid
6 sidebar conversations and to speak one at a
7 time.

8 And you can even repeat these
9 rules during the focus group. If things get
10 out of hand, which they oftentimes do, it's
11 not -- it's not wrong to remind your
12 participants what the ground rules are because
13 it will be better for you if you can
14 understand what they're saying to you and it
15 certainly will be better for the scribe.

16 Tallying the hand counts. If you
17 will repeat out loud how many you have
18 counted, that will be very helpful to your
19 scribe, or how many are nodding their heads.

20 Because your scribe's head is
21 down. He or she is typing, and so that's very
22 helpful to them.

1 The other thing is, when you hear
2 an acronym that you know like the back of your
3 hand, but he or she might not, just mutter it
4 under your breath. Like I said to Karen
5 earlier today, USERRA, U-S-E-R-R-A, because
6 one of the briefers had mentioned it. And
7 that's very helpful to them.

8 Last year somebody used the term
9 "rocker" at the Fort Benning, I guess, site
10 visit, and that was a slang term that none of
11 us knew actually, and Jess Googled it. Do you
12 know what it is?

13 Yes. Yes. Well, yes. Obviously,
14 right. We didn't know. So, it's helpful, if
15 there is slang or acronyms and you happen to
16 know them, we welcome that, because we Google
17 them otherwise.

18 Okay. I do want to let you know
19 that the scribes also will take notes during
20 the site level briefings, but those notes are
21 not nearly as exhaustive as the focus group
22 transcripts, because we're getting hard copies

1 of those -- of those briefings.

2 And then finally, these are just
3 some resources that we provided you all last
4 year. We're not throwing them at you this
5 year in order to avoid inundating you with
6 materials, but if anybody is interested in
7 more materials on focus group moderating, we'd
8 be happy to share these with you.

9 Thank you very much.

10 LT COL KEANE: I know. Is there a
11 tab that has which visits we'll be going on
12 personally, or how it's broken down?

13 MS. DAILEY: Sir, we'll get that
14 to you. Justin, we gave you a copy this
15 morning. Yes, was that what you were looking
16 for?

17 (Off-mic comment.)

18 MS. DAILEY: Okay. John. I'll
19 get John. Steven. Get me a couple more
20 copies of what that -- of what installation
21 visits the members had signed up for, dates
22 and business meetings.

1 So, I do have a chart where I have
2 everyone who is signed up for an installation
3 visit published, and we'll have that in your
4 books for tomorrow.

5 MG STONE: Just a comment, not for
6 decision. Having done, now, a number of site
7 visits, there are some people who are
8 naturally very good at facilitation, and
9 there's others of us that, frankly, aren't
10 quite that good.

11 I found that in my attempt to
12 facilitate, I often wasn't listening well
13 because I was thinking about the next
14 question, and I was really failing to observe
15 the room.

16 I thought that it was much easier
17 as a Task Force member to be the observer or
18 to be the second person in the facilitator.
19 And I would submit for consideration only the
20 idea of using a professional facilitator or at
21 least identifying those members of the Task
22 Force that happen to be really good at this

1 that would allow the process to go through
2 smoothly and have them facilitate the majority
3 of these type of sessions, and then allowing
4 the rest of us that might not be as good at
5 that to observe.

6 And I'm strictly speaking from the
7 fact that I felt that I got way more out of it
8 when I wasn't in a position of facilitation.

9 MR. DRACH: You know, I think you
10 might be right there, General. I did not
11 facilitate last year, but the Task Force
12 member who did the facilitation did a
13 fantastic job.

14 But I can understand what you're
15 saying because I was doing the same thing,
16 just not -- even though I wasn't facilitating,
17 I was thinking about the next question and
18 sometimes wasn't paying attention to what was
19 going on.

20 So I think if you maybe did have a
21 third-party facilitator it might facilitate us
22 doing a better job.

1 CO-CHAIR CROCKETT-JONES: I'm just
2 going to submit the idea that I think we need
3 to be as hands-on as possible to get that --
4 I don't want that emotional content to be lost
5 by turning it over to someone who is doing
6 this -- I'm not saying that professionals
7 would have less investment, but they -- but
8 they actually might.

9 Well, as long as we're all done,
10 thank you, Suzanne. Thank you, Jess.

11 Tomorrow morning, 8:30?

12 MS. DAILEY: Yes. Tomorrow
13 morning, 8:30, ladies and gentlemen. I do
14 have -- or I do not have anyone from the
15 public speaking tomorrow.

16 So, we can start at 8:30. Now,
17 I'm bringing in WWCTP a little early, but what
18 I'm saying is, we do have some time there in
19 the morning for admin time and then I'll
20 probably get WWCTP to start about 8:45, 8:50.

21 So, we'll gain a couple of minutes
22 there. It's a long morning. I've got two

1 high-impact briefings in a three-hour period.

2 From nine till twelve we have WWCTP.

3 It's not just an hour. I have
4 three hours there and I'm splitting it up
5 actually between WWTCP, an hour and a half,
6 and the National Guard Bureau is going to come
7 in and brief you on a case management process
8 that they'd like, and that they're piloting
9 for National Guard members.

10 And so, it doesn't -- it's not
11 well-reflected in the agenda right now, but I
12 have three hours there that I want to split up
13 between both of those organizations, and they
14 should be probably a couple of your most
15 informative briefings.

16 So, we'll start as early as
17 possible on those. And again, you have some
18 admin time if you want to talk tomorrow
19 morning and start at 8:30. Good.

20 Thank you very much for your
21 attention this afternoon, gentlemen. Very
22 appreciative. And ladies. Thank you to my

1 audience and those of you that are still here.

2 Thank you all.

3 (Whereupon, the above-entitled

4 matter went off the record at 4:55 p.m.)

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A				
abide 338:16	302:8,10 304:9	222:9 359:6	additional 25:6	advantage 91:19
abilities 110:4	312:12 321:8	actionable 180:7	33:15 82:15 89:15	advantageous
134:7	accessed 185:17	227:10	94:12,14 143:14	35:19
ability 46:6 57:1,2	accessible 233:12	actions 211:12	200:6,14 209:15	Adventure 276:9
60:5 96:15 108:7	303:14 328:10	active 87:18,20	210:22 213:18	289:18 297:6
128:11 208:1	accessing 296:7	94:11,13 102:10	214:19 224:8	304:13
220:21 224:8	Accessions 326:19	104:20 106:8	285:11	adverse 354:6
225:21 228:20	337:15	107:2 158:10	address 59:15,15	advertising 160:12
296:10	accident 260:2	185:8 186:11	95:3 185:18	advice 40:18
able 22:18 24:8	accommodate	191:2 195:21	206:14 326:7	Advisory 242:19
78:18 98:18	334:10,17	196:6,8 198:7	337:5 346:3,8	advocacy 316:4
110:12 114:3	accommodation	220:13 221:10	367:21	advocate 295:4
141:10 155:5	198:21	230:22 245:22	addressed 338:21	335:11 350:8
156:10 157:5	accommodations	261:12,18 278:13	342:19	advocated 309:17
159:4 160:21	111:11,13,15	278:19 279:2,6,8	addresses 224:15	advocates 327:19
170:8 209:14	accomplish 315:13	279:17 287:22	addressing 36:9	affairs 2:6 3:7
210:5 227:15	accomplishment	297:19 299:9	228:12 360:3	99:10 178:22
246:19 249:14	138:17	300:1 309:8 312:8	adds 57:13	179:10 212:7
254:17 258:10	accomplishments	312:10	adhere 32:5	213:13 216:6,10
275:10 296:21	110:9 111:20	activities 21:13	adjunct 67:11	221:5 241:12,13
305:17 320:10	account 144:8,9	22:14 23:15,16	adjusting 328:5	241:14 255:6
321:1	148:22 149:3	115:1,3	admin 373:19	308:11
able-bodied 77:9	222:6,13	activity 17:10	374:18	affect 130:10 198:8
above-entitled	accountability	115:11 178:19	administer 101:18	affiliates 95:19
41:10 99:4 176:10	37:13	219:18	157:4 224:8	afford 82:3 171:14
228:1 321:21	accountable 38:2	actual 51:18 125:6	administering	267:6 297:18
375:3	211:21	125:9 146:11,21	80:13	Afghanistan
Absolutely 158:2	accounts 10:4	146:22 149:14	administration	191:11 225:1
abuse 75:21 356:6	247:13,14	208:21 215:13	42:13 91:7	259:21
356:7	accurate 14:19	219:1 303:20	Administrations	AFHSC 178:2,7
academic 211:16	accurately 352:22	351:8 364:8	43:21	179:6 182:9 184:8
academically 102:8	achieve 116:17	actualized 109:10	administrative	188:20 189:9
142:21 233:15	117:8 168:3	actualizing 109:7	8:22	214:2,18,19
academics 211:18	228:11	acute 199:5 298:20	administrator	afternoon 15:14
Accelerator 125:8	acknowledge 347:7	329:22	95:15	374:21
accept 250:2 346:4	362:12	ad 215:3	administrators	afterthought 67:19
accepting 319:18	acquaint 193:19	ADA 112:20	92:6	after-action 5:18
access 40:12 90:21	acquiesced 88:5	add 12:20 38:16	Admiral 304:3	6:3,8
111:17 115:6	acronym 103:2	289:15	admissions 91:13	age 51:12 151:8
130:12 136:13	369:2	added 33:10 76:9	ado 100:2	158:8 197:14
144:10 149:20	acronyms 369:15	216:2	adult 354:21 356:8	279:18,19 280:20
151:16 186:8	act 59:8,18 66:10	adding 93:11	adults 302:16	302:15 303:12,13
190:15 193:10	83:7,8 246:11,15	addition 192:15	advance 16:4 39:19	agencies 150:3
197:17 260:19	246:18 338:3	201:1 209:10	87:2 100:3	338:6
261:10 274:18,18	Acting 1:14,18	210:17 220:21	advances 67:6	agenda 8:3 10:21
294:12 301:7	action 3:2 181:8	245:9 333:10	86:13 92:14 96:13	18:1 100:5,6
	212:1 221:21	345:22	96:14	374:11

agendas 8:4,4 31:1 34:7,8,13	74:10 90:20 202:18 224:13	98:3,4 278:6	366:16,21 367:2	applying 149:7 172:1
agent 179:9 211:21	247:22 255:3,13	amputee 58:18 82:1	answered 113:3 336:18,20,21	appointment 108:12,18,20 109:6,7,10 168:19 169:4,8,9 171:22 172:16 175:5
Ages 51:12 52:12	299:20	amputees 57:13 58:5	answering 10:22 13:9 157:22	appreciate 17:3 166:18 175:15 190:5 227:10 270:2 314:22 315:1 321:11,14
aggregate 365:13	allowing 128:9 322:3 372:3	analyses 184:22 187:7,8,12 190:22 200:14 215:3 222:7	antecedent 45:11	appreciation 210:16
ago 28:12 31:15 66:7 188:10 276:8 319:4 327:22 362:9	allows 101:19 102:2 121:10 135:21 260:14 299:16	analysis 2:10,12 129:17,21 176:17 177:1 181:4 187:6 190:7 193:5,7 195:16 197:7 198:3 199:11,22 202:4 203:1 206:15 207:10 209:15 210:5 213:11,18 214:16 218:2 223:4,13 346:8	antibiotics 92:15	appreciative 27:22 89:7 374:22
agree 25:14 30:3,15 208:8 332:2 365:18	alluded 362:8	anatomy 46:5 96:15	antibodies 186:16 188:8	apprenticeship 114:15 157:5
agreeable 109:5	all-volunteer-led 271:13	ancient 47:14 53:4	Antietam 97:7	apprenticeships 157:16,20
agreeing 30:16	alphabetical 236:2 271:13	and-half 365:10	antimicrobial 184:5	approach 43:7 311:5 320:13
ahead 5:1 41:21 100:5 148:7 270:14 321:16 323:9	alphabetically 235:18	and/or 279:11	antiseptic 48:8	approached 211:15 314:21 316:6
ahold 242:10	Alternate 2:3	Anecdotally 171:17	antiseptics 48:10 86:15	approaches 91:8
aid 255:15,19 310:11,16,21	alternative 26:5	anger 290:8,11 312:19	anxiety 285:16	approaching 101:20
Aide 310:12	altogether 295:3	animal 221:4,8	anybody 40:5 190:11 370:6	appropriate 22:16 109:22 220:17 306:21 359:6 360:6
air 12:1 39:6 92:17 93:21,21 236:17 236:18 307:5 337:16,17,18	amazing 253:1	Anne 2:3 62:9	anymore 301:18	approval 117:2 164:19 338:15
Airmen 228:13	ambitious 324:16	annexes 93:17	anytime 103:10 222:17	approve 117:3 161:16 163:17,20
airplane 34:10	ambulances 47:21 87:6	annoyance 256:21	anyway 153:11 303:17	approved 131:4 134:11 135:10 175:9 253:9 338:12
airplanes 35:13	ambulatory 185:6 185:22 195:12	annual 7:17 49:12 146:14	apart 67:12	approximately 135:5 280:2
air-time 366:6	America 140:1 143:17 235:17	annually 187:22 188:2	apartment 248:21	April 239:8
Akaka 319:2	American 42:6 55:17 56:10 58:22 59:22 62:11 66:21 70:4,18 71:10,18 72:12 78:12,13 79:7 81:4 86:9 207:18 243:1	anonymity 20:14 358:4,9	apologize 127:5,9 247:1 340:7	aptitudes 107:22 110:4 134:7
akin 81:3	Americans 71:20	anonymous 235:3	apparently 151:19	area 39:17 80:15
alcohol 279:11	amount 120:18,19 123:18 129:8 255:3	anonymously 357:8	appeals 69:16	
alcoholics 91:11	amounts 255:14 296:12	anoxic 258:18	appear 186:16,17	
Alexander 73:4	amputated 57:11 81:14	answer 13:10 112:10,17 150:16 151:1 237:12 247:1 251:1	appears 209:12	
alibis 40:5 41:4	amputation 72:1,4 72:5 81:9,15,22 82:7		appendices 31:13	
align 305:7,11 307:4,13	amputations 57:18 58:3 81:8 88:11		Appendix 333:4	
Allies 63:15			applicants 119:15 153:9 285:5	
allotment 50:9			application 103:14 107:1,4 108:11,22 148:18 168:22 169:1 172:5 180:21 306:5	
allow 52:15 89:11 209:3 293:8 296:1 299:20 332:10 333:1 372:1			applications 170:2 170:4	
allowance 116:18 121:6,12			applied 76:3 171:18 172:15	
allowed 67:15			apply 142:9,11 149:1 168:17 275:20 338:16	

81:17 103:5 140:22 162:21 163:3 223:16 236:8 240:19 249:14,17 263:6 263:10 267:8 274:15 291:5 327:8 346:15	232:16 236:10,19 253:21 286:18 287:22 306:10 307:5 326:19,20 327:2,18 335:11	assets 327:21 assign 256:6 assigned 200:21 227:2 255:5,9 assignment 95:13 115:10 321:12 assimilate 344:4 assist 356:19 assistance 102:12 103:3 126:17,18 260:15 263:6 355:3 assistive 126:6 associated 79:22 154:10 265:5 association 2:20 3:17 150:2 269:21 270:2,7 277:19 305:3 310:9 assume 237:10 340:12 assure 33:22 asylum 45:1 atmosphere 351:5 atrophy 252:19 attach 294:15 attached 293:22 attack 88:20 attempt 91:4 314:20 371:11 attempted 25:5 attend 164:6 168:18,19 272:3 280:16 281:8 342:9 attendants 255:16 255:19 310:11,12 310:17,22 attended 345:4 attendees 349:15 attention 128:2 198:5 219:10 235:9 333:22 354:4 372:18 374:21 attentive 259:4 attract 139:5	attributes 189:15 audience 375:1 augmentee 282:2,6 augments 333:12 August 23:5,7 88:16 121:9 127:6 277:11 Augusta 327:4 Augustus 47:8,10 author 56:21 authorities 354:19 authority 60:11 66:15 133:10 136:20 authorized 72:15 authors 50:5 96:19 autistic 302:1 automated 187:18 automatically 144:8 available 94:21 147:16 148:3 150:10 158:9 165:9,14,15 166:11 183:5 199:13 213:1 226:1 299:15,17 300:15 352:3 356:13,16 358:17 avenues 114:16 136:16 average 52:2,17 54:6,6 61:15 108:21 109:1 146:14 172:18 173:11,16,21 174:2 175:11 286:16 averaged 278:4 averaging 173:11 278:6 avoid 368:5 370:5 aware 153:16 220:10 256:4 270:15 293:18 309:10 324:3 336:10 337:21	awareness 337:2 awful 274:5 AW2 293:21 350:8 a.m 1:13 4:2 41:11 41:12 99:5,6
areas 38:21 136:1 151:12 210:22 263:7 272:4,5 295:20 321:8 331:22 334:2 336:15 361:22	ARNG 1:19 array 330:18 Arrears 83:7 arrived 345:14 arsenal 305:12 article 191:9 193:8 193:9,19 202:2 209:12 articles 64:16 72:22 187:9 articulate 21:2 articulated 150:21 artillery 88:22 ascertain 348:20 ASD 179:10 aside 67:12 asked 13:10 160:18 213:22 240:15 272:12,22 273:11 273:22 280:6 326:7 335:16 346:3 353:1	assistive 126:6 associated 79:22 154:10 265:5 association 2:20 3:17 150:2 269:21 270:2,7 277:19 305:3 310:9 assume 237:10 340:12 assure 33:22 asylum 45:1 atmosphere 351:5 atrophy 252:19 attach 294:15 attached 293:22 attack 88:20 attempt 91:4 314:20 371:11 attempted 25:5 attend 164:6 168:18,19 272:3 280:16 281:8 342:9 attendants 255:16 255:19 310:11,12 310:17,22 attended 345:4 attendees 349:15 attention 128:2 198:5 219:10 235:9 333:22 354:4 372:18 374:21 attentive 259:4 attract 139:5	backbone 54:5 background 178:3 190:13 222:8	
arena 243:4 argued 74:3 83:17 arguing 207:11 arises 53:13 69:3 aristocracy 73:12 Arkansas 267:17 Arlington 1:13 arm 40:20 60:18 216:21 219:21 armed 1:4 2:11,13 3:9 176:17 177:2 177:14 180:9 337:3 armies 43:9 54:8,9 armor 222:21 arms 59:13 army 5:14,15 12:1 46:21 47:5 49:16 49:22 50:1 51:10 55:13 56:10,11 62:8,16 63:8 65:15,16 66:16 70:15,19 71:10 77:20,21 78:18 80:2,3 84:17,19 85:1,2,5 87:16,22 88:5,9 94:7 96:1 175:14 177:16 178:18 179:9 190:19 204:21 205:17,20 206:8 213:15 221:6 226:18,20 230:16	articles 64:16 72:22 187:9 articulate 21:2 articulated 150:21 artillery 88:22 ascertain 348:20 ASD 179:10 aside 67:12 asked 13:10 160:18 213:22 240:15 272:12,22 273:11 273:22 280:6 326:7 335:16 346:3 353:1 asking 284:18 311:21 329:12 331:13 335:15 351:18 353:6 359:2 368:4 asks 355:12 asleep 84:18 aspects 318:10 346:18 Asperger's 302:1 assess 9:4 22:18 23:18 40:17 110:3 110:3,3 228:19 229:5 304:5 assessing 22:12 304:1 322:11 assessment 103:6 109:12 121:4 134:6 assessments 107:21	attributes 189:15 audience 375:1 augmentee 282:2,6 augments 333:12 August 23:5,7 88:16 121:9 127:6 277:11 Augusta 327:4 Augustus 47:8,10 author 56:21 authorities 354:19 authority 60:11 66:15 133:10 136:20 authorized 72:15 authors 50:5 96:19 autistic 302:1 automated 187:18 automatically 144:8 available 94:21 147:16 148:3 150:10 158:9 165:9,14,15 166:11 183:5 199:13 213:1 226:1 299:15,17 300:15 352:3 356:13,16 358:17 avenues 114:16 136:16 average 52:2,17 54:6,6 61:15 108:21 109:1 146:14 172:18 173:11,16,21 174:2 175:11 286:16 averaged 278:4 averaging 173:11 278:6 avoid 368:5 370:5 aware 153:16 220:10 256:4 270:15 293:18 309:10 324:3 336:10 337:21	awareness 337:2 awful 274:5 AW2 293:21 350:8 a.m 1:13 4:2 41:11 41:12 99:5,6	
arm 40:20 60:18 216:21 219:21 armed 1:4 2:11,13 3:9 176:17 177:2 177:14 180:9 337:3 armies 43:9 54:8,9 armor 222:21 arms 59:13 army 5:14,15 12:1 46:21 47:5 49:16 49:22 50:1 51:10 55:13 56:10,11 62:8,16 63:8 65:15,16 66:16 70:15,19 71:10 77:20,21 78:18 80:2,3 84:17,19 85:1,2,5 87:16,22 88:5,9 94:7 96:1 175:14 177:16 178:18 179:9 190:19 204:21 205:17,20 206:8 213:15 221:6 226:18,20 230:16	articles 64:16 72:22 187:9 articulate 21:2 articulated 150:21 artillery 88:22 ascertain 348:20 ASD 179:10 aside 67:12 asked 13:10 160:18 213:22 240:15 272:12,22 273:11 273:22 280:6 326:7 335:16 346:3 353:1 asking 284:18 311:21 329:12 331:13 335:15 351:18 353:6 359:2 368:4 asks 355:12 asleep 84:18 aspects 318:10 346:18 Asperger's 302:1 assess 9:4 22:18 23:18 40:17 110:3 110:3,3 228:19 229:5 304:5 assessing 22:12 304:1 322:11 assessment 103:6 109:12 121:4 134:6 assessments 107:21	attributes 189:15 audience 375:1 augmentee 282:2,6 augments 333:12 August 23:5,7 88:16 121:9 127:6 277:11 Augusta 327:4 Augustus 47:8,10 author 56:21 authorities 354:19 authority 60:11 66:15 133:10 136:20 authorized 72:15 authors 50:5 96:19 autistic 302:1 automated 187:18 automatically 144:8 available 94:21 147:16 148:3 150:10 158:9 165:9,14,15 166:11 183:5 199:13 213:1 226:1 299:15,17 300:15 352:3 356:13,16 358:17 avenues 114:16 136:16 average 52:2,17 54:6,6 61:15 108:21 109:1 146:14 172:18 173:11,16,21 174:2 175:11 286:16 averaged 278:4 averaging 173:11 278:6 avoid 368:5 370:5 aware 153:16 220:10 256:4 270:15 293:18 309:10 324:3 336:10 337:21	awareness 337:2 awful 274:5 AW2 293:21 350:8 a.m 1:13 4:2 41:11 41:12 99:5,6	
arena 243:4 argued 74:3 83:17 arguing 207:11 arises 53:13 69:3 aristocracy 73:12 Arkansas 267:17 Arlington 1:13 arm 40:20 60:18 216:21 219:21 armed 1:4 2:11,13 3:9 176:17 177:2 177:14 180:9 337:3 armies 43:9 54:8,9 armor 222:21 arms 59:13 army 5:14,15 12:1 46:21 47:5 49:16 49:22 50:1 51:10 55:13 56:10,11 62:8,16 63:8 65:15,16 66:16 70:15,19 71:10 77:20,21 78:18 80:2,3 84:17,19 85:1,2,5 87:16,22 88:5,9 94:7 96:1 175:14 177:16 178:18 179:9 190:19 204:21 205:17,20 206:8 213:15 221:6 226:18,20 230:16	articles 64:16 72:22 187:9 articulate 21:2 articulated 150:21 artillery 88:22 ascertain 348:20 ASD 179:10 aside 67:12 asked 13:10 160:18 213:22 240:15 272:12,22 273:11 273:22 280:6 326:7 335:16 346:3 353:1 asking 284:18 311:21 329:12 331:13 335:15 351:18 353:6 359:2 368:4 asks 355:12 asleep 84:18 aspects 318:10 346:18 Asperger's 302:1 assess 9:4 22:18 23:18 40:17 110:3 110:3,3 228:19 229:5 304:5 assessing 22:12 304:1 322:11 assessment 103:6 109:12 121:4 134:6 assessments 107:21	attributes 189:15 audience 375:1 augmentee 282:2,6 augments 333:12 August 23:5,7 88:16 121:9 127:6 277:11 Augusta 327:4 Augustus 47:8,10 author 56:21 authorities 354:19 authority 60:11 66:15 133:10 136:20 authorized 72:15 authors 50:5 96:19 autistic 302:1 automated 187:18 automatically 144:8 available 94:21 147:16 148:3 150:10 158:9 165:9,14,15 166:11 183:5 199:13 213:1 226:1 299:15,17 300:15 352:3 356:13,16 358:17 avenues 114:16 136:16 average 52:2,17 54:6,6 61:15 108:21 109:1 146:14 172:18 173:11,16,21 174:2 175:11 286:16 averaged 278:4 averaging 173:11 278:6 avoid 368:5 370:5 aware 153:16 220:10 256:4 270:15 293:18 309:10 324:3 336:10 337:21	awareness 337:2 awful 274:5 AW2 293:21 350:8 a.m 1:13 4:2 41:11 41:12 99:5,6	
arena 243:4 argued 74:3 83:17 arguing 207:11 arises 53:13 69:3 aristocracy 73:12 Arkansas 267:17 Arlington 1:13 arm 40:20 60:18 216:21 219:21 armed 1:4 2:11,13 3:9 176:17 177:2 177:14 180:9 337:3 armies 43:9 54:8,9 armor 222:21 arms 59:13 army 5:14,15 12:1 46:21 47:5 49:16 49:22 50:1 51:10 55:13 56:10,11 62:8,16 63:8 65:15,16 66:16 70:15,19 71:10 77:20,21 78:18 80:2,3 84:17,19 85:1,2,5 87:16,22 88:5,9 94:7 96:1 175:14 177:16 178:18 179:9 190:19 204:21 205:17,20 206:8 213:15 221:6 226:18,20 230:16	articles 64:16 72:22 187:9 articulate 21:2 articulated 150:21 artillery 88:22 ascertain 348:20 ASD 179:10 aside 67:12 asked 13:10 160:18 213:22 240:15 272:12,22 273:11 273:22 280:6 326:7 335:16 346:3 353:1 asking 284:18 311:21 329:12 331:13 335:15 351:18 353:6 359:2 368:4 asks 355:12 asleep 84:18 aspects 318:10 346:18 Asperger's 302:1 assess 9:4 22:18 23:18 40:17 110:3 110:3,3 228:19 229:5 304:5 assessing 22:12 304:1 322:11 assessment 103:6 109:12 121:4 134:6 assessments 107:21	attributes 189:15 audience 375:1 augmentee 282:2,6 augments 333:12 August 23:5,7 88:16 121:9 127:6 277:11 Augusta 327:4 Augustus 47:8,10 author 56:21 authorities 354:19 authority 60:11 66:15 133:10 136:20 authorized 72:15 authors 50:5 96:19 autistic 302:1 automated 187:18 automatically 144:8 available 94:21 147:16 148:3 150:10 158:9 165:9,14,15 166:11 183:5 199:13 213:1 226:1 299:15,17 300:15 352:3 356:13,16 358:17 avenues 114:16 136:16 average 52:2,17 54:6,6 61:15 108:21 109:1 146:14 172:18 173:11,16,21 174:2 175:11 286:16 averaged 278:4 averaging 173:11 278:6 avoid 368:5 370:5 aware 153:16 220:10 256:4 270:15 293:18 309:10 324:3 336:10 337:21	awareness 337:2 awful 274:5 AW2 293:21 350:8 a.m 1:13 4:2 41:11 41:12 99:5,6	
arena 243:4 argued 74:3 83:17 arguing 207:11 arises 53:13 69:3 aristocracy 73:12 Arkansas 267:17 Arlington 1:13 arm 40:20 60:18 216:21 219:21 armed 1:4 2:11,13 3:9 176:17 177:2 177:14 180:9 337:3 armies 43:9 54:8,9 armor 222:21 arms 59:13 army 5:14,15 12:1 46:21 47:5 49:16 49:22 50:1 51:10 55:13 56:10,11 62:8,16 63:8 65:15,16 66:16 70:15,19 71:10 77:20,21 78:18 80:2,3 84:17,19 85:1,2,5 87:16,22 88:5,9 94:7 96:1 175:14 177:16 178:18 179:9 190:19 204:21 205:17,20 206:8 213:15 221:6 226:18,20 230:16	articles 64:16 72:22 187:9 articulate 21:2 articulated 150:21 artillery 88:22 ascertain 348:20 ASD 179:10 aside 67:12 asked 13:10 160:18 213:22 240:15 272:12,22 273:11 273:22 280:6 326:7 335:16 346:3 353:1 asking 284:18 311:21 329:12 331:13 335:15 351:18 353:6 359:2 368:4 asks 355:12 asleep 84:18 aspects 318:10 346:18 Asperger's 302:1 assess 9:4 22:18 23:18 40:17 110:3 110:3,3 228:19 229:5 304:5 assessing 22:12 304:1 322:11 assessment 103:6 109:12 121:4 134:6 assessments 107:21	attributes 189:15 audience 375:1 augmentee 282:2,6 augments 333:12 August 23:5,7 88:16 121:9 127:6 277:11 Augusta 327:4 Augustus 47:8,10 author 56:21 authorities 354:19 authority 60:11 66:15 133:10 136:20 authorized 72:15 authors 50:5 96:19 autistic 302:1 automated 187:18 automatically 144:8 available 94:21 147:16 148:3 150:10 158:9 165:9,14,15 166:11 183:5 199:13 213:1 226:1 299:15,17 300:15 352:3 356:13,16 358:17 avenues 114:16 136:16 average 52:2,17 54:6,6 61:15 108:21 109:1 146:14 172:18 173:11,16,21 174:2 175:11 286:16 averaged 278:4 averaging 173:11 278:6 avoid 368:5 370:5 aware 153:16 220:10 256:4 270:15 293:18 309:10 324:3 336:10 337:21	awareness 337:2 awful 274:5 AW2 293:21 350:8 a.m 1:13 4:2 41:11 41:12 99:5,6	

230:15	291:18 297:22	behaviors 197:15	41:15	147:6 171:11
backup 245:8	299:11 304:18	364:10 365:6,20	best 16:5 74:9	178:3 187:2 190:7
backwards 162:12	305:17 306:20	366:1	162:21 164:13	190:13 193:6
backwater 91:12	313:22 317:8	behooves 54:10	242:3 243:5 244:5	200:4 213:17
bad 35:2 310:7	320:22 330:15	beings 306:18	247:1 268:20	221:13,16 223:16
348:8,13	338:16,20	believe 18:9 28:4	297:3 334:22	224:6,16 230:14
badgering 341:21	basis 85:18 90:22	34:9 127:3 132:20	343:13,17	256:21 258:4,21
balance 330:20	92:9 94:22 97:1	140:21 148:7	Bethesda 238:8	273:5,15 278:12
balanced 298:6	116:18 187:21	191:8 197:17	345:14	283:6 284:9,16
balancing 367:6	190:10,16 207:17	259:17 260:13	bets 223:3	290:19 343:4
Balboa 39:8 103:5	208:4 218:4 223:7	267:19 271:9	better 16:12,21	346:12 367:5
291:4	272:4 294:11	337:16	25:10 26:14 36:2	bite 221:8
Ballroom 1:12	304:4	belong 184:13	36:12 43:17 46:8	bites 128:4 218:12
BAMC 291:4	bathing 115:3	350:11	55:19 69:7 71:13	221:4
banded 50:17	250:7	belt 33:21 177:17	86:7 129:4 139:8	bits 156:6
bankrupt 269:4	bathroom 248:13	beneath 28:9	221:13 229:14	blank 343:10
Barb 243:13	battle 52:3 71:2,10	Beneficence 341:10	270:7 320:11	364:21
Barbara 2:18	78:17 79:18 88:14	342:4	340:14 368:13,15	bleeding 57:1
269:18,22 328:6	88:17,18 97:7	benefit 61:14 96:5	372:22	blinking 69:18
barber 113:15,15	204:8 223:21	101:16 102:1	beyond 28:13 47:3	blocks 13:2 356:3,3
114:4,6	battlefield 44:19	124:10 142:14,15	106:13 314:21	blood 53:7 92:15
barber/surgeon	46:2 52:16 55:4	152:3,6 157:3	bias 202:20	blue 111:7
53:13	63:17 68:2,14	160:4 168:16	bifurcated 96:4	blurbs 148:16
barrage 227:11	71:8 80:6 85:11	170:10 181:18	big 23:21,21 34:1	board 139:15 144:6
barrier 316:11	86:20 87:7 97:12	274:17 296:15	119:7 181:12	306:18 331:16
barriers 105:22	battles 63:12 71:17	305:7,18,18 306:5	242:22 243:2	338:11
158:22 231:18	bear 265:1	306:6,14,16 312:8	312:11 345:7	boards 338:6
313:6,7	beautiful 183:7	312:15	biggest 94:1 145:19	body 191:20 209:1
base 40:13 281:11	beauty 133:11	benefits 43:2,3 50:7	145:22 163:21	252:4 340:11
295:5 301:8	becoming 269:3	50:13 51:4 73:16	261:5	Boer 68:4,5 69:20
319:15 320:1	beds 80:10,14,16	83:13 101:17	bill 95:3 120:12,14	bone 57:9
337:18	bedside 239:16	102:5 104:15	120:22 122:12	bono 267:9
based 49:4 75:18	245:5,19	107:5 108:3	156:2,14 161:13	bonus 49:11
75:18 81:22 85:19	bedsore 259:3	109:20 120:1,17	166:4 169:10	bonuses 74:4
108:15 118:16	began 141:17	122:1 137:2 142:6	170:19 256:7	book 46:15 48:20
121:16 135:2	230:19	142:9,15 146:14	319:3	49:1 55:14 204:18
165:18 170:4	beggars 54:18	147:7,9 151:17,21	billion 185:2	315:5
174:15 263:13	begging 58:6,6	153:2 157:2,10	Biloxi 51:8	books 5:21 99:12
316:12 327:10	beginning 80:11	165:8,11,13,15,18	bio 177:3	116:19 120:18,19
bases 217:19 263:5	96:10 125:13	166:2,11 246:2	bipolar 288:9	121:1,3,18 340:19
basic 115:2 194:16	309:3 350:21	256:7 271:8	birth 77:6 283:21	371:4
326:1 328:19	351:12	274:14 305:5,21	288:7	booty 62:3
basically 57:5	begins 41:4 106:7,9	306:19 308:13,14	bit 6:4,14,17 8:3	border 85:12
72:20 92:10	175:7	311:5 312:12	12:22 16:21 18:1	borders 47:4
184:21 187:14	behavior 69:14	benefitted 304:22	22:4,7 102:11	bore 194:22
221:9 276:18	behavioral 205:1	Benning 369:9	104:5,11 106:17	boring 262:19
281:14 286:7	313:11	Bernard 2:4 3:4	120:10 132:13	born 91:1 303:6

boss 29:3	23:19 34:19,20	357:17	124:16,20 125:5,7	152:20
bottom 148:18	40:18 103:7	broke 27:10 32:22	125:10 128:15,21	campaigns 63:9
337:2,11 366:11	119:19 153:11	45:8 235:11	130:3 141:11	89:1
bought 303:14	154:13 228:10	broken 208:19	295:3 370:22	camp 79:17 80:21
bounce 25:12	262:19 322:8,15	370:12	Buster 256:5	93:18 273:16,17
boundaries 320:16	322:22 326:21	brought 16:7 19:3	busy 32:19 34:13	273:18 276:4,9,12
boy 25:21 288:5	329:7 330:5	21:3 22:5,8 26:19	290:14,20	280:6
boys 286:11	336:21,22 344:6	28:1 33:1 52:3	buttons 184:2	campus 104:4,9,13
Bradley 95:14	345:20,21 369:20	67:14 91:21 92:13	buy 82:3 268:5	140:5 141:14,19
brain 233:3 244:4	370:1 374:1,15	203:20 207:3		142:1 157:11,13
248:8 258:18	briefly 131:16	292:12 296:19	C	157:18
262:5 278:5 290:3	182:17 193:12	360:18	C 41:20 240:12	candid 18:12
brainer 318:19	195:17 200:17	browse 148:21	cadre 17:6,15 18:2	candidly 18:7
branch 267:14	338:19 354:12	Brundage 190:18	18:5,10 350:8	capabilities 189:11
branches 53:8	362:8,16	buckets 129:12	calendar 27:21	capability 318:5
brass 17:12	briefs 215:2	bud 21:12	California 323:4	capable 56:5
break 6:12 41:7	brigade 241:9	budget 83:15	325:5	capacity 58:14
78:8 83:11 99:2	293:13 329:6	135:11 136:20	call 23:16 26:8	95:12 343:6
176:8 185:22	brigs 71:19	184:15	75:21 105:9,21	CAPT 2:7 176:21
227:22 321:17	bring 4:4 8:11,16	budgeted 255:21	189:17 192:6	211:5 212:2,15
322:3	10:3 12:3,6,7,10	build 156:5 263:1	237:18 240:2	215:4,21 218:20
breakdown 194:21	13:7 31:15 38:4	building 8:8 55:22	244:10,21 319:6	227:7,13
breakdowns 195:3	40:17 67:13 89:16	94:7 123:3 177:20	called 51:16 54:3	Captain 176:15,21
breaking 304:16	183:6 226:6 265:1	263:5	56:21 66:14 86:2	182:8 190:3,8
break-up 54:2	286:6 312:20	builds 95:19	87:20 104:21	195:17 214:1
breast-to-breast	333:21 348:10,10	built 45:6 105:6	164:6 179:1,3	225:16 226:15,16
79:13	354:4 357:7	305:5	235:17 236:17	captive 71:20
breath 369:4	bringing 11:17	Bull 79:17,18	239:9 251:21	captivity 71:21
breeze 34:2	49:21 55:10	bullet 23:2,5,6 88:8	252:21 253:10	capture 16:6 20:5
brick 317:6	228:12 273:10	88:21 366:11	260:14 264:11	20:20 39:14 141:5
bridge 309:12	312:22 373:17	bullets 339:2,5	282:7 285:2	196:4
323:5	brings 95:16	351:11 363:1	301:20 317:15	captured 14:22
brief 10:20 99:1	218:15	365:3	354:6	15:16,21 71:16
102:13 107:9	Britain 58:21 61:5	bump 121:22	calls 7:11 24:21	captures 100:22
196:17 214:19	63:16 65:20 67:20	bumped 120:10	25:6 26:4,12,14	195:21
242:18 329:1,3	73:13 191:21	bumping 294:10	26:18 27:14,17	capturing 18:17
374:7	British 59:5 62:8	bunch 217:4	140:9 218:22	21:1 158:6 330:16
briefed 12:9 35:22	62:11,16 63:8,14	320:17 327:20	219:1 267:7 292:9	353:22
264:13 265:10	64:16 65:15 67:5	Bureau 90:19 91:3	294:20	Cardinal 55:20
278:2 318:8 326:5	68:6,8,11 69:13	161:1 374:6	camp 63:2 71:8	cardiovascular
briefers 11:4 326:7	70:7,7 71:11,14	bureaucracy 129:2	273:4,21 275:8,8	253:7
346:3,5 369:6	72:12,21 74:6	burial 50:18,22	275:10,12,18	care 1:3 3:4,14,17
briefing 9:6 18:12	86:5 88:19 89:1	burn-out 304:12	276:15,18,21,21	8:22 38:10,18
41:21 98:16 154:1	broad 44:3,8 45:18	Bush 42:13	277:5,6,14 285:4	39:3 42:17,18,18
337:15 340:19	179:8 231:15,20	business 7:17,21	289:19 293:22	42:20 44:7,15
briefings 6:19 8:14	232:5	8:20 31:3,7 32:9	297:6	45:6,12,12 46:1,7
8:15 9:12 10:8	broadly 44:6	113:10 114:8	campaign 67:18	46:11,14 47:1,5

49:14 50:3 52:1,7 52:18 54:5,11,11 55:10,17 56:1,13 60:2,3,13 61:19 62:21 63:12,16,18 63:20,22 64:1,21 68:2 69:17 76:20 77:9,15 79:16,17 79:18 80:7 81:21 82:20 83:1 84:7 84:11 85:11 87:21 90:15 94:20 95:4 115:5 195:21 201:13,16 207:8 211:2 232:3,7 236:20 237:6 238:14 239:10 244:7,11 249:9,13 249:18 250:1,9,12 250:15 251:8 255:6 257:16,18 258:10,12,22 259:7 263:11 264:6 266:3,10 268:21 274:15 284:4,7 287:6 290:14,15,16,17 294:7,8,13 295:20 296:7 297:20 298:2 299:18,18 301:2,20 302:3,8 302:16 303:9,22 304:10 306:3 308:6 312:5,6,20 313:2,12,14 319:9 327:6 328:2 330:1 335:9 361:16	carefully 187:19 346:13,21 347:6 363:7 caregiver 82:20 239:5,21 244:17 258:8 262:11 287:3,13 304:12 304:18,22 305:5,6 305:7,8,19 306:5 306:6 307:19 309:1,7 310:20 312:15 319:5 caregivers 235:2 242:5,9 243:22 245:18,21 246:3,5 247:15 257:13 259:5 264:2,3 277:2 289:22 290:14 291:20,22 292:14 307:11 312:16 caregiving 234:7 246:21 caretakers 40:12 care-giving 234:10 245:7 caring 52:13 61:11 77:20 312:2 Carolina 260:9 carried 53:18 63:2 carries 53:18 62:3 70:11 carry 114:3 carrying 65:1 75:7 341:9 cars 113:12 Carter 43:21 carts 47:22 case 18:3,6 23:1,3 65:10 68:15 71:5 71:6 83:16 88:22 94:13 96:18 114:4 117:13 118:17 122:4 178:4 218:3 219:9,16 220:13 220:14 221:10 235:4 256:12,18	265:13 266:10 293:17 294:9 295:2 328:1,1 335:5,14 355:19 357:1 374:7 Caseload 129:21 cases 109:8 172:21 189:3 214:4 357:12 case-manage 122:5 cash 44:21 58:16 58:17,19 Castille 55:11 casualties 42:17 44:20 61:6 78:17 88:15,17,18,21 casualty 66:5 catalyst 232:8 catastrophic 305:10 310:2 catastrophically 231:11 catastrophically-... 240:17 catastrophically-... 244:16 catch-up 155:14 categories 206:17 359:20 360:8,9 category 114:1 caught 24:4,12,16 cause 173:6 341:13 caused 28:21 30:8 causes 151:10 152:12,15 caution 358:10 CBOC 137:7 CBWTU 323:4 324:22 325:4,8,13 325:15,16 CBWTUs 296:2 324:18 325:20 CDC 179:14 212:12 cell 179:3 Cells 327:17 Census 147:17	center 2:11,14 3:10 9:4 141:21 176:18 177:2,15 226:10 226:12 232:20 260:12 318:13 337:6,18 centers 9:2 179:19 232:16,17 302:22 316:22 317:4 318:4 327:22 central 78:6 180:8 220:22 century 48:20 53:5 62:6 63:11 64:8 65:4,6,19 67:1 75:15 89:12 97:3 certain 26:7 82:4 117:4,5 120:18,19 132:5 151:12,12 151:13 163:17 164:17 167:6 219:15 263:13 308:12 326:21,22 348:18 certainly 27:15 57:7 86:8 98:6 195:5 206:7 245:17 246:19 247:18 257:19 332:12 359:4 368:15 certificates 110:10 111:22 certification 114:7 certifications 112:1 cetera 186:2 chain 117:5 189:19 335:10 355:2 358:3 chair 315:6 chairs 39:18 340:21 challenge 145:19 145:22 147:12 155:3 234:5 243:1 245:10 247:2 257:15	challenges 138:8 163:22 191:4 232:22 234:2,7,14 234:16,17 245:14 250:18 255:11 285:22 challenging 26:12 283:7 CHAMPVA 300:17,21 chance 232:9 262:18 change 19:11 32:21 33:6 45:15,15 46:19 47:8 54:1 95:11 156:18 157:3 169:4 212:1 215:9,10 274:7,8 335:20 changed 43:15 46:7 57:18 71:3 86:6 245:11 changes 7:4 12:16 30:11 35:2 56:17 66:17 67:3,8 79:20 80:4 82:7 86:22 97:21 98:3 156:2 290:4 293:11 333:13,21 335:2,3 336:9 changing 36:7 46:12 chaplain 238:13 Chapter 101:13,18 101:18,19 102:2 107:3 119:16 133:10 334:3 336:13 character 172:22 173:3 characteristics 195:4 326:11,12 327:11 333:8 charge 79:15 307:1 308:6 charged 88:2 90:14 charges 79:14
---	---	--	---	---

charity 61:16	chose 298:9	clean 56:20	146:19 147:18	collecting 353:12
Charles 203:17	chosen 38:13 296:8	cleaner 257:1	149:19 150:1,11	collection 181:4
205:10,11,16	chunk 19:11	clear 80:18 200:18	150:14 151:1	collections 212:21
chart 146:13	church 52:19,19	352:12	153:12,18 155:19	collective 244:4
158:16 221:18	53:2,5 54:2	clearance 145:13	156:12,17 157:1	collectively 338:13
324:6 371:1	circumstances	clearly 64:4 98:1	158:3,14 159:12	346:7
charts 146:20	163:17 291:9	236:2 250:13	159:19 160:6	college 157:18
chat 317:8,15	292:6	260:21 339:12	161:2,7 162:5	162:3 164:5
cheaper 52:7	cited 331:5	341:2 351:18	164:22 167:14	248:20 249:1
check 220:17	citing 333:3	361:19 368:5	168:5,9 169:21	colleges 143:19
295:12 356:2	citizen 46:21 53:14	clerical 123:2	170:12 172:3,17	157:13 161:12
checked 356:9,12	citizenship 49:19	click 165:7 166:9	172:20 174:3,6,14	163:12,14 164:3
checking 365:3,4	50:2	cliente 236:8	175:12 176:5	Collins 315:20
check-off 62:1 77:6	City 1:13 303:17	climate 248:18	code 200:20 222:20	Colonel 4:14 228:5
Cheek 241:4,7	city-state 46:19	clinical 138:22	codes 201:2,2,8,14	colonial 59:3 70:5,8
chief 2:8 80:3 96:2	civil 50:12 56:11	Clinton 43:21	coffers 75:15,22	colonies 59:22
177:1	57:7 61:3 66:21	clip 148:13	cognitive 262:7	63:10 65:2 70:13
child 238:14	67:7,21 76:16,17	clock 175:1	cognizant 20:16	73:14 76:5
256:10 283:21	76:22 78:9,22	close 136:1 184:2	Cohon 2:18	colonists 59:2
284:4 288:4,6	79:2,7 81:2 82:10	293:6 297:16,16	269:19,22 270:1	colony 70:11
302:1 303:5,6,9	84:2,6,17 87:4	315:2 331:15	277:21 282:5	color 183:8
312:2 354:21	93:18 95:18 97:4	closed 122:16	287:18 309:10	Colorado 277:16
children 50:14	civilian 112:6,9	closely 104:4	311:4 314:15,18	combat 43:5,6 46:9
76:14 84:9 233:6	123:9 273:20	332:13	315:5,18 316:2,15	191:17 205:18,18
238:14 245:4	285:15,19 303:1	closely-related	316:21 319:2	206:8,13,15,22
248:8 273:2 277:3	326:20	138:14	321:10,13 328:7	208:3 210:17
277:5 278:20	civilians 223:22	closer 276:17	cohort 197:13	222:21 223:10
279:16,17 280:1,7	civilization 44:11	282:21 295:19	285:20	224:2 260:7,20
283:17 284:7,20	clarify 177:10	312:20	cohorts 273:20	261:2 353:3
285:14,15 287:7	clarity 8:11 367:1	closing 3:22 82:6	coin 21:6	combat-injured
287:12 288:3	Clark 2:12 177:5	174:22	COL 370:10	260:5
290:6,16 292:7,12	178:10 182:11	clothes 256:22	cold 301:13	combat-wounded
292:16 297:12	183:3 187:3	clue 37:15 39:11	collaborate 143:17	259:12 260:18
302:14,17,19	189:22 190:3	clustered 151:12	150:1 227:15	combination 124:8
303:12,19 356:7	204:10,12,16	CMS 1:19	collaborating	154:9
359:21	205:4,9,22 206:5	Coakley 5:3	139:22 140:4	combine 333:16
chime 347:13	206:10 207:20	coalescing 34:20	143:20	combined 90:18
chip 337:14	208:6,8,13 209:5	Coalition 236:20	collaboration	178:14 189:16
Chloroform 81:7	212:14 213:3	327:6	157:9	combining 91:2
choice 163:8 164:7	216:16 217:1,16	coast 2:8 39:8	collaboratively	178:8
168:17	220:6 221:15	160:20,20 177:12	118:22	come 18:4 27:11
choose 121:14,16	222:15 225:3,8	177:14,17,18	collates 15:3	33:14 44:8 59:2
168:18 283:14	226:15	coats 31:21	collect 146:6 159:7	78:4 98:6 110:5
339:22 341:14	class 51:20 65:11	Cocker 2:5 99:8,13	161:2 212:20	112:4 122:11
346:4 347:22	65:12	99:15 108:14	351:16 358:22	128:5,7 133:22
358:18	classroom 163:12	132:20 136:14	collected 181:19	137:8 142:5 146:4
chooses 168:17	163:13	140:3 145:18	224:11	149:22 156:3

164:4 169:7,8 171:5 178:10 182:10 192:9,11 197:19 265:21 269:15 270:3 272:18 276:10 293:1,7 294:18 310:17 315:11 320:9 321:17 328:11 350:14 360:13,17 374:6 comes 46:9 65:13 69:12 74:8 95:13 98:7 111:18 145:21 213:11 251:14 293:13 297:1 306:4 357:16 comfortable 29:11 29:22 258:2 339:8 342:22 348:6 coming 9:13 13:7 24:3,8 27:7 31:11 50:1 67:21 77:4 81:17 96:22 97:21 101:10 102:13 103:7 110:8 120:7 123:5 128:12 132:5 152:21 154:16 173:13 182:9 190:16 251:22 273:13,20 276:19 277:14 293:4,6 296:22 321:19 command 4:19 37:8,8 67:15 117:5 189:19 217:18 220:11 221:6 325:11 326:19 335:10 337:15 commander 5:3 39:10 134:12 241:9 300:13 commanders 47:6 commander's	231:2 Commands 215:20 216:14,21 220:9 comment 20:14 191:3 202:2,13 314:22 367:18 370:17 371:5 comments 30:18 315:2 commissary 301:7 Commission 66:14 66:20 85:20 235:13 commitment 74:2 82:8 87:10 94:19 98:11 250:3 committed 250:19 committee 26:21 27:13 28:17 29:10 29:21 38:6 39:2 66:12 88:3 89:10 217:4 227:9 242:19 Committees 241:15 common 53:4 62:16,22 65:5,7 73:15 188:3 199:6 272:10 273:12 communicable 86:15 communicate 215:19 217:3 227:19 291:18 320:7 342:21 communicating 137:12 218:19 287:10 communication 288:10 320:5,11 communications 182:18 287:10 communities 60:10 60:16,22 100:18 community 60:8 93:21 115:6,17 123:21 147:11 162:3 165:17	225:20 232:16 257:3 261:20,22 263:12 265:1 266:21 267:2 281:7,9,11 282:16 282:18 288:22 334:6 community-based 295:17 302:22 company 232:14 264:11 compare 333:17 compared 53:14 179:13 207:1 332:6 comparison 192:21 194:13 compartmentaliz... 25:11 compartmentaliz... 35:17 compartmentaliz... 17:22 compassion 59:20 compensation 46:13 102:19 242:17,20 255:2 255:19 264:15 305:6,8,20,21 310:11,21 compete 123:10 163:6 Competition 125:21 competitive 110:11 111:19 114:18 117:20 123:8 134:10 complaint 14:18 complete 84:22 141:10 169:14 185:8 353:6 354:10 completed 50:8 98:15 141:13 completely 43:22 65:22 69:15 86:12	91:16 298:18 completing 353:8 complicated 27:5 264:19 comply 338:14 component 190:21 191:2 195:21 196:6,8 198:7 261:12 278:14,18 279:1,7,9 components 123:8 185:10 271:21 275:20 composition 338:5 comprehensive 144:2 180:7 compressed 28:10 comrades 233:22 concentrate 218:14 concern 39:20 52:13 55:7,9 59:7 59:8 69:4 92:20 98:2 199:21 217:22 227:8 357:11 concerned 52:2 54:20 95:2 98:5 255:7 258:8 292:15 332:19 355:7 356:20 357:15 concerns 75:20 97:2 191:15 206:22 215:16 concerted 198:2 concluded 253:15 conclusion 11:9 351:9 concurrent 76:6 condition 103:20 132:6 192:19 199:6 247:11 251:19 conditions 42:21 42:22 55:19 192:13 193:14,16 193:21 196:19	197:10,12,20 198:8,12 199:17 199:19 200:20 201:9 202:5 210:7 condo 303:17 conduct 338:7 conducted 7:18 8:1 conducting 238:5 confederation 70:13 73:1 conference 189:17 218:22 conferencing 128:11 confidentiality 350:17 confines 339:19 confirmation 171:21 268:1 confirmed 172:2 confirming 348:17 conflagration 28:22 conflict 45:19 78:3 79:5,5 86:19 96:11 210:6 confused 177:11 336:4 Congress 70:12 72:15 75:1 83:22 91:7 228:19 241:16 274:6 congressional 213:14 congruent 365:5 conjunction 164:14 connect 208:10 211:20 268:2 320:21 connected 38:18 142:19 144:7 Connecticut 311:18 connecting 166:8 227:9 connection 38:20 39:2 83:12 94:22
--	--	--	--	--

150:3,6 connections 90:22 343:12 conscious 364:10 consent 338:21 339:15 351:2,15 352:6 357:19,20 358:20 consented 351:17 consequences 339:22 340:2 conservation 54:13 55:8 consider 27:16 29:20 240:18 241:22 250:2 317:10 331:7 344:20 367:2,4 consideration 17:14 270:22 371:19 considerations 259:9 318:19,20 considered 61:4 82:11 249:5 270:9 312:10 considering 196:19 207:6 270:15 consistency 331:16 332:3 consistent 69:13 93:7 318:9 consistently 331:5 consists 183:20 323:20 constant 259:4,4 280:22 Constantine 1:19 4:16,17 9:10 19:12 149:19 150:8 153:5,13 161:11 164:20 221:15 224:17 225:4 226:13 264:9 316:17 318:7 331:11 constantly 290:22	367:6 constituents 273:6 constitute 187:7 constitutional 73:4 constraints 167:8 contact 144:16 206:7 214:18,19 266:8 267:15 329:14 342:16 contacted 220:20 241:17 contemporaneous 82:21 content 8:5 31:1 363:2,16 373:4 contents 34:7 continent 63:9 continental 70:12 92:13 continue 36:13 50:5 78:22 231:8 251:17 323:15 340:20 continued 57:6 61:2 95:1 191:11 238:20 continues 43:11 57:7 continuing 13:1 251:12 continuously 60:19 continuum 43:12 contract 19:7,9,14 253:3 contractors 320:16 contracts 319:21 contractual 20:8 contrarian 11:13 contrasting 365:4 contribute 181:21 227:15 348:2,4,5 contributed 141:21 337:8 contributing 176:18 183:3 330:20 contributions	50:19 69:19 control 46:6 48:11 48:12 57:1,2 72:2 78:19 92:10,11 96:16 147:6 180:22 181:8,16 controlling 86:14 CONUS 311:15 CONUS-based 193:1 convalescent 80:20 93:17,18 94:7 convalescing 48:1 convenience 109:11 Conventions 64:5 conversation 348:3 355:11 conversations 118:17 137:5 360:12 368:6 converse 365:22 conveyances 47:22 convoys 222:10 cooking 115:4 cooperate 220:8 221:13 coordinate 69:19 161:9 218:22 219:5 335:8 coordinated 189:8 coordinating 155:21 coordination 189:18 307:22 coordinator 101:7 101:8 141:21 145:2 237:4 243:21 265:9 266:2,17 335:9 coordinators 119:3 149:17 293:19 294:4,9 327:18 copayments 296:16 copies 14:2 369:22 370:20 copy 10:17 191:8	370:14 cord 253:19 258:16 core 151:4 Corelli 319:19 Corporation 2:4 corps 12:2 47:11,15 56:4,9 58:10 62:22 63:6 72:8 72:11 85:14 205:20 206:9 221:18,22 236:21 259:17 286:16 298:4 307:6 308:22 Corpsman 248:7 248:10 Corps's 327:17 correct 29:1 127:2 150:11 156:16 208:6 corrected 29:16 106:1 correction 119:12 correctly 204:15 correlate 205:7 corroborating 348:17 cost 50:22 117:2,4 121:6 162:7 163:7 164:18,19 247:22 264:14 couching 344:20 Council 179:11 216:1,3 counseling 102:4 107:17 108:12 124:19 135:17,20 138:13 168:19 201:8 291:2,10 317:1 318:2,14 counselor 104:10 107:18,19,19 109:3 112:14 117:3 118:15 130:18,18,22 131:11,14,15 134:17,18 137:2	137:13 138:9,15 139:5,12 141:8,19 153:20 157:12,19 162:9 164:1,4,16 172:6,12 174:16 counselors 120:2 122:5 124:17 129:3 130:12 136:8 138:4,12 142:13 143:2 154:21 163:1 273:17 counselor's 131:22 321:1 count 306:8 counted 368:18 counterbalance 9:16 counterbalances 322:21 countered 52:9 counterpoint 13:8 country 59:2 61:21 62:12 67:7 120:4 188:14 234:7 235:2 238:10 countryside 59:10 counts 368:16 county 179:22 couple 18:18 31:21 37:3 89:9 118:5 133:22 136:15 180:11 201:5 202:8 207:15 228:9 291:14 319:13 370:19 373:21 374:14 couples 291:12 course 6:12 8:8 19:20 95:21 123:4 133:7 210:6 242:5 243:22 322:13 339:7,16 349:16 courtesy 39:15 court-martials 62:2 cover 34:14 42:2,11
---	--	--	---	--

309:5 331:21 covered 9:2 42:6 309:1,9 362:4 covers 42:8 362:3 co-chair 1:14,14,17 1:18 4:7,8,21 5:2 5:7 10:6,13,16 14:14,17 15:2 18:14,20 31:2 35:15 36:18,21 41:13 108:9 158:4 159:9,16,20 171:15 172:13,19 173:22 174:4,10 176:13 265:6 268:8 269:16 331:20 360:10,16 373:1 co-moderating 349:21 co-moderators 363:21 crafted 22:9,11 31:12 crafting 7:16 craftsmen 64:12 create 50:18 149:3 149:10 211:14 312:5 created 21:10 56:4 66:9,13 92:5,7 98:4 231:14 263:16 312:5 creates 25:10 47:10 creating 8:20 96:4 148:22 150:4 creation 85:5,6 credentials 163:5 crew 93:22 Crimea 65:21 66:15 Crimean 65:14,14 67:5 71:6 crisis 269:8 criteria 263:13 critical 167:1 Crockett-Jones	1:14,17 4:7,8,21 5:2 10:6,13,16 14:14,17 15:2 18:14,20 31:2 35:15 36:18,21 41:13 108:9 158:4 159:9,16,20 171:15 172:13,19 173:22 174:4,10 176:13 265:6 268:8 269:16 331:20 360:10,16 373:1 cross 66:21 85:21 229:15 crosses 310:14 crown 61:11,17 64:12 cruising 293:9 crushing 56:18 Crystal 1:13 CSM 4:19 24:2 30:3 32:19 155:7 156:1,16,18 158:2 159:21 160:8 161:6 262:21 cultivate 364:12 culture 261:9 275:13 313:10 Cumulative 286:11 current 3:10 128:2 128:4 140:20 182:20 183:6 235:14 288:15 currently 100:1 104:15 116:2 125:22 135:2,4 158:10 236:13 263:20 279:5 289:8 curriculum 313:10 customer 212:8 213:10 322:19 330:16 customers 188:4,5 212:5 330:21 cut 46:16 91:5	314:7 334:12 cutest 308:17 cutting 334:16 cycle 252:22 293:5 330:22 cycling 293:14 C-O-N-T-E-N-T-S 3:1 C-3 260:2 <hr/> D <hr/> D 2:4,15 99:12 dad 248:20 258:22 259:4 289:12,14 308:3,15 312:2 Dailey 2:2 4:3 5:22 6:1 10:2,12,15,19 11:10,15,21 13:4 14:16 15:1,6,12 17:1,20 18:19 19:1,6 21:4,16,19 24:19 25:17,20 27:18 28:20 29:1 29:6 30:2,17,20 31:5 32:9,13,18 33:7 36:16,19 37:1 38:3 39:22 40:6,7,16 41:8 89:20 90:4,7 98:20 99:1 228:4 340:18 355:1,11 356:10 358:2,12 359:18 360:15,21 361:4 362:5 370:13,18 373:12 daily 62:18 115:1,3 189:18 223:7 daresay 91:10 dark 51:12 117:12 DASD 178:22 data 22:20 23:11 23:18 151:7 161:5 174:1,3,14,15 181:5,19 184:20 185:5,7,11,13 195:18 211:15,19 212:20,21 224:11	225:22 263:5 322:10,13 337:6 362:11 database 144:11 185:2,16 195:20 263:17 databases 144:12 data-gathering 342:10 date 106:4,5,9 108:22 109:4 172:4,5 257:19 293:4 306:9,11 356:1 dates 174:5 370:21 daughter 248:20 289:13 Davis 1:13 dawn 42:9 44:11 278:10 day 9:17 25:21 26:14 31:13 69:2 108:21 240:4 249:21 276:17 281:19,19 293:9 324:21,21 344:16 days 31:9,12 32:20 70:12 78:22 88:16 97:10 108:21 109:1 115:8 118:13 171:20 172:3,7,17 173:12 173:18,19,19,21 175:1,5,11 243:12 243:14,14 244:2,9 257:19 258:3 261:9 306:12,12 324:12,14,17,19 344:6 day's 27:4 64:17 DD 239:2 DD-214 105:14 228:16,21 229:9 229:15 328:5 deadliest 61:4 78:13 deadly 96:13	deal 43:9,10 76:19 79:13 191:6 201:12 259:10 290:1,8,13 292:1 292:4 314:20 dealing 207:8 292:3,8 312:18 314:5 317:6 dealt 206:18 293:11 Dear 254:2 death 48:21 50:20 56:22 57:5 66:7 81:11 83:13 127:14 217:8 218:1,5,14 deaths 66:8 71:9 debilitating 69:6 debrief 35:9 decades 60:12 293:3 decentralization 51:13 decentralized 60:2 60:2 92:9 decide 134:4 169:9 297:7 decided 109:13 211:18 276:20 284:21 decipher 142:17 decision 108:1,16 118:15 164:13 172:6,8,9 174:17 175:2 339:13 371:6 decisionmakers 209:2 decisionmaking 24:17 decisions 209:3 215:11 224:18 274:12 296:22 deck 126:21 131:6 158:16 decks 329:16 declaration 117:22
--	--	---	--	---

declare 117:20	delivery 38:19	286:4,14 293:1	55:4	Diego 103:5 226:11
declared 118:1	dementia 308:4	deployer 192:6	destination 162:15	differ 326:4 328:15
decline 120:14	demobilization	193:2 197:13	destinations 324:4	differed 47:12
decrease 210:13	88:6	deployers 192:3,20	324:7	difference 86:17
decrees 53:5	demographic 158:6	194:1,19 196:11	destroys 54:5	122:3 181:10,12
Decrepit 77:12	158:18 195:2,3	196:21 197:8,22	detail 98:18 106:18	260:20 278:13
deducted 64:17	270:12	198:6 202:14	178:21 180:13	285:13,14 286:12
deductions 222:7	demographics 16:3	deploying 221:18	224:13,14	293:20 294:3
deeper 11:20	16:17 194:17	deployment 191:7	detailed 177:12,14	320:2 325:1
defeated 65:16	195:1 277:21	194:2,5 195:4	334:21	differences 221:17
Defense 1:1 5:20	demonstrate	197:1,4 201:21	details 20:3 195:1	221:22 331:18
41:1,17 175:13	287:19	202:6,17 203:15	detected 189:4	332:16 348:15
195:19 208:12	demonstrated	204:7 207:7	determinants	different 7:10
227:2 241:1	84:22 210:11	210:12 226:11	180:19	45:14 82:6 88:18
298:12 337:5	demonstrates	284:12 285:21,22	determine 162:15	100:22 101:15
defer 89:10 340:21	195:11	286:12,19 288:8	162:19 192:17	126:22 130:2
deficits 262:7,8	Denise 2:2 9:10	288:15,20 289:8,9	determined 117:19	136:16 141:5
define 193:15	24:2 28:15 39:16	289:12 293:5	361:1	143:10 160:13
357:18	230:4 301:15	deployments 190:1	determines 105:2	163:13 171:17
defined 181:6	323:14 324:7	191:17 194:10,17	300:14 361:3	172:14 178:8
219:12 224:7	329:13 333:15	201:19 203:5	detract 171:2	179:20 181:20
346:15	340:16 354:17	205:16 206:7,11	detrimental 53:20	182:6 186:7,15
defining 42:16	359:5,17 361:3	206:19 210:8	develop 34:6 111:1	187:8 198:9 220:1
definitely 206:21	department 1:1 2:6	221:16,17 224:20	134:8 164:8	239:15 261:12
219:17	3:6 40:22 65:22	286:13,15 287:1	developed 80:20	263:7 272:2
definition 29:8	92:1,3,4 99:9	depression 91:6	133:8 134:20	280:17 305:9
305:9 346:18	175:13,16 208:12	192:2	173:6 187:20	309:13 326:2
degree 111:22	226:18 227:2	depth 11:12 21:1	243:9,11 244:10	327:20 328:20
114:2,15 138:14	241:1,11 298:12	deputy 2:18 5:13	341:10	336:11 347:11
170:1	departments	39:10 99:8 216:4	developer 145:20	349:3 357:13
degrees 110:9	179:17 180:1	269:19	developing 130:3	differentiating
138:13	Dependency 83:8	des 55:21 105:10	device 236:11	159:17
DeJONG 1:19 4:19	dependent 354:21	105:12 107:13	devices 126:7	differently 35:20
4:20 24:2 30:3	354:21 356:8	131:9 296:18	diagnosed 196:12	difficult 81:9
32:19 155:7 156:1	359:22	describe 333:1	200:19	112:10,14 113:2,2
156:16,18 158:2	dependents 185:12	356:2	diagnoses 199:20	160:14,15 168:1
159:21 160:8	281:4	described 146:17	203:4 208:21	169:22 204:4
161:6 262:21	depending 263:19	167:19 356:16	210:14	251:11 295:4
DeJong's 325:12	294:13	describing 333:10	diagnosis 196:13	difficulties 9:15
delay 173:6	deploy 192:15,17	descriptions 96:21	201:10,17 210:20	285:19 289:10
delaying 296:9	206:13 259:20	deserve 69:7,8	diagnostic 196:14	difficulty 102:8
deliberate 341:11	283:15,15,16	Designated 2:2,3	diagram 179:8	167:5 273:6
delimiting 106:3	deployed 194:11,12	designed 49:9	dictated 299:13	284:12 285:17
deliver 242:1 244:8	194:19 195:6	144:3 346:14	dictates 299:14	292:8 294:6 296:7
deliverable 13:20	202:21 203:11	desire 362:9	die 52:5,15 223:22	308:10
23:21	259:18 279:13,15	despite 332:15	died 49:1 71:14,14	dining 259:1
delivered 241:14	280:3 283:22	destabilizing 54:19	71:21 76:12 86:20	direct 66:20 102:5

150:6 180:14	discern 332:10	199:4,20 200:18	131:3 355:8	246:22 251:7
directed 339:17	discerned 365:12	disparities 309:22	356:18 357:12	270:15 275:17,21
direction 253:18	discharge 101:20	dispatched 63:7	358:18	276:1,7,9 289:8
directives 130:8	106:9 172:22	66:12	documentation	291:2 293:2
directly 67:21	173:3 301:10,12	displaced 64:11	359:15	304:11 317:9,12
217:3 241:3	304:6	disqualified 305:15	documenting	318:6 362:16
265:22	discharged 74:12	disrespectful 89:18	360:12	364:1 372:15,22
director 2:2,15,18	105:13 233:10	disseminate 209:8	documents 7:7,7	373:5
99:9 176:2 182:9	256:4	216:19	13:19 21:21 22:1	DOL 118:22 119:1
229:18 237:5	discipline 71:12	disseminated 215:1	22:4 34:21 358:22	147:19 150:3
269:19 327:6	78:19	dissemination	362:2	154:4
Directory 236:1	disclaimer 177:21	181:7	DoD 1:14,18 3:5	Dole 94:13
directs 94:3	disclose 364:21	distance 296:12	5:7 131:2 135:3	Dole-Shalala
disabilities 75:7	disclosing 339:10	distinct 104:19	151:2 155:9	235:12
93:1 96:21 97:16	disconnect 27:3	distinction 74:7	159:22 178:14,17	dollar 73:3
100:11,14 108:6	36:8 174:11	146:22	179:14 180:7,15	dollars 255:18
109:17 113:7	disconnected 26:21	distract 352:18	189:5 201:11	domains 22:13,16
116:10 126:15	discreet 360:8,9	distracted 352:22	207:6 208:18	22:19
disability 50:21	discuss 32:17 137:2	distribute 184:16	209:14 211:4,20	domiciles 77:3
68:20 74:17,19	178:2 190:6	352:8,11 353:13	214:3 218:18	dominated 53:17
75:18 82:16 83:3	discussed 107:12	354:11	220:2,22 221:5	donations 69:16
83:6 94:19 95:2	discussion 346:14	distributed 240:14	222:18,22 223:4	275:1
101:4,5 102:14	347:10 348:7	240:15,22	274:5 284:19	donor 275:2 276:10
103:11,17,18,19	354:1 360:4	distributing 351:13	294:7,15 297:21	double 220:16
103:20,22 105:3	discussions 38:17	353:11	299:16,16 301:3	downsized 303:16
105:17 106:6	disdain 65:4,11	distribution 180:19	305:6,8,9,19	dozen 14:1 256:1
107:15 111:11,13	disease 44:13,14	District 327:17	307:3,4,12 309:1	Dr 3:4 4:18 12:20
112:12,18 114:1	46:6 48:11 66:4,7	dive 225:21	310:4,5 311:14	17:5 21:5,17
132:6 142:10	71:11,15,21 78:15	dividing 53:8	361:14	25:14,18 31:17
154:11 165:22	78:21 81:7 83:2	division 2:10,13	DoDI 23:4 361:1	32:11,14 35:4
242:17,19 255:2	86:21 96:16 181:9	93:3 176:17	DoD's 305:12	41:15,22 89:3,4
255:18 264:15	181:16 184:5	182:16,19 183:19	310:11,18	89:13,21 90:2,6
disabled 44:21	188:18	184:19 186:22	DoD-wide 187:5	90:10,13 98:20,22
54:17 56:2 58:9	diseases 86:16	187:2	doing 16:5 20:9,11	147:14 166:21
60:9 68:22 69:1,2	180:22 184:10	divisions 182:15,17	35:21 74:22 107:2	167:17 168:7
69:22 72:7 74:9	disease-focused	divorce 303:18,21	124:5,20 127:14	169:19 170:6
74:11 77:11 83:1	184:1	DMDC 337:6	127:15,16 128:20	177:5 178:10
87:15 93:6 94:11	disenroll 300:12	DMTS 184:20	128:21 129:20	182:11 183:2
95:4 97:11 102:12	dishonest 112:16	doctor 253:19	130:2 153:19	187:3 189:21
119:2 126:3,18	112:22	254:10,15	154:3 157:14	190:3,17 204:10
disabling 103:22	dishonorable 173:4	doctors 63:19 72:2	167:2 175:9,10	204:12,15,16
105:4	301:9,11	doctor's 317:21	186:3 199:18	205:4,9,22 206:5
disagree 11:8	disk 328:13,14	doctrine 53:3	211:4 214:12	206:10 207:12,20
207:12	disorder 203:14	document 6:9 14:4	217:5 220:13	208:6,8,13 209:5
disagreement	308:5 312:18	14:6,10 15:3,7	225:12 227:3,5	212:14 213:3
348:21	disorders 191:16	16:15 20:22 23:17	230:6,8 234:10	216:6,7,16 217:1
disbanded 84:18	197:19 198:15,20	24:14 25:2 28:6,7	235:7 240:21	217:16 220:6

221:15 222:15 223:15 224:5 225:3,8 226:15 254:2 269:18,22 269:22 277:21 282:5 287:18 292:18 309:10 311:4 314:15,18 315:5,18 316:2,15 316:21 319:2 321:10,13 322:6 328:18 331:19 332:1 340:6,16 341:9 346:20 347:15,19 348:11 354:13 356:22 357:14 359:2 362:7,19,21 Drach 1:20 4:12,13 4:13 15:8 26:3 37:3 132:12 139:21 246:8,14 266:18 372:9 draft 7:15 28:2,16 28:16 29:9,9 30:1 35:13 drafts 32:15 draining 247:13,13 dramatically 75:14 205:2 draw 13:22 dregs 65:9 dress 112:9 dress 115:4 drill 36:10 166:16 323:22 drive 296:11 driving 274:6 drop 98:3 dropped 202:7 Drum 320:21 dry 256:22 DTAP 102:10 119:19,20 126:19 127:1,12,20 128:1 128:12 154:1,7,8 DTM 23:6	dual 278:19 283:10 dual-income 247:4 duty 52:15 56:8 80:20 87:18,20 94:11,14 102:10 104:20 106:8 107:2 158:10 186:11 230:22 245:22 261:12,18 278:13,19 279:2,7 279:8,17 287:22 297:20 299:9 300:2 312:8,10 DVA 151:3 DVOPs 150:4 dwell 197:5 203:2,3 203:13 dwelling 367:4 dynamics 33:14 D.C 149:18 <hr/> E E 1:12 2:3 176:20 333:4 EAdvantage 125:9 125:14 eager 367:14 earlier 65:17 122:19 133:2 135:19 141:4 153:7 230:5 312:16 324:7 344:22 369:5 early 35:1 39:6 46:18 48:7,10 51:1 59:4 64:10 65:18 70:6,8,11 78:22 81:20 97:10 100:21 104:8 155:9 169:20 219:7 373:17 374:16 earn 251:6 earning 247:7 ears 271:17 earth 65:8 easier 32:2,8	371:16 easiest 230:9 easily 25:9 257:4 East 49:18 160:20 easy 64:8 107:10 158:20 212:3 348:16,18 363:20 367:5,9 easy-to-use 130:13 ebbing 120:6 eBenefits 144:7,8 echelonment 87:6 echo 61:20 93:17 312:13 echoes 73:19 economy 114:12 233:20 editor 176:18 183:3 editorial 191:3 202:2,13 educate 139:2 education 90:17 106:2 111:21 120:16 123:10 134:9 151:17,21 157:10 educational 43:2 102:1,3,5 104:15 107:20 110:9 111:20 114:16 138:11,16,18 139:6 141:16 142:3 162:19 166:2 171:3 effect 68:17 189:22 192:4,6,8 193:2 194:9 215:9 270:20 314:8 341:18 344:8 effective 29:17 33:5 48:9 121:8 217:15 336:3 364:10 365:20,22 effectively 130:6 150:20 175:21 218:19 effectiveness 7:7	21:20 22:1,12 23:17 34:21 228:18,20 229:6 effort 4:10 167:2 198:3 227:16 345:10 efforts 175:16 209:9 211:2 eight 66:8 144:10 149:20 150:9 235:1 258:20,21 286:16 Eighteenth 62:6 either 21:12 103:11 111:21 134:21 147:16 166:4 202:17 238:19 272:5 282:7 283:14 290:6 296:9 298:3 316:13 elect 121:12 electrical 253:2 eleven 288:11 302:15 eleven-year-old 288:3 289:2 elicit 332:5 eliciting 367:8 eligibility 100:8 102:20 103:12 104:2 105:15 106:4 107:12 109:6 171:21 172:1,8,8 eligible 103:21 104:18,19 115:22 121:10 142:16 151:17 159:11,13 169:3 294:5 eliminated 334:18 Elizabeth 59:16 77:14 Elizabethan 58:22 email 122:9 253:20 254:1,2 embargoed 200:3	embarked 207:18 embed 313:10 embedded 338:18 embedding 313:18 emergency 314:12 emerging 178:14 184:9 emotion 15:17,20 21:1 367:18 emotional 245:10 262:7 285:19 373:4 emotionally 269:3 emphasis 343:18 emphasize 181:6 Empire 47:9 employability 118:11 employed 74:21 151:14 152:8 employee 288:16 employees 141:1 employer 111:16 149:9,10,12 303:1 employers 123:14 123:16,17 144:4 144:14,17 145:11 146:7 149:5 152:19 153:1 159:5 166:9 employer-sponso... 246:2 employment 2:5 3:6,8 60:21 64:14 99:11,20 100:11 100:12 101:15 105:18,21,22 106:11 108:3,8 109:15,19 110:12 110:16,19 111:17 111:19 113:5,8 114:9,18,21 116:7 116:8,11 117:11 124:11 126:5 128:16 134:8,10 144:2 145:2,17 149:17 162:22
---	--	---	---	--

163:6 170:14	ensure 13:8 143:18 331:16 339:9 359:5 361:15	errand 259:21	275:15	201:20 210:10
enable 103:20	ensuring 351:1	error 126:20 127:9	event 242:22 258:9	217:19 218:21
enabling 102:19	enter 168:15	especially 38:13	284:2 351:22	219:6 222:19
encountered 360:1	Enterprises 232:13	89:7 170:18	354:7 355:21	248:6 252:1
encounters 196:10	enters 175:6	172:21 220:9	356:2	255:15 267:4
220:22	enthused 15:14	245:3 249:16	events 58:22	272:20 311:10
encourage 146:4	entire 45:11 202:2	255:4 257:6 283:2	155:21,22 180:20	325:10 326:9,13
171:13 182:20	206:20 280:17	290:2 297:1	186:1 189:17	326:17 328:14
183:12 186:19	entirely 45:14	298:11 312:17	224:3 281:18	329:5 334:4,7
343:22 344:18	entities 136:22	essential 341:3	360:4	335:4,17 359:11
364:9,19	entitled 60:15	essentially 195:20	eventually 51:20	examples 327:9
encouraged 329:13	104:18 105:18	196:9,21 198:21	58:8 61:10 66:13	exams 62:17
329:15	108:2 109:14	202:20	67:15,16 75:1	exceed 247:22
encouraging 365:3	110:1 115:22	establish 109:4	88:5 93:2 266:6	exceeded 349:13
endeavors 141:16	174:21	113:15 338:7	even-handed	exceeds 117:5
142:3	entitlement 109:13	established 58:9	342:17	164:17
ended 135:16	175:1	69:18 70:9 77:14	everybody 18:12	excellence 9:2,4
309:14	entity 215:14	77:15 78:7 82:13	75:19 182:20	excellent 70:15
ends 294:14	environment 31:20	85:10,14 93:15	304:20 341:2	128:17,18
enemy 223:21	269:9 330:1	107:11 239:11	everybody's 178:3	exception 329:20
energy 256:20	339:17 346:16	261:21 338:4	340:13	329:21
enforcement 40:20	347:21 349:2	establishes 103:12	everyday 292:2	exceptions 325:17
engage 38:12 39:18	envy 186:7	162:10	everyone's 244:4	excess 21:13
264:20 313:13	epidemic 219:12,17	establishing 86:1	everything's	excessive 193:14,15
341:16	epidemiologic	109:5 114:1	293:10	193:22 196:19
engaged 79:9 88:16	180:9 183:22	establishment	evidence 105:6	197:12,21 198:12
engagement 223:20	epidemiologist	55:13 77:2	319:15 320:1	199:16
engendered 217:22	176:16 183:4	establishments	evil 339:5	exchange 301:7
engineering 143:6	epidemiology 2:10	77:19	evolution 45:7	excited 125:15
England 54:2	2:12 176:16 177:1	estate 113:12	55:15	130:15 135:12
55:16,16 59:1,6	178:5 180:17	et 186:1	evolved 43:16 45:3	138:5 140:11,14
64:15 65:18,20	181:3 183:18	Europe 57:12	45:7,8 51:17	230:3 293:3 316:7
66:10 73:14	186:3	59:12	exacerbated 44:17	332:20
English 61:3,5 62:4	episode 21:9	European 78:12	exact 105:6	exclude 192:14
75:8	episodes 21:8	evacuation 44:19	exactly 21:13,14	excuse 340:1
enhancements	equal 49:11 342:9	80:6	33:13 62:3 250:22	Executive 2:2,15
148:5	equally 317:3	evacuations 92:16	332:1	179:9 229:18
enjoyed 231:4	equals 313:22	92:17 278:7,8	examine 186:15	exempt 50:12
enlarged 248:12	equipment 136:17	evaluate 150:17	example 22:1 40:11	exercise 252:16
enlist 49:17	137:7,11 252:9	evaluating 167:5,8	51:7 54:3 72:10	343:14
enlisted 74:7,11	253:1 254:13	363:8	97:8 110:8 113:14	exhaustive 346:2
75:5,12 355:15,16	equivalent 179:18	evaluation 133:16	115:14 116:9	369:21
enlistment 71:2	337:17	134:5 169:13	152:4 165:17	exist 271:10 278:21
Enlistments 70:21	era 49:15 87:10	306:18	166:13 167:18	294:4 298:14
enroll 300:15	err 358:10	evening 7:11 24:21	170:15 188:6,11	existed 235:20
enrolled 72:8		25:6 26:4,8,13	188:19 189:20	existing 247:15
254:11,12 300:11		27:17 34:11	197:16 198:14	268:4 298:22

exists 51:6 96:6 137:8 312:7	223:9 224:2 237:11 249:11	371:12 372:2,11 372:21	209:6 282:2 314:16 354:6	248:4,7,9 250:4 257:3 258:5,14
exit 103:7	exposures 223:11	facilitating 372:16	familiarized	263:14,18 264:8
expand 77:21 190:7 319:11 335:19	express 39:19	facilitation 371:8 372:8,12	195:15	265:1,12,21 267:3
expanded 47:3 77:21 120:7 143:14 317:7	expressed 17:13	facilitator 362:21 371:18,20 372:21	families 21:3 52:22	267:4,5,9,13,17
expanding 316:19 318:4	expressing 17:8	facilities 80:7 95:20 180:2 313:17 327:21	58:18 100:19	268:6 269:20
expansion 143:16	extend 49:16	facilitating 245:6,19 294:16 300:12,16	231:7,9,10 234:6	270:2 271:15
expect 44:8 201:19	extended 50:14 301:20 302:3	facilitating 232:22	234:9,14 235:21	275:22 276:6
expectations 351:6	extends 48:20 62:10 333:12 342:5	facilitating 234:2,7 271:3	236:6,10,11,14	277:6,8,9 279:6
expected 94:17 219:14 363:19	extension 73:15 309:5,16 312:7	fact 39:10 60:7 61:7 86:18 89:7 103:14 149:12 210:16 222:9 227:11 278:2 281:17 286:22 333:4 363:19 372:7	237:3 238:2,11	281:1,6 282:21
expeditionary 66:1 66:2	extensive 87:13	factor 194:6 264:16 283:2 301:22	240:16 241:22	283:5 284:13
experience 33:20 42:6 67:22,22 86:5 123:5 139:13 171:18 174:12 196:22 206:13 208:18 231:1 242:12 246:9	extent 317:18	fact 29:16	242:1 243:6,10	285:17 286:3,7
experienced 224:3	external 327:14,15 328:8 330:5 350:9	factually 29:14	244:6,14,21 245:3	287:8,9 288:1
experiences 10:4 206:8,8 347:9	extra 82:19 95:4 171:11	failed 127:8	247:5,12,18 249:7	289:16 291:2,10
experiencing 210:7	extraneous 350:7	failing 366:12 371:14	249:11 250:6,18	294:18,20,20
expert 156:5 272:5	extraordinarily 38:11 150:19	failure 49:4 166:22 168:8	251:4 255:1,4	295:8 297:14
expertise 343:11,14 343:15	extraordinary 218:14	factors 270:18 282:1 285:11 287:16,20 314:3	256:2,15 257:6,6	299:4,6,8 300:5,7
explain 150:12,21 193:15 195:8 239:22 339:20 351:5 358:5,5	extreme 51:13	facts 29:16	257:21 259:16	300:8,9,18 305:1
explaining 206:18 232:21	extremely 64:15	factually 29:14	262:3 263:9,18	308:2 313:13,22
explicitly 363:22	extremity 81:10	failed 127:8	265:7,11 268:19	314:1,4 330:3,13 330:17 349:8
exploits 66:11	eye 60:18 69:18 199:1 342:16	failing 366:12 371:14	269:3 270:5,10,19	family's 249:5
explosion 97:15	eyes 271:16	failure 49:4 166:22 168:8	270:20 271:4	famous 55:22
explosions 97:17	e-con 264:11	fairly 27:4 43:7 134:15 191:20 201:4 278:21 331:5 350:20	272:11,14 274:10	Fanning 99:9
explosive 236:11		faith-based 123:20	274:22 277:13	fantastic 259:13 372:13
exposed 188:16 222:10	F	fall 51:11 179:7,9 179:13 212:6 215:22	281:22 282:13	far 24:3 28:13 35:17 52:1 95:2 133:6 232:6 270:8 270:12,18 272:10 272:13,16,17,19 273:6 274:1,3,6 274:17 275:2 276:5 278:1,15,17 280:7 283:4 284:19 287:13 289:19 292:3,4 293:16 295:1,6,17 296:2,10 297:3,20 299:3,5,7 300:4 302:6,7,18,19 303:3,8,15 310:9 310:21 311:5,8 312:1,1,22 313:4 313:19 314:5 315:7,9 316:22 317:8 320:6
exposure 188:15 220:16 221:8,8	face 73:5 129:3 135:20 234:15,16 234:17 245:15 250:18 257:6 317:6	fallen 275:5	283:1 285:11	
	face-to 135:19	falling 62:21	287:20 289:20	
	face-to-face 26:5,6 33:9 120:2 122:7 131:14 172:6 174:20 219:1	falls 59:14	291:8 295:11	
	facilitate 364:9	Fallujah 222:1	296:20 298:13	
		familiar 190:9,11	300:21 301:1,12	
			304:2,7,10,19	
			311:7 313:1,1	
			317:2,11,16 320:2	
			320:22 328:5	
			family 2:19 3:16 40:12 46:22 50:14 82:22 171:4 185:11 203:10 204:3 229:3 231:2 232:3,7,14,16,17 232:19 234:19 235:2 238:16,18 238:22 239:5,10 240:3 242:4,8 243:22 244:11 245:18 246:10,12 246:14,17,18	

328:16 332:19 fared 68:14 faring 328:5 334:6 fascinating 72:18 faster 170:22 fault 231:19 favorites 342:12 fear 71:7 feathers 30:7 febrile 184:4 February 12:8,11 12:18 232:2 federal 2:2,3 78:7 83:15 84:10,13,16 85:15 88:3 90:16 123:17 237:4 243:21 256:12,18 265:9,13 266:1,10 266:16 271:19 293:19 294:3 327:18 335:8 338:1,18 341:3 feed 272:6 feedback 6:14 8:6 17:3 27:19,21 30:5,8,9 40:4 160:13 263:12 316:18 feeding 250:8 feel 10:7 11:7 15:16 15:21 153:15 169:5 198:4 202:13 213:8 257:7,7 347:22 348:5,22 351:22 feeling 320:7 366:13 fees 60:6 116:20 121:18 fell 51:12 53:10 84:17 233:13 fellow 41:16 felt 16:6 35:16 201:14 253:6 277:6 372:7 female 63:1 198:5,6 females 278:17,18	Ferdinand 55:11 FES 252:21 feudalism 51:12 fiduciary 255:9 field 214:6 272:3 fielded 70:19 field-tested 85:11 fifteen 78:16 Fifty 303:20 fight 63:8 79:12 97:7 296:3 fighting 79:11 290:21 fighths 73:11 figure 16:11 36:10 244:5 253:11 figures 333:9 figuring 136:9 193:4 file 33:3 173:10 fill 26:9 44:4 107:9 107:10 144:4 168:21 345:19 352:21 355:11,16 filled 357:10 filling 352:17,20 359:8 final 24:17 30:10 30:11 finalize 32:15 finalized 116:3 finally 46:8 55:2 94:1 186:22 292:14 324:2 342:8 370:2 financial 247:10,15 284:11,13 302:7 312:11 financially 117:8 170:21 269:4 304:20 find 18:16 20:22 32:1 35:6 60:21 93:22 112:21 113:19 126:13 144:3,4 155:15,20 174:1 176:20	192:18 197:7 223:6 228:14 233:12 234:4,13 235:15 236:5,6,12 252:11 257:22 265:7 267:2 268:4 282:15 284:4 285:8 286:9 294:20 298:8 303:20 310:3 finding 166:8 192:4 203:6 220:14 221:10 263:11 296:20 320:12 findings 28:9 203:1 239:7 331:6 333:3 333:12 365:12 fine 22:10 293:10 finer 62:2 finish 35:6 152:9 323:15 367:6 finished 89:13 237:14 finite 30:11 firewall 159:5 firmly 45:6 70:6 first 4:9 6:5 7:15 9:1 13:16,17 28:2 28:16,16 29:9,9 30:1 31:12 35:16 42:7 47:10 58:4 62:20 75:15 77:3 79:3,16 81:18 85:15 86:19 88:8 95:7 106:5,22 107:22 108:1,18 108:20 109:9 115:21 125:12 131:3,4,11 162:10 162:15 163:8 167:18,19 169:2,7 169:8 171:22 175:5 177:5 189:3 191:9 193:9,18,19 194:1 196:13 202:6,17 207:15 208:14 212:7,8	214:16 217:8 226:4 232:1,5 233:17,19 234:13 245:17 267:1 272:21 279:20 281:19,19 289:18 289:22 304:12 335:21 340:7 351:11 354:15 363:1 366:3 first-person 10:4 first-time 197:8,21 323:11 fiscal 5:18 122:15 122:15 135:10 174:8 Fisher 238:19 fishing 348:8,9 fitness 253:8 fits 21:18 five 12:11,19 84:14 90:11 99:2 111:7 115:20 116:15 173:18 195:7,7 239:15,20 240:7 271:7 323:2 349:12 362:19 fix 152:15 flag 275:15 flap 82:4 Fleet 232:15,19 flexible 318:16 Florence 66:11 Florida 141:18,20 248:17 325:4 flow 71:3 106:15 348:19 flowing 120:7 flows 106:21 flu 86:18,21 FMLA 246:15 focus 7:1,3 13:12 13:19 14:7,11,18 14:22 15:15,18 17:7,17 22:5 23:20 24:9 34:17 34:19 35:11,21	96:10 110:19 170:21 184:8 187:2 211:1 215:15 244:22 264:22 270:16 276:20 277:1 292:11,20 322:14 329:18,19,21 330:1,11 331:4,9 333:12 336:17,19 337:22 338:22 339:3 343:5,16,18 343:19 344:5,10 345:1,22 346:6,13 349:6,8,9 350:11 352:2 355:13,14 357:4,15 358:6,19 358:21 359:12 368:9 369:21 370:7 focused 187:16 359:19 focuses 220:1 focusing 152:10 184:9 347:8 folks 12:22 21:14 41:14 186:11 227:18 231:17 237:15 257:10 267:11 327:16 337:8 367:12 follow 332:14 366:12 followed 77:4 230:20 325:3,8,12 followers 63:2 following 33:2 40:15 72:6 196:22 351:7 follows 351:8 follow-up 40:14 118:5,13,16 food 110:16 forbears 62:4 forbidden 53:6 force 1:3,12 2:21 2:22 3:2 5:16
---	---	---	--	--

12:2 36:17,22 37:2,7 38:7 39:6,7 55:8 66:2 93:21 100:15 126:4 151:3 178:22 179:10 185:8 191:2 209:4 215:22 230:7 236:17,18 271:14 307:5 315:1 316:9 328:12 333:1 337:17,17,18 343:2,11 344:3 357:9 359:10 361:2 371:17,22 372:11 forced 59:7 61:18 66:10 forces 1:4 2:11,13 3:9 30:6 54:13 93:22 160:10 176:17 177:2,15 180:9 337:3,6 foreigners 49:22 forerunner 64:4 66:19,20 68:5 forever 245:12 foreword 31:14 forgive 241:6 forgot 241:8 256:5 form 37:13 48:7,8 51:1 83:19 129:15 223:20 339:15 351:15,15,20,20 352:6,6 354:3,7 355:9 358:20,22 359:9,13,20 360:11 361:1 formal 17:10 18:16 47:10 formalized 215:19 217:2 format 9:6,11 34:13 former 327:6 forming 47:8 forms 221:1,3	223:17 352:5,8 353:13 355:12 Fort 320:21 326:17 327:3 337:16 355:14 369:9 forth 167:22 168:8 317:14 318:1 340:3 fortified 48:9 fortunate 195:19 fortunately 205:14 fortunes 73:6 forum 243:2 340:15 360:3 forward 41:20 46:17 53:18,19,22 97:21 135:11 195:9 196:15 243:6 268:19 275:2 276:11 285:7 293:1 319:1 319:7 forwarding 359:13 forward-deployed 284:5 for-profit 161:12 161:22 163:8 164:3 232:13 foster 267:18 332:3 332:4 fought 46:22 62:12 92:8,10 found 14:14 15:14 24:2 41:19 112:13 112:15 136:6 142:4 145:16 200:16 237:2 241:22 371:11 foundation 2:16 3:13 229:19 230:14 231:8,13 232:4 266:19 founded 271:11 founder 232:10 four 22:13 54:12 55:6 115:21 118:7 135:15 182:15	189:3 224:20 268:17 269:12 276:8 277:13 288:16 289:8 290:9 296:6 297:8 297:11 324:10 325:10 330:10 335:7,16 349:18 351:11 359:20 360:7,9 363:1,17 Fourteen 78:15 fourth 335:10 four-year 162:4 frame 30:14 frameworks 347:1 France 55:15 63:15 68:15 69:4 frankly 153:10 371:9 FRCs 265:10 327:18 free 275:10 317:16 339:20 340:1 freely 347:22 348:1 French 58:3 67:5 68:12 69:1 72:7 86:5 88:19 89:1 frequent 122:8 frequently 198:18 217:18 freshman 248:22 Freudian 97:19 friendly 127:13 friends 46:22 front 203:9 238:1 346:2 frontier 50:10 56:7 frontiers 48:6 fruition 65:14 frustrated 39:5,7 frustrating 213:7 225:6 frustration 39:15 175:19 211:8 FTE 135:9 full 34:15 56:5 76:1 76:3 115:8 124:9	141:19 170:15,17 210:16 fully 87:12,19 142:14 full-blown 69:12 103:6 full-time 244:6 262:11,13 288:15 funded 42:5,11 61:20 189:4 funding 113:19 271:19 funds 74:2 furiously 20:6 furloughed 58:15 furniture 281:1,5 further 74:1,1 100:2 177:13 226:1,8 252:5 future 227:16 FY 3:2	gathered 22:20 23:11,19 gathering 32:16 322:10,13 343:19 353:10 363:4 gauge 137:17 Gauging 166:22 gear 348:6 geared 77:19 93:13 298:19 GEIS 178:17 183:19,21 gender 193:21 198:4 genders 198:8 201:21 general 5:7,8,14 12:13,21 17:11 19:2 30:3,15 65:11,17 68:16 80:1 82:11,14 85:6 87:16 92:9 93:16 106:15 128:3 147:10 179:19 193:12 196:16 211:5,6 213:16 214:2 216:5,13 241:4,6 319:19 332:6 353:5 367:17 372:10 generalizable 181:22 generally 47:1 48:3 49:13,18 50:9 63:2 70:22 84:11 132:19 192:7 193:21 205:16 Generals 241:4 generate 181:21 226:7 generated 331:1 generation 308:2 308:18 generations 50:15 generous 49:8 72:13 82:12
--	--	--	--	---

G

gain 373:21
gained 252:15
gainful 108:8
109:15,18
ganging 341:22
gaps 26:9 234:18
234:20,20,21
237:9 298:10
garage 248:16
garden 325:21
Garfield 48:22
garnish 62:1
garnished 64:20
garnishes 61:19
garrison 48:2,5
72:10 77:20,20
84:20 205:6
garrisons 56:7 72:9
gas 249:18
gastrointestinal
184:4
Gater 254:3
Gateway 236:2
gather 272:1

Geneva 64:5	263:9 265:22	178:21 180:12	134:19 135:6,8	good 4:3 6:1,10
gentleman 31:8	269:12 270:11,13	182:5 187:1,19,21	136:21 137:4	9:19 10:5,5,18,20
gentlemen 4:4	272:20 299:17	193:12 198:1	141:7,12 142:18	11:21,21 13:4,4
13:18 14:6 24:22	318:1 326:17	199:13 202:1	144:19,20 145:1	13:11 15:10 17:2
27:22 33:11	342:15 358:16	216:12 220:5,7	154:14,22 156:3,4	17:3 18:13 19:3
228:11 373:13	366:18	221:9 245:16	156:10,20 160:9	24:20 25:3,20
374:21	given 16:22 46:7	246:19 253:14	161:8,16,20 162:1	26:19 27:19,19,21
geographic 151:13	73:3,9 94:15	256:12,14 257:14	162:18 164:9	27:21 29:17 33:7
geographical	146:9 150:9	258:3 262:20	169:10 170:13,14	35:2 39:22,22
151:13	164:10 259:7	264:6 268:14	170:21 173:18	71:17 79:13 89:8
geography 135:22	355:3	275:10,20 285:9	175:10 177:5	102:6 125:18
George 73:18	giver 3:14,17 343:8	293:12 296:2	178:6,20 182:13	136:14 146:22
Georgia 277:12	gives 120:5 127:18	297:8 298:9 303:7	182:16 183:6	150:14 182:21
German 67:22	190:19 210:21	304:10 307:14	184:19 189:22	190:12,12 211:14
getting 5:5 24:4,16	221:12 283:21	311:14,18 317:20	192:16 193:11	211:22 213:4
29:22 30:7 36:8	give-and-take	317:22 321:18	195:1 199:8 218:8	219:6 222:15
40:11 110:7,17	72:19	340:9,12 344:15	223:4 224:18	253:12,13,16
131:19 133:3	giving 16:9,19	346:22 347:17	229:17 230:1	254:7 268:22
140:9 146:11	27:16 51:18	348:18 357:21	234:9 235:10	288:14 318:9
147:18 152:17	160:13 229:11	358:1 359:11	245:12,16,20	344:16 348:9,13
160:4 161:9	glad 207:3	365:7 372:1	246:1,3 247:20	353:4 367:11,15
171:21 172:1,6	glasses 199:2	goal 110:14,22	251:17 256:6,9	371:8,10,22 372:4
173:8 198:22	global 178:14	111:5 116:11	257:20 258:9,11	374:19
233:14 248:21	179:1,4 184:8	140:15 162:11	260:9,10 261:17	goods 83:20
263:12 274:2	271:16	168:3 234:3,13	262:17 266:5	good-bye 280:18
286:1 291:9,21	glossy 183:7	goals 111:1 234:12	270:6,11,17,20	Google 369:16
297:20 298:2	go 5:1 8:14 13:12	234:22	271:2 277:11,15	Googled 369:11
311:6 317:12	13:13 14:7 22:9,9	goes 65:21 68:6	284:6 285:8	gosh 245:11
366:7 367:7	23:12 25:2,3 26:1	96:1 98:7 135:11	286:18 294:21	gotten 56:15 96:8
369:22	26:1 29:12 35:14	156:7,7 205:1,5	297:2 302:16,21	131:1,3 161:12
Gettysburg 79:15	40:8,16,20 41:21	216:9 291:6	303:1,21 307:3,4	191:8 217:12
GI 95:3 120:12,14	60:20 79:2 86:4	297:12 301:18	307:5,7,8,11,21	government 2:18
120:21 122:12	91:15 98:19 99:18	302:3 304:18	310:3 311:19	70:1 73:1,4 75:16
156:2,14 161:13	100:4,5 106:17	305:1 345:16	313:19 314:3,13	78:7 81:12,19
166:3 169:10	111:12 117:4	348:14 354:15,16	315:20 317:8	82:8 84:10,13,16
170:19 256:6	121:11 122:11	going 4:6 5:17 6:4	318:8 319:22	123:17,19 126:8
girls 248:15 286:10	127:19 132:13	6:22 7:3,6 8:2	321:16 324:1,1,2	147:21 148:1
give 5:22 15:4	133:16 134:5	9:11,21 12:3,5	325:11,14,16	167:4 238:12
25:12 43:17 90:10	137:6 138:19,21	13:22 24:13 33:13	328:7 331:13,14	240:10 259:11
115:10 119:9	143:19 144:22	41:14 42:4,14	331:17 337:13,19	265:17,18 269:19
123:7 135:7	146:12 148:7,7,20	45:17 60:17 70:3	338:7 341:21	go-to 122:10
145:10 150:15	153:11,14 154:1,8	94:18 99:7,18	346:11 347:10	grab-your-attent...
166:12 177:5,8	154:11,14 161:17	100:4 105:7,7,11	349:21 354:12	127:17
178:1 180:3 185:7	161:20 163:9	111:5 116:11	356:4,5 358:13	graduate 139:18,19
199:9 200:3	164:18 165:22	124:1,3 126:13	362:17 364:13	graduated 147:1
242:18 245:18	166:3 169:12	130:20 131:8,9,18	370:11 372:19	281:21
258:2 262:18	170:16 174:18	131:18,20 134:15	373:2 374:6	grandparents

233:6	352:2 355:13,15	guy 230:16 341:22	238:17 239:22	77:7,8 88:4 90:17
grant 72:15 248:1	357:4,15 358:6,20	345:12	302:18 359:12	160:1 176:17
249:4,6	358:21 359:13	guys 23:18 25:12	happening 23:16	177:2,13,15
granted 60:11	363:12,15 364:2	156:10,21 191:8	42:15 134:15	178:22,22 179:2,4
graph 213:19	365:9,9 366:6	193:10 195:15	228:15 272:11	179:10,10,17,19
graphic 195:11	368:9 369:21	197:17 200:8	291:11 295:1	180:1,10,19,22
great 45:5 61:5	370:7	202:1 263:4,14	299:8 353:7	181:1,8,13,14,17
65:20 76:18 78:11	groups 7:3 15:15	268:13 301:16	happens 106:15	182:3 189:6
95:3 96:13,14	15:17,18 17:7	341:21 347:13	108:18,20 118:3	191:15 192:2,12
98:2 110:13	31:11 34:17 35:21	G-1 326:20	134:14 213:11	192:19 198:7
126:14 139:21	192:7 206:19		226:22 259:6	199:20 200:17,19
191:21 201:12	210:18 270:16	H	261:11 284:6	201:3,9,13,16,17
210:18 227:3,5	310:4 322:14	H 323:17	301:12 303:10	203:14 205:1
268:10 276:11,16	329:19,20,21	hair 334:19	355:5	206:22 207:5,7,8
297:20	336:18 344:5,11	half 83:15 185:2	happy 15:5 25:4	210:13,19 211:10
greater 8:11 74:15	345:22 349:6,8	256:1 324:10	89:20 161:7	212:6 213:13
76:3 78:16 219:14	grow 54:9,10	340:11 365:9	268:13 298:1,5	215:20,22 216:6
Greece 49:18	growing 52:10	374:5	353:10,12 370:8	216:10,14,21
Greek 46:19	grown 72:14	half-pay 72:21	harbor 71:19	217:10,17 218:16
Greeks 46:16 48:14	gruesome 56:21	73:18,19 75:4	236:21	218:18 219:18,20
53:17	GS-5 139:14	Hamilton 73:4	hard 34:8 124:16	219:21 220:8,11
Green 5:7 332:7	GS-7 139:17	Hammond 80:1	187:20 230:10	221:5,6,14 224:21
grew 75:14 88:9	Guarantee 142:7	hand 134:16	252:3 254:21	226:10,10,11,21
grocery 256:21	Guard 2:8 85:17	137:20 237:8	255:1 257:2,17,22	238:13 246:1,6
ground 191:12	128:10 155:2,10	358:17 368:10,16	305:4 334:14	249:13,18 250:1,9
206:3 207:21	160:15 161:1	369:3	367:21 369:22	250:12,14,21
324:12,13,17	177:12,14,17,18	handbooks 81:20	harder 283:6	257:16 268:21
351:3 368:12	185:10 191:2	handicap 105:18	harm 341:10 342:4	274:15 278:7
grounds 59:20	196:3,5 261:4,6	105:21 106:11	356:4,6 359:20,21	279:14 284:8
group 7:1 13:12,19	282:7 283:2	108:4	359:21,21	287:3,5 288:9,11
14:7,11,18,22	294:16 295:18	handle 94:6 168:2	harming 357:22	288:13 291:1
16:4,17 17:17	374:6,9	314:9 360:6,8	HART 236:17	294:7,12,13
22:5 23:20 27:8	guardian 255:5	handling 308:10	havens 63:18	299:17,18 301:2
31:18 33:1 34:19	guess 30:7 117:12	hands 47:6 49:3	Hawaii 281:4	301:20 302:3,11
35:11 59:13 69:18	155:12,17 169:2	151:7 365:17	311:16,17,19	302:22 304:9
128:13 194:13	225:5 294:19	hands-on 373:3	head 368:20	306:2,2 307:17,20
222:18 224:19	295:8,15 322:6	hand-feed 145:4	Headquarters	313:4,9,12,14,15
271:6 276:21	323:9 369:9	hand-off 43:10	160:10	313:18 316:10,20
277:1 292:11	guidance 25:22	175:22	headquarters-level	317:1,10 318:18
316:4,4 322:3	guide 113:1 125:8	hantavirus 188:8	322:22 336:20	319:7,8,11,17
330:2,11 331:4,10	162:2	188:15	heads 53:11 368:19	320:15 321:8
333:12 336:19	guided 338:1	HAP 260:14	heal 48:15	328:2 351:21
338:1,22 339:3,19	guidelines 338:4	happen 161:20	Healing 276:9	356:17
343:5,16,18,19	guiding 268:17	220:5 258:9 293:9	289:18 297:6	healthier 192:20
344:14 345:1,4	Gulf 44:1	337:20 342:1,3	304:13	healthy 52:4 192:6
346:13 347:11	gun 56:16,20 58:1	369:15 371:22	health 2:7,11,13	192:8,17 193:1
349:9 350:11	gunshot 57:4,8	happened 131:7	3:9 53:20 61:19	287:8 313:22

314:1	141:7,8,14 142:1	121:16 123:9	hold 101:12 171:6	43:15 44:4 98:16
health-related	142:17,21 143:2	127:2,4 151:9	230:12 276:20	224:15 227:14
181:5	144:3,4 145:9	170:19 279:2	holders 243:2	341:12 342:20
hear 9:18,20,22	148:14 152:1	285:16	holistic 311:5	346:5
36:4 99:8 184:22	156:4 163:14	higher-level 123:11	Holland 63:16	hoped 228:11,14
200:13 213:5	166:5,7 175:20	215:1	home 35:14 46:22	303:5
215:7 216:17	201:13 212:20	highlight 43:14	51:8 58:16,20	hopefully 133:20
227:18 229:17	234:17 235:20	94:12 112:7	77:13 96:22	161:8 170:20
269:18 290:22	237:3 243:12	115:20	101:10 115:5	191:3 225:19
291:20 292:13	247:19 249:8	highly 214:10	120:7 134:21	226:5 337:14
322:21 327:7	254:8 257:3 261:2	Highway 1:13	135:1 136:19	349:10 363:5
352:20 367:17	263:14 267:3,21	high-cost 164:17	137:12 142:7	hoping 126:12
369:1	268:4 269:6,9	high-impact 374:1	148:11 165:4	152:21
heard 167:10	283:4 292:1 320:6	Hill 264:10	203:9 204:1 233:9	Horan 9:14
172:14 178:18	346:5,6 353:10	hindsight 27:1	233:13 237:20	horrendous 67:4
252:22 290:8	363:22 365:6	HIPAA 294:21	238:21 239:14,18	68:11 79:19
292:18 295:10	helped 242:6	318:19	243:10 244:7,15	horrible 225:1
296:5 301:10	252:10	hire 138:15 139:7	245:3,6,7 246:21	250:14 259:6
303:19 304:13	helpful 9:7 10:8	139:13 140:19	247:20,21 248:10	hospices 52:20
344:5,8 353:19	11:9,14 14:8 15:9	144:17,18 149:5	249:2,10,13,17	hospital 48:3 80:12
362:12 364:18	15:11 35:7 36:4	hired 285:1	250:1,9,12,14,20	80:19 93:19 94:16
366:22 367:22	40:3 160:12	hires 140:16,17,18	251:13 252:8,13	238:2,17,19 245:8
hearing 10:14	167:12 194:14	hiring 123:14	254:13,14,19	253:6 254:15,22
171:17 176:14	268:10 331:2	138:6 144:15	257:7,15,17	hospitalization
202:10 272:13,16	335:5 368:18,22	historic 45:1	258:20 260:16	195:12
273:2,5,7,16	369:7,14	historical 45:3 71:6	261:19,20 267:18	hospitalizations
274:1 305:14	helping 111:9	207:16	269:7,8,9,10,12	185:6,22
362:10 363:3,8,9	112:15 118:10	histories 43:8	269:14 287:6	hospitals 48:1,5
364:17	164:7 168:3	history 3:4 42:6,9	295:19 312:21	49:14,15 52:21
hearts 97:5	236:13 245:1	43:22 44:4,9	317:21 325:12	62:19 63:7,18
heart-to-heart 29:3	250:3	45:18 46:18 52:9	326:18,19	64:18,19 67:16
heat 91:6	helps 34:4 107:22	61:5 70:4 72:18	Homefront 243:16	68:3 71:12 77:3,9
held 276:15 289:17	125:6,16 228:17	78:2,11,12,12,14	266:12 285:3	78:4,6 80:5,10,13
Hello 176:21	229:5,7 320:8	93:8 98:13,13	homes 61:21,22	86:1 87:6 88:4
help 19:5 20:10	Henry 54:3	107:20,20 284:8	84:11,12,15	90:21 93:15,17
43:18 58:17	hero's 275:14	288:8	100:19 116:13	94:8,10 238:9,9
100:10,17 102:4,7	hesitate 42:3	hit 160:16 302:7	248:2 313:19	host 159:4 169:6
102:16 104:13,16	Hey 267:17	304:20 306:11	hometown 134:16	329:2,3 344:1
110:2,3,5 111:11	Hi 269:22	hits 29:14	134:18	hot-off-the-press
112:5 113:1,4,20	high 43:20 64:15	hitting 160:9	homework 321:12	131:7
113:21 114:17,22	72:4 149:21 163:7	HIV 185:5	honest 112:19	hour 6:2,10 35:8
115:2,9,12,15	164:19 188:14	hoc 215:3	honestly 214:21	89:15 374:3,5
116:13 117:14	207:9 248:12,22	Hoge 203:17	honorable 173:3	hours 31:22 171:9
118:19 125:3	251:10 281:21	205:10,16 223:15	301:9	249:21 254:10
126:1,2,15 132:8	higher 105:8,17	224:5	hook 310:12	318:14 374:4,12
132:11 133:17	111:21 114:14	Hoge's 204:15	hooked 321:5	house 238:19
134:7 139:10	120:15 121:6,12	205:11 207:12	hope 5:6 36:3,13	241:15 249:19

260:10 263:10 297:19 303:14 household 290:16 houses 326:14 housing 43:2 233:12 248:1 295:11,12,16 301:5,6 hover 166:14 hub 225:20 226:10 hubs 219:21 221:14 huge 78:3 128:21 257:5 291:1 302:7 316:7 human 44:9 46:5 96:15 338:2,7 350:5 hundred 44:9 121:17 135:7 257:8 300:20,22 308:5 hundreds 238:6 241:19 hurdles 163:20 hurt 289:14 husband 9:15 230:15 233:2,10 308:4,13 husband's 233:9 Hyatt 1:12 hyperlipidemia 197:19 hypertension 197:18 hypotheses 226:7 H1N1 188:21 189:4 189:5	359:8 371:20 373:2 ideally 343:7 ideas 9:5 15:4 25:13 216:18 226:7 227:19 268:10 347:12 ideation 201:3 identifiable 167:10 345:10 identified 129:14 135:4 identifies 351:21 identify 151:4,22 167:7 170:8 191:1 272:10 identifying 14:8 110:21 371:21 IDES 104:7 105:11 130:16,19,20 133:7 134:17 135:6 153:19 175:15 296:18 idle 65:12 ignore 342:15 II 42:10 61:7,9 74:8 74:10,12 91:8,17 91:18,22 93:16 95:9 96:9 97:22 308:3,15 Iliad 96:21 ill 1:4 38:7 40:11 77:15 231:11 240:17 244:17 280:3 Illinois's 325:16 illness 44:1 219:13 219:14 247:17 305:12,13,16 306:8 310:1 ill-prepared 39:17 imagine 247:10 immediately 325:3 325:8,13 352:4 355:1 impact 92:18 203:3 242:4 246:10	273:2 284:20 299:6 300:4 312:11 impacted 45:20 impacts 46:9 284:13 impeded 302:8 impetus 94:1 implement 41:1 Implementation 216:1,3 implemented 30:13 40:10 137:15 importance 52:10 important 38:5,11 48:18 54:15 108:2 128:10 154:19 155:1,5 180:5 182:1 194:3,4 196:2,3 201:14 210:2 218:5,5 230:10 242:15 243:7 265:15 278:12 279:3,19 280:14 281:18 282:13 283:14 313:15 314:10 340:10 345:1 346:17 350:22 351:4 352:3,7,14 352:19 365:5 366:4 importantly 85:13 363:7 imported 83:19 impossible 334:16 impression 17:6,19 344:17 impressions 344:21 improve 56:12 181:17 321:8 improved 55:19 68:1 improvement 128:19 129:15 237:21 251:18 252:6	improvements 129:13 improving 229:13 inadequate 69:15 incapable 83:9 incidence 204:22 285:16 incidentally 61:4 include 41:1 43:2 62:15 104:8 114:5 147:22 305:13,16 305:20 306:1 310:1 329:1,3,6 351:12,14 included 178:19 255:15 includes 51:22 109:2 134:9 172:7 173:12 305:12 324:18 including 62:11 96:3 216:13 income 76:1 247:7 247:8,10 255:13 inconsistency 299:10 300:1 incorporate 223:14 240:20 362:10 incorporated 86:12 197:6 231:14 incorporating 87:3 incorrect 29:15 increase 58:2 62:7 83:22 84:1 93:4 95:7 103:11 170:4 192:1 201:5,20 202:5 231:16 251:2,3 279:11,14 287:11,13 increased 92:16 95:13 98:10 101:4 120:9 142:11 170:5 206:22 211:1 increases 54:18 56:22 increasing 96:17	191:16,17 203:4 Incubator 125:6 independence 115:3 independent 85:16 100:16,18 110:22 114:19,22 116:1,4 116:7,12,13 indexed 183:10 Indian 319:9 Indiana 297:13 indicate 356:6,7 indication 48:17 indicative 201:15 indigent 45:2 46:14 57:14 58:5 61:12 91:10 94:20 individual 47:6 55:9 103:6 111:18 113:14 114:13 115:14 116:3,10 117:10,17 118:4 142:1,5 143:3 156:13 170:13 173:12,17 217:18 218:4 223:9 225:11,14 282:1,5 314:5 332:15 347:9 361:21 individually 357:3 individuals 9:13 21:3 101:11 112:4 113:7,22 114:20 116:22 119:13 124:10,14 135:21 137:21 138:2 140:10 151:11 152:1,2 344:2 361:10 individual's 345:16 industrial 64:10 79:3 industry 125:1,20 126:2 251:14 ineffectual 97:6 infection 46:6 48:17 49:2 57:2
I				
ICD-9 200:20 ICF 338:11 349:22 idea 11:17 19:3 25:15 37:10 44:2 120:5 190:20,22 192:8 241:20 248:19 270:13 318:9 353:4 359:4				

72:2 86:15 96:16 184:4,4 infections 48:12 184:7 infectious 178:15 183:22 184:10 infer 175:18 influence 343:12 343:15 influenced 344:7 influenza 188:21 189:14 218:21 informal 31:20 32:16 42:1 information 5:21 15:3 18:17 35:10 41:19 89:8 127:21 128:14 133:21 141:6 147:15,19 147:20 158:6,11 158:18 159:2,8 161:10 164:2 167:11 182:22 209:19 210:22 211:19 212:19 213:8 215:8,11 270:12 272:1,7,18 274:11 335:4 339:11 343:8,9 345:10 357:6,8 363:4,14 367:3,7 367:8 information-gath... 366:9 information-shar... 366:8 informative 374:15 informed 164:7 338:21 339:13,14 351:1 inherit 74:6 inherited 48:13 initial 107:16 108:12 initially 93:20 135:9 276:16 initiative 104:7	130:14,16 135:18 138:5 139:22 140:2,17 153:19 232:1,5,6 327:5 initiatives 100:1 104:6 124:2,3 125:2,16 141:9 injured 1:4 40:11 231:12 233:2 237:19 244:16 258:19 262:4 280:3 306:8 327:17 injuries 86:20 222:5 260:6,17 264:1 278:5 injury 181:9,16 219:13 233:3 247:16 248:8 258:18 262:5,6 270:21 278:14 281:15 287:21 290:1,3 291:13 293:8 295:6 297:13 299:3 354:20,20 358:11 innately 202:15 innovation 125:21 126:1 inpatient 239:1,3 239:16 245:5,19 252:17 299:13 input 21:7 242:6 347:2 inputs 22:13 inquiries 187:8 inquiry 66:13 334:3 336:15 inserted 22:15 inserting 133:1 insight 229:11 installation 3:19 30:22 34:7,8,16 36:5,13,19 37:4 134:18 180:14 233:12,16,21 262:1 281:12	282:17 300:14 322:5 326:14 327:3,11 370:20 371:2 installations 40:9 130:19 325:21 326:9 instance 359:14 instances 14:21 163:11 205:12 262:12 365:21 institute 73:18 80:4 institutes 114:14 institution 53:13 56:8 67:21 214:2 institutional 338:5 338:11 institutions 9:9 88:1 90:14 instructional 131:3 instructive 200:5 instrument 333:20 instruments 53:12 323:20 330:9,11 333:14 336:9 338:10 insurance 51:2 90:16 246:1,6 251:14,19 intake 279:11 integral 85:8 integrate 14:12 integrated 67:17 integration 67:9 229:12 integrity 129:7 intel 222:22 intelligence 207:2 intend 318:22 intense 252:16 290:12 357:5 intent 181:15,21 interact 217:17 interacting 155:17 160:4 interaction 36:7 122:7 347:10	interactions 122:9 interactive 128:1 interest 76:7 139:9 182:14 217:12 226:6 227:14 346:15 interested 133:18 133:19 138:21 140:10 144:15 161:11 189:1 194:8 200:13 202:9 211:13 217:7 219:2,3 220:12 271:15 272:6 318:17 348:13 370:6 interesting 58:13 83:9 188:12 202:3 202:22 203:6 208:14 277:22 interestingly 69:3 81:12 201:18 interests 107:21 110:4 134:6 interim 323:6 interior 92:12 international 189:11 internet 235:7,15 internship 139:17 interpretation 181:4 interrupt 340:5 intervene 342:2 intervening 335:13 intervention 73:17 100:21 102:7 104:8,14 155:9 169:20 211:3 321:4 interview 112:10 118:21 interviewing 235:1 interviews 357:1 intimately 336:10 intrigued 197:7 introduce 4:22	315:21 352:8 introduced 155:13 315:16 319:3 introducing 4:11 87:5 introduction 31:14 56:16 177:7 193:18 229:17 introductory 329:1 342:19 352:12 intrusion 53:3 inundating 370:5 invalided 50:6 Invalides 55:21 56:3,4,9 58:11,14 72:8,11 invalids 69:5 invaluable 24:3,15 30:10 invented 81:7 investigating 21:14 investigation 21:10 38:22 39:1 investment 373:7 invitation 44:13 invitational 299:12 invite 17:14 invited 155:13 242:16,18,21 328:11 involved 191:13 203:10 217:20 219:7,19 266:10 361:10 involvement 39:9 191:11 in-brief 343:17 in-depth 99:18 in-line 128:2 in-of-one 365:7 in-service 42:18 45:11 Iowa 325:14,15 Iraq 191:11 222:2 225:1 IRB 338:14 352:7 354:5 357:15
--	---	---	---	--

359:11,14 361:5,6 361:12,13,15 IRS 147:16 Isabel 55:11 Isabella 55:12 isolated 167:3 issue 61:13 117:2 170:9 172:22 173:1 191:5,10 193:13 194:5 196:17 200:11,15 203:21 204:18 218:16 220:10 223:5 224:16 235:11 261:5 270:13 286:22 287:12,13 294:13 303:2 318:13 350:6 issues 3:14,17 8:22 13:3 17:8,9 20:8 27:5 32:22 86:14 88:10 115:15 151:4 152:14,16 186:15 190:15 191:4,22 192:3 198:6,17 199:1 202:16 218:18 229:12 246:11 271:2,12,16 284:11 286:11 287:7 288:10 289:20 291:1 294:21 302:18 308:20 314:20 320:5,11 353:4 360:18 italics 180:5 items 100:7 166:20 337:8 itineraries 328:15 328:22 329:1,9 itinerary 326:3 346:1 i.e 312:13	J 1:22 JAGGER 2:22 346:20 347:19 354:13 357:14 January 8:19 89:21 90:1,3,5,5 98:16 Jefferson 1:13 Jess 336:8 345:7,7 346:19 354:11 369:11 373:10 JESSICA 2:22 JFHQ 323:4 324:21 325:2,12 329:20 JFHQs 324:18 325:18 JFHW 325:14 JHFQ 325:6 Jim 327:5 job 110:7,13 111:12 112:2,3 117:14,14 118:4 118:12,21 144:6 144:21 145:9 147:21 148:14,18 149:1,14,16 150:4 166:8 169:5 170:9 170:11,16 171:7 171:14 215:7 233:7 245:20 246:20 250:2 288:20 353:21 354:14 367:16 372:13,22 jobs 122:21 123:11 144:3,4,11,12,22 145:14 146:16 148:1,2,21 149:7 149:11,21 150:5,6 150:9 246:6 251:11 job-ready 117:20 117:21 Joe 342:14 jog 31:16 John 190:17 370:18,19	join 5:8 joint 160:10 198:15 joints 199:5 Jones 239:21 240:1 240:6 267:17 345:11 journal 183:8 211:16 journey 237:17,22 239:12 240:7 joy 341:6 July 7:18 28:4,6 jump 70:3 100:7 163:19 Jumping 53:22 junction 303:11 323:15 June 28:3 92:2,3 junior 248:11 justice 342:8 justices 60:7 Justin 1:19 4:16 332:12 370:14 J.D 1:19	284:18 350:15 key 168:11 287:4 300:2 338:17 keywords 145:12 kick 81:15 141:10 152:21 258:3 351:4 kicked 120:12 121:8 125:14 kickoff 338:22 kicks 306:5 309:7 kick-off 350:21 351:7 358:6 368:4 kids 233:14 273:17 275:9,9 276:3,12 276:13 281:1,13 292:18,20 298:4 kill 44:16 killed 44:14 66:4 223:22 Kim 290:18 328:6 Kimberly 2:15 229:18 230:13 kind 6:16 13:20 14:3 24:5,9,12 26:8 30:8 35:12 40:2 64:22 65:13 66:18 82:6 127:13 129:11 138:1 156:5,7,7,20 157:21 185:19 193:11 195:8 199:9 203:3 204:7 223:2 226:8 228:17 229:12 231:3 233:7 247:10 252:3 255:22 258:11 261:14 262:19 264:22 265:4 270:19 293:5,12 298:9 316:17 318:15 336:4 341:22 348:17 366:10 kinds 62:15 157:6 187:4 235:7 237:2	246:11 254:17 255:14 257:18 kinetic 221:21 king 58:3 kings 240:4 kitchen 271:7 knee 198:17 knew 237:12 297:15 369:11 knights 51:22 52:1 know 10:10 12:7 16:13,13,18 20:3 20:19 21:17 24:5 28:12 32:4,5,12 35:5,21 37:14,17 37:18,19,19,20,22 37:22 38:17 97:8 105:7 109:9 126:7 126:7,10 127:21 128:3 132:16,18 133:17 138:18 142:6,6,8,9 143:4 143:10,11 145:18 147:22 151:8,16 151:18 152:13,16 152:18,19 153:3 154:17,18,18,19 155:3 156:6 159:10 162:13,14 162:17 163:3 165:13,20 168:2 168:22 169:9 173:2 175:9 178:3 179:8 190:8,12,20 191:10 195:15 198:22 199:1 200:8,11,16 203:10 206:12 207:21 209:6,18 210:9,15 213:2,5 213:10,13,14 214:1,5,9,11 217:10,13,21 219:2,11 220:6 221:2 222:16,18 224:10,18 225:5 227:1,17 230:16
J		K		

235:11 237:8	337:16	law 82:11 121:7,21	legislation 59:22	licensures 157:21
240:10 242:10,12	Korean 42:12	319:5	70:8 310:7 315:17	lies 91:20 270:14
244:19 246:16	92:18 96:8	lawn 263:10	legislative 274:7	323:9
247:4 249:7,16	Kozo 292:19	layer 275:13	legitimate 149:12	lieu 58:16,20
250:6,22 251:1		layering 270:20	149:15	Lieutenant 4:14
252:22 254:3,5,17	L	314:2,8	Lejeune 276:22	228:5
255:17,20,20	L 2:7	lead 68:16 199:9	294:1	life 2:16 3:13 51:1
256:11,13,16,19	labor 83:10	349:20	lengthy 339:2	60:16 64:7 72:21
258:2,14 261:1,2	laboratories	leader 81:17	LESLIE 2:12	73:10,16,19 76:1
264:4 265:3,15	184:12,16 189:5	leadership 38:12	lesser 247:8	76:3 84:8,8 204:3
266:5 267:12,12	laboratory 189:11	38:17 39:9	letter 169:2 172:10	229:19 230:14
267:20 268:19	189:16	leading 79:17	174:19,21	231:8,13,16 232:4
273:7 276:4	lack 39:9 84:22	lean 268:18	Letterman 80:2	233:13,16 244:18
279:18,21 280:2,8	256:19 292:20	learn 183:16	Letterman's 87:3	245:13 264:13,16
280:10,11,15	319:15	learned 44:7	letters 275:16	280:22 297:12
282:19 285:10	Lackland 337:17	335:14	letting 269:14	303:7,11 318:11
288:22 290:1,6,7	ladies 4:3 13:17	learning 114:14	348:9,12	lifetime 280:17
290:12 291:12,17	14:6 24:22 27:22	212:21	let's 6:7,17 13:12	lifted 336:12
293:4 294:3	31:7 33:10 228:10	lease 113:20	21:20 22:3 24:21	light 56:8 111:6
298:13,15,16,16	373:13 374:22	leave 18:3 25:18	131:16 143:9	344:15 348:7
298:21 299:14	lady 84:6	200:9 229:7 245:2	211:22 212:13	light-weight 366:20
301:17 304:19	laid 234:12 240:13	246:10,15,18	216:7 304:4	liked 30:14
316:3,22 318:9,15	268:18	257:14,17 291:5	323:21 362:15	likewise 146:7
318:19,20 322:10	land 50:9 72:15	304:16 307:3	364:4	limb 82:16
322:18 324:3,5	Landstuhl 329:22	313:21	level 13:3 56:13	limber 253:8
335:12 340:20,22	330:2	leaves 304:3,8	139:4 150:5 161:4	limbs 57:10 253:3
343:9 347:4	lane 38:10	leaving 55:2,3	179:21 180:15,15	limit 20:18 108:7
348:12 349:13	language 352:12	233:5,7,7 259:22	201:10 205:6	117:2,3,4,6,7
350:20 354:17,19	laptop 353:17,21	led 63:14	210:12 221:6	limitation 151:15
355:13 357:2	large 28:6,7,7	LEDERER 2:21	224:21 225:13,15	limited 19:15 58:15
363:11 364:6	54:17 55:12 57:13	322:6 328:18	225:19 226:5	75:9 124:10 148:1
369:2,12,14,16,18	58:4 80:14 97:5	331:19 332:1	234:10 249:9	185:13,13 228:21
370:10 372:9	157:17,18 184:15	340:6,16 341:9	251:10 259:7,11	limiting 163:18
knowing 93:11	193:6 248:13	347:15 348:11	259:12 261:7	231:18
331:17	296:1	356:22 359:2	265:3 266:9	limits 117:1
knowledge 46:4	largely 52:21 77:18	362:7,19,21	291:19 322:15	line 22:22,22 33:5
67:3 123:6 130:6	77:18 91:9	left 26:1 52:5 63:21	336:22 358:13	38:12,15,16,18
141:3 181:22	larger 48:5 247:8	112:11,12 229:3	360:20 369:20	39:3 42:3 54:15
208:11 209:2	362:11	233:2 238:22	levels 248:12	93:13,19 95:7
210:4 211:10,10	largest 186:5	239:3 282:22	levied 62:2	108:10 171:16,22
211:11 255:22	late 24:4,8 46:10	292:10 295:2	Liaisons 328:2	211:9 340:9
261:7,15	47:18 67:1 76:14	301:12	license 114:6	lines 22:8
knowledge-based	83:4 97:21 296:21	left-hand 148:15	licenses 112:1	link 146:3 310:10
114:11	306:16	leg 60:19 72:5	113:17 121:18	linkages 266:20
known 163:4 192:8	laudable 48:14,19	legal 21:7	licensing 156:20	linked 144:13
knows 264:17	53:19	legally 355:4	313:6 315:17	links 182:22
Knox 326:18	launch 353:15	legion 48:4 49:10	licensure 157:6	list 217:9 218:9,11

219:8 256:13	116:12 121:6	186:9 285:3 299:5	129:22 148:12	295:1,20 296:3
257:21 280:8	248:4,10,15 261:9	long-term 114:9	181:11 183:4	298:11,19 304:9
listed 118:20 183:9	265:2	250:3 296:22	185:19 253:16	305:14,22 311:7
196:13 235:18	Loan 142:7	look 6:18 10:22	323:17	312:16 313:8
334:3	lobbying 316:13	24:21 46:4,12	lord 51:22 52:18	314:2 317:1 323:4
listening 322:9	lobbyist 316:4	47:11 56:14 103:9	63:9	327:15 335:14
363:7 371:12	local 54:10 60:3,6,6	140:18 148:21	lords 51:14 53:1	345:20 365:18
Lister 48:10	60:8,10,16,22	162:20 165:8	Lorraine 327:5,13	lots 36:6 182:21
listing 8:15 236:3	61:13 94:16	174:6 182:21	lose 245:20 246:1,4	192:13 195:6
literally 238:6	123:19 150:5	183:12 185:21	246:5,6 252:18	198:13 206:1
329:10	165:9 252:11	186:3 192:19,22	358:4,9	209:13 272:1
literature 191:21	267:2 351:21	193:20 194:5	lose-lose 304:17	loud 368:17
204:17	locally 359:9	197:2 201:14	305:2	Louis 58:4
little 6:4,13,17 8:3	located 263:20	210:5 211:21	loss 60:17,18,18,18	love 77:11 216:17
8:17 16:20 18:1,6	295:7 297:14	212:8,10 213:17	82:16 281:16,16	loved 237:18 290:5
18:15 22:3,7 32:2	327:20	214:14 222:17	lost 92:10 373:4	320:5
32:7 35:17,20	location 128:12	229:7 250:17	lot 8:20 15:15 25:8	low 64:9 257:20
71:13 102:11	137:9 267:14	267:11 272:9	42:1 98:18 100:7	lower 261:7 275:15
104:5,11 106:17	290:2	278:14 279:3	100:20 113:11	lower-level 187:11
126:19 132:13	locations 119:22	305:2 313:3 314:6	114:12 121:2,5	LT 370:10
147:5 148:13,16	log 149:9	319:18 323:21	123:4,5 137:20	LTC 1:21 4:14 19:2
156:6 171:10	logging 149:6	330:9 331:8	138:10,17,20	26:11 40:7 308:21
178:2,4 181:20	159:3	332:18 337:1	140:9,13,13	340:4,7 341:8
187:2 190:7,13	logistical 245:14	looked 193:13	141:11 142:4	luckily 354:9
200:4 213:17	350:15	201:1,7 203:2	153:14 158:22	lucky 86:3
221:12,16 224:6	logistics 45:21	205:19 206:16	160:9 161:13	Ludwig 2:7 176:15
224:16 230:14	47:20 87:3 96:14	223:13 241:21	163:19 164:1	176:21,22 190:4,8
256:21 258:4,20	207:1 222:8	285:4 299:5	165:12,17 167:1	195:17 211:5
273:15 278:12	log-in 148:19 149:9	looking 8:6 35:10	168:21 171:5	212:2,15 214:1
283:6,6 284:9,16	London 69:22	41:20 43:15	181:11 182:3,4	215:4,21 218:20
290:10,18 297:12	long 28:12 31:15	120:20 123:11	197:13 199:18	225:16 226:15,16
298:21 299:2	98:13 211:9	126:6 128:22	200:9 202:14,16	227:7,13
308:17 339:21	233:19 234:11	135:18 136:15	205:11 209:8	lumped 332:9
343:4 346:12	247:9 249:22	143:21 144:22	214:6,22 215:2,3	lunch 176:8,14
373:17	261:11 262:20	145:6 156:4 188:7	217:22 221:18,20	luxury 161:15
little-known 90:19	313:19 334:13	191:5,21 194:14	222:4 224:9,13,13	205:15 224:5
live 249:1,16	357:19 366:15	196:8,9,12 198:11	225:14 226:3	LVERs 150:4
263:10 280:13	373:9,22	199:18 200:19	228:13 230:10	
281:8,9,10 288:21	longer 34:18 75:18	203:20 204:18	231:1 232:14	M
297:4,7 298:9	118:8 169:5	205:12,15,17	235:9 237:22	machine 123:2
lived 233:20	173:20 203:12	218:6 270:22	238:16 245:2,2	macro 323:21
lives 28:13 76:21	251:16 253:4	273:9 274:15	249:18,22 251:6	Madigan 294:1
245:11 281:18	258:10 283:18	284:19 304:6,11	253:6,11 259:10	295:16
286:7	334:15 367:5	304:17 312:7	262:2,7,10 273:14	maimed 50:4 70:10
living 55:19 71:7	longest 191:12	313:4 355:20	274:2,5 281:22	main 48:22 71:6
95:8 100:16 111:1	longhand 19:20	370:15	283:3 290:17	91:4 148:11 157:8
114:19 116:1,4,8	longitudinal 185:1	looks 29:10,21	292:21 294:22	157:11 184:21

331:4	328:1,2 335:5,14	288:2 311:12	209:14 235:11	MEDLINE 183:10
maintain 51:7,22	managing 363:1,2	marry 76:19 84:6	medical 18:3,6	183:10
52:20 77:9 84:19	363:16,18	Mary 62:9 342:16	22:22 23:3 38:10	meet 99:3 137:2
108:8 184:21	Manassas 258:15	Master's 138:13	38:18 39:3 42:21	172:11 247:15
185:16 186:5	mandated 34:14	match 267:20	43:9 44:15,18	248:3,14 274:21
252:14 254:20	mandatory 130:21	material 10:21	45:12,21,22 47:5	289:19 318:14
283:4	131:12 132:14	42:2 177:21	47:11,15 49:14	meeting 1:6 4:4,9
maintained 52:22	133:14 136:20	323:19	52:1 54:5,11,11	5:10 7:17,22 9:1
maintaining 129:7	146:10 153:21	materials 351:12	55:9,10,12,17,19	12:8,17,19 17:11
maintenance	154:22	351:14 370:6,7	62:14,17,19 63:19	25:9 27:7,10
251:12,20	maneuvering 35:19	math 143:4	65:21 66:16 67:3	28:10 29:3 31:3,7
Maison 55:21	manned 72:11	matter 41:11 91:15	67:10,10,14 74:11	32:10 33:18,19
major 4:20 85:21	manner 41:6	99:5 176:11	74:13,13,14 77:18	89:22 90:3 107:18
92:14,20 209:8	130:13 216:19	211:15 228:2	80:3,7,18 81:20	130:22 131:11,13
325:11 335:20	217:15 227:12	239:1 247:8	85:3,7,14 86:13	132:14 133:14
majority 123:15	331:15	321:22 331:12	87:3 91:9 92:1,3,4	169:17 217:4
206:6 279:20	manning 72:9	350:6 375:4	92:5,16 93:8,12	232:9 332:8 336:7
281:10 344:14	manor 53:1	matters 330:18	93:16,21 94:15	meetings 18:21
348:16 365:8	Manpower 337:6	maximum 117:16	95:19,20,20 96:4	25:7 26:5,6,9 33:9
372:2	manual 83:10	118:14	96:14 101:12	33:10,15 219:1
making 26:18	162:8 163:9	ma'am 19:2 155:7	142:8 176:19	272:3 370:22
30:10,11 79:14	manuals 47:16,18	262:21 264:9	178:19 183:1	meets 174:16
121:4 152:18	85:10	308:21 340:4,8	187:10 189:17	member 4:10 20:2
153:21 154:6,22	manufacturer	mean 19:10 24:14	191:5 195:19,21	87:12 104:20
155:20 156:14	253:10	25:20 42:17 167:1	196:9,10,22	106:6,21 107:7
198:2 252:5 305:4	man's 259:17	167:9,12 168:1	200:21 211:10	109:4 110:8
309:11 311:9	map 165:3,6	214:17 215:12	212:15 220:17,21	127:18 130:20
314:10 320:1	March 242:22	226:3 264:18	222:4 225:10	131:9 133:15
males 76:4	Margarita 2:5	281:8 310:5 316:9	226:17,18 245:8	142:16 148:19
man 19:10 28:13	132:12	336:18 345:20	246:10,14,18	161:15,19 203:10
56:7 258:12 259:2	Marine 12:2 77:4	350:10 359:10	253:16 278:1,8	214:18 231:11
manage 161:3	205:20 206:9	meaning 109:14	306:17 313:18	245:22 262:4
363:19	221:17,21 232:11	meaningful 45:9	317:19 321:2,4	267:5 279:12,15
management 1:3	236:21 259:17	means 86:14 108:6	medically 45:2	282:6 283:22
23:1,3 117:13	286:15 298:4	282:3 283:16	55:3 61:12 300:7	286:4 289:6 290:5
118:18 129:18	307:5 308:22	348:5 351:16	300:18	292:3 294:14
130:6 141:3	327:16	meant 32:11 36:7	medically-retired	300:3,18 301:14
184:20 293:18	marines 77:12	87:13 242:14	300:4,6,10 301:4	304:3,5,8,21
295:2 312:19	218:11 228:13	measure 108:14	medically-separa...	306:7,8 307:16
374:7	Marine's 232:20	168:11 169:11,21	300:3,10 301:1	309:6 311:12
manager 164:19	Mark 4:13	175:4	medical/medical	313:13 330:17
265:14 266:3,10	marker 186:15	measures 168:13	313:5	343:2 349:8 350:1
managerial 122:22	market 123:9	MEB 132:18,18	medication 273:19	350:8 371:17
123:6	marketing 152:20	mechanics 346:12	288:9 307:18,19	372:12
managers 18:4,6	Marlborough 63:9	mechanism 60:1	medicine 53:3,7,15	members 1:4 3:2
122:4 235:4 237:7	married 230:20	307:2	53:16 183:14,15	8:21 17:9 20:2
256:12,18 294:9	233:18 278:11	media 164:2	190:18,21	24:6 36:17,20,21

37:1 40:12 82:22 101:1,19 102:13 107:2 114:14 115:21 119:13 133:4 135:6 141:15 153:1,16 162:1 172:15 173:13 175:14,20 185:12 195:22 196:3,5 198:6 221:19 228:5 229:2,3 240:18 259:12,16 261:4,6 274:6 278:4,9 279:6 299:8 308:7 317:12 328:12 330:3,14 332:13 347:11 349:16,18 349:19 350:12 370:21 371:21 374:9 membership 323:6 member's 248:4 memo 132:16 memorandum 102:17 104:21 107:13 133:6 173:2,8,14 memory 14:1 16:8 31:16 115:15 men 75:6,12 76:19 198:14 mental 191:15 192:2,12 199:20 200:17,19 201:3,8 201:13,16,17 203:14 206:22 207:5 210:13,19 224:21 238:13 278:7 279:14 284:8 287:3,5 288:8,11,13 291:1 294:12 302:10,22 306:2 307:17,20 313:8,15,18 316:10,20 317:1 319:6 351:21	356:17 mentally 77:15 mention 5:3 177:9 180:13 345:3,3 mentioned 58:10 78:1 90:14 122:19 135:19 141:3 176:22 177:4 184:17 216:9 218:21 283:11 296:6 301:21 324:7 327:13 330:6 342:18 344:22 369:6 mentoring 366:7 MEP 186:13 MEPS 185:5 Merchant 77:4,10 mess 333:19 met 1:12 33:5 230:18 232:20 241:2,3 249:4 method 40:8 193:12 217:3 322:10,12 methodologic 194:4 methodology 193:20 333:5 336:19 metric 160:11 metrics 160:22 metro 180:1 Mexican 78:1,14 85:12 MG 1:14,18 5:1,12 11:2,11,16 15:13 20:13 26:16 28:15 28:21 29:2,7 38:4 40:5 41:3 89:3,5 89:14 90:8,12 99:7 136:12 145:15 146:12 150:12,17 175:12 176:7 204:10,14 204:20 205:5,19 206:2,6 207:14	208:2,7,9,22 211:8 215:18 216:20 217:2 218:10 226:14 227:8,21 229:16 314:15,19 315:10 315:22 316:12 321:10,15 322:2 341:1 360:22 361:19 362:6,18 362:20 371:5 MHAT 204:11,13 204:22 middle 52:12 90:4 97:3 148:12 middle-class 64:11 Midwest 160:20 mid-Eighteenth 63:11 Mike 232:10,12 mil 185:18 militarily 214:14 military 2:19 3:16 52:11 61:21,22 63:7 67:11,14 68:17 80:5 94:5 97:19 101:3 112:8 112:11 131:19 180:2,10 183:18 186:12,14 188:13 191:13 192:9,11 192:14 195:3 207:17,18 208:5 229:4,7 231:6,9 231:10 232:14 233:11,11,16,21 236:15 237:2,11 238:9 243:19 262:1 266:7 269:20 270:1,5,10 270:19 271:15 272:11,14 274:10 274:22 275:13 280:1,11 281:3,3 281:8,22 282:20 282:22 285:14,15 294:15 300:5,11	301:15,18 302:4 302:12 304:1,3,9 313:9,17 317:11 339:16 350:10 militia 78:20 militias 85:16 million 88:9 95:8,8 95:10 144:11 149:21 150:9 194:18 279:6,16 millions 79:10 mimicking 59:4 mind 133:21 189:19 204:8,8 331:9 344:12 mindful 341:18 343:22 344:18 366:4,5 367:10 minds 65:9 minimal 333:14 335:1 minimum 118:12 171:10 350:16 minisurvey 352:15 352:16,20,21 353:6,8,11 mini-survey 332:17 332:19,21 333:11 335:2,3,6,15,18 335:21 mini-surveys 330:12 333:9 minute 177:9 185:1 321:17 minutes 89:6 90:11 99:3 228:8 262:17 321:16,20 323:8 362:19,20 366:15 373:21 misfortune 231:17 mishandling 360:4 mismatch 79:10 missed 281:17 missing 18:11 228:4 284:1 mission 100:8,9 180:3 231:15,15	231:20 232:5 Mississippi 51:8 misspend 255:8 MMWR 212:14,15 MOAA 243:17 mobilization 70:16 85:18 91:19 mode 45:3 366:8,9 model 22:11 46:19 56:1 72:7 85:19 239:12,19 240:18 240:21 modeled 72:20 73:13 models 207:16 208:2 moderate 308:4 moderating 370:7 moderator 342:2 343:5 349:20 366:4 moderators 365:6 modern 97:18 modification 19:8 248:1 modifications 247:20,21 modified 248:3 mom 248:20 258:22 259:3 288:8,13,15 289:12 312:1 moment 119:6 237:18 239:13 244:20 302:4 309:14 327:22 moments 362:9 Monasteries 54:4 money 19:9 59:17 120:1 167:2 171:11 251:6 monitor 366:10 monks 53:11 Montana 166:14 166:15 Montgomery 120:21 122:12
---	--	---	--	--

166:3	312:6 330:8	355:17,18	16:11 20:21 21:6	307:1,19 312:5
month 30:13	347:17 364:7	names 79:21 345:3	25:22 26:1 31:2	negative 348:7
120:22 156:19	366:17	Napoleon 65:16	39:18 80:19 105:5	neglect 356:7,8
183:17 272:8	moveable 68:3	narrow 234:9	106:22 107:7	neglected 63:13
278:5	moved 18:5 28:13	narrowly 359:19	109:16 110:15	183:7
monthly 116:18	71:3 238:18	nation 101:9	111:15,19 112:2,5	net 165:20,21
120:15 121:3	244:14 282:21	232:17	113:18,19 114:18	262:13
176:19 183:2	288:16,19,21	national 2:19 3:16	115:13 118:5	network 189:16
187:10 190:16	297:13 319:20	54:9 61:13 74:21	123:8 127:20	233:8 295:21
212:12 255:18	movement 44:19	85:17 150:2	130:1,2 134:3,9	networks 263:21
278:1	69:10 252:3	179:14 235:22	136:2,13 152:1,8	neuropsychiatric
months 12:10,11	moves 310:19	267:11 269:20	163:5 169:5 178:4	57:20
12:19 35:11 86:22	moving 36:14	270:1 338:3 374:6	180:12,18 182:5	neutral 342:13,17
101:21 117:16	46:17 89:2 133:5	374:9	198:5 223:8 228:6	never 29:5 30:5
118:1,5,14 172:16	134:13,19 173:9	nationally 136:10	234:13 244:4	204:7,8 259:3
205:2,3,5 233:1,5	179:15 261:19,22	138:3 150:7	248:3 254:6,17	289:12 292:12
235:1,6 245:5,18	269:8 274:19	naturally 371:8	255:22 256:6	293:11,15
247:6,6 274:2	362:15	nature 45:18,20	262:3 263:10	nevertheless
286:11,14,17,17	MSMR 187:9	96:11	267:15,22 269:13	332:15
286:18,21 289:7,8	190:1,2,6,10	Naval 77:12	276:5 292:1	new 5:5 23:2 24:5
309:9,16 323:2	198:3 209:7	navigate 111:9	304:15 306:15,20	52:7 65:2 71:17
324:10,11 335:13	212:11 213:21	115:12,13 124:16	311:4 312:17,20	73:3,14 79:11
morale 55:5,7	214:13	132:8	313:3 314:6 317:3	87:10 92:4 95:20
morning 4:3 6:1	Mullen 304:4	navigating 294:7	337:20 346:7	98:14 101:4
275:14 370:15	multiple 71:1	Navy 5:4,6 51:8	347:7 354:10,16	103:16,19 117:18
373:11,13,19,22	194:11 201:19	77:5 203:9 226:10	354:22 355:3,8	120:16 140:15,17
374:19	202:21 203:4,11	236:21 248:7,10	358:1 360:19	140:18 156:18
mortality 72:3 81:6	multiplier 316:9	307:6	362:3 366:18	183:11 231:21
mortar 317:6	multitask 353:1	Navy's 293:2	373:2	245:13 278:10
mortuary 308:10	Munoz 2:15 229:18	NDA 299:20	needed 13:3 21:15	288:20,21 289:4,9
mother 239:21	229:22 230:13	NDAA 116:2	82:4,20 116:16	292:9 303:17
345:15	246:12,16 263:16	near 46:22 97:14	162:20 233:15	323:6 330:4,9
motivation 43:13	264:21 265:8	97:17 244:3	237:13 267:5	334:2,2,7,10,17
motorcycle 260:1,2	266:22 268:9,12	260:11 328:10	355:19	335:3 336:11,14
motorized 87:5,5	328:6	nearby 238:21	needing 199:2	336:14,14
MOU 131:1	muscles 253:3	nearest 137:9	273:18	news 148:16
move 47:4 173:10	musculoskeletal	nearly 369:21	needs 20:16 37:12	NGO 66:18,19
195:9 196:14	198:16	neat 252:20	38:1 71:2 116:12	nice 25:15 186:2
211:18 233:11	mustered 73:22	necessarily 282:9	117:10 118:16	224:22 227:1
239:14 243:5,10	mutter 369:3	291:9 325:7 339:6	130:1 142:18	night 284:15 302:9
253:3,4 260:11,16	myopia 199:2	344:13,16	182:11 234:18	Nightingale 66:11
261:19 269:7	M.D 1:14,18,22	necessary 26:8	244:7 248:14	nights 257:19
277:17 280:15		82:7 87:20 93:22	249:4,5 254:6	nine 28:8 146:14
287:16 288:17	N	339:5 350:14	267:13,18 270:21	177:16 235:1
295:5,8 297:7,18	naive 364:17	366:12	274:21 283:1,9	280:16 335:17
299:9 308:20	naivete 364:16	neck 258:16	288:6 301:19,22	374:2
311:1,14,17 312:3	name 253:18 266:1	need 9:3 14:3,4	303:6 306:17	Ninety 71:11

nipped 21:12	notably 55:10	127:6,7 135:3	283:12 322:15	OJT 114:15 157:5
nitty-gritty 222:13	note 47:17 55:18	172:14 213:19	occurred 92:15	OJTs 157:15,20
NMFA 243:13	70:17 72:6 98:12	349:13	217:11 220:13	okay 8:19 10:2,5,5
nobody's 287:10	159:21	numerous 214:4	247:17	10:12,15,19 11:1
nodding 363:13	noted 57:22 83:4,6	nurse 249:20	occurring 155:22	11:10,15,21 13:4
368:19	84:5 86:10	nurses 62:22 63:6	occurs 219:14	13:6,10 14:16
nods 365:18	notes 19:19,20 33:8	85:22 243:15	OCTOBER 1:9	15:1,6,12 17:1,1
non 87:14 313:4	369:19,20	nursing 249:9	Odysseus 96:22	18:13,13 19:1,1
noncollege 114:15	notice 341:20	291:16	Odyssey 96:22	21:4,16,19,20
noncombat-injur...	noticed 58:3 97:15	nutshell 119:8	OEF/OIF 101:6	24:19,20 25:3,17
259:15	notification 108:16		328:1	27:18,21 28:1,4
noncombat-wou...	109:1 239:15	O	offer 306:2	28:15 29:22 30:2
260:21	notified 239:13	obligated 339:6	offered 335:6	30:2,17,20 31:6
noncompetitive	noting 81:1	obligation 51:15	offers 317:14	32:9,18 33:7 34:5
139:20	notion 48:19 51:3	61:17 64:1 342:2	office 155:17 160:5	37:2 38:3 39:22
nondeployed 205:6	52:6 57:14 81:6	343:3	161:3 165:10	40:1 90:7,11,12
283:8	83:12 85:7 92:21	obligations 50:12	273:8 317:21	99:3 100:4 104:17
nondeployers	97:19,20 164:5	247:16	321:1,3	122:14 124:1
192:22	notions 53:17	observation 203:19	officer 2:2,4 77:12	130:14 135:17
nonemployed	not-for-profit	365:8	80:3 82:2 94:14	148:9 156:1 158:3
284:21	263:2	observe 371:14	203:9	159:20 161:6,10
nonjudgmental	November 88:17	372:5	officers 62:17	165:1,2 172:13
343:7	231:14,21 259:21	observer 371:17	72:20 73:2,9	178:17 181:18
nonprofit 236:5	277:15	observers 350:3,4	74:10,14 75:4,12	190:11 204:14
240:12 259:11,14	no-fault 260:1	obstacles 34:1	85:7,8 355:15	208:7,22 217:9
260:22 267:11,16	nuances 225:14	obtain 102:16	officership 73:14	224:19 248:18
271:18	number 11:3 29:4	108:7 346:14	74:7	315:10 320:4
nonprofits 235:5	29:15,15 43:8,20	obvious 37:7 143:3	offices 101:9 119:4	328:16 332:20
235:19,20 241:17	50:12 57:13 79:8	364:15	119:21 136:2	341:9 346:11
266:12	89:10 95:16	obviously 19:16	145:3 161:5	347:15,16 349:5
nonstate 165:14	108:21 119:19	21:6 167:3 187:1	official 9:18	349:14,19 350:19
nonthreatening	127:2 149:22	187:18 221:20	officially 351:17	354:13 356:21
346:16 347:21	153:7,8 157:17,19	262:4 284:3,11	officials 9:22 60:7	362:5,15,21
349:1	170:1 175:5	287:5,7 346:22	offline 343:16	369:18 370:18
Non-DoD 1:14,17	191:14,17,18	365:21 369:13	Off-mic 370:17	old 44:10 52:8 56:1
non-Federal	201:2 202:4	occasion 349:22	off-site 244:3	68:10 288:4 291:3
165:15	203:20 206:12	occupation 117:18	oftentimes 192:18	older 76:19 199:1
non-medical	208:19 213:12	138:9,11 143:7	198:7 205:18	oldest 248:19
320:13	223:19 268:18	223:19	213:10 224:1	Omar 95:14
non-spouse 312:1	278:17 286:13,13	occupational	225:9 226:9 249:3	once 19:14 109:12
norm 81:10	314:8,20 315:13	183:15 192:7	366:14 368:10	117:18 118:3,11
normal 75:5 292:9	325:10 326:18	206:17,19 210:18	oh 139:9 142:20	122:8 123:7
normally 275:12	337:8 353:21	222:17,20	146:19 227:13	137:10 138:2
295:13	355:15 371:6	occupations 92:5	OIF 278:10	139:8,19 162:17
north 71:3,4 83:18	numbers 58:5 76:2	122:18	OIF/OEF 237:6	164:11 187:19
260:9 342:14	78:9 91:20 97:6	occupied 80:16	266:3 294:9	194:12 208:22
north-south 342:15	119:18 127:1,2,4	occur 209:12	308:13	220:12 223:2

226:19 230:12	126:2 128:19	123:21 165:18	159:4 273:4	parent 238:15
237:14 238:22	opportunity 25:12	167:5 178:9,13	276:15	245:21 246:5
247:3 272:7 291:5	40:1 49:17 164:10	179:20 186:7	out-of-pocket	247:14 258:8
300:12 301:17	190:5 256:9 270:3	216:13 228:12,15	296:15	280:4 281:17,17
306:4,10,11 310:1	289:19 293:16	229:1,10 238:7	out-of-pockets	283:17,17 286:1
339:18 342:11	302:6 311:13	261:1 263:2	116:21	292:5,6 359:22
349:14	312:3 316:8	319:14 326:13	overall 36:1 193:14	parents 276:3
ones 167:18 297:22	326:21 327:7	374:13	195:11 197:8	284:3 303:3
onesie 282:8	342:9 344:4	organized 86:6	199:6,16	Paris 55:22
OneSource 301:15	opposed 167:16	178:7 208:4	overcoming 231:18	Park 258:15
301:18	188:17 194:1	orientation 323:11	overlap 197:11	Parliament 59:7
one's 210:4 362:11	222:1 343:8,20	original 76:10	198:13 199:3	60:5,11,14 66:10
one-on 362:10	Ops 236:20	92:21 202:13	overload 164:2	66:12 69:17
one-on-one 18:15	opting 121:5	333:20 335:6	overly 334:20	part 6:22 11:3
357:1,6 360:12	option 113:9	originally 74:20	overrule 66:15	17:10 31:19 32:14
one-week 308:22	114:21 124:12	75:10 127:6	overruled 91:7	36:5 48:18 63:7
ongoing 104:3	125:18 301:21	135:12,15 309:12	overseas 94:4	65:18 75:15 85:8
117:12 181:3	302:3 313:4	orphans 75:10 76:8	oversight 262:10	101:14 109:19
221:11 296:3	options 89:9	76:10,11	overview 3:10	110:21 116:8
online 183:5	120:21 131:21	orthodontics 267:5	99:18 166:17	122:13 130:16
199:13,13 202:1	132:10 143:10	267:7,9	178:2 191:9	132:22 157:3
317:8,15	164:11,12 311:11	OTSG 213:15	193:11 196:17	177:6,8 178:21
on-site 130:18	335:7	ourself 268:7	198:11	181:2 187:20
134:22 322:15	order 4:5 89:15	outbreak 219:11	overwhelm 78:10	188:13,14 189:21
327:20 337:20	136:13 138:14	outbrief 343:21	302:21	199:10 217:11
on-the-ground	187:1 333:18	344:19 345:5	overwhelmed	219:5 225:6 242:9
322:20	334:9,17 338:15	outbursts 290:8,11	298:17	296:1 298:13
open 31:9,11 33:4,4	361:15 364:19	outcome 87:9		311:7 345:8
147:3	370:5	outcomes 22:14	P	347:16,18 358:6
operate 64:5	orderlies 63:20	194:7 228:18	page 3:1 148:12	358:19 361:2,7
Operation 243:16	orders 299:12	298:21 334:5	pager 107:10	partaking 48:4
266:12 273:15	ordinance 236:11	outlawed 58:6	pages 28:8	partial 75:6,6
275:7,21 276:4,9	ordinary 64:7	outlet 352:2	paid 50:20 60:3	participant 356:13
276:12 278:10	73:21	outline 178:1	61:22 76:21 83:13	357:18 358:21
280:6 285:4	organization 11:6	outpacing 278:8	83:18,19 84:13,16	participants
289:18	44:18 45:22 177:7	outpatient 238:20	120:1 121:19	119:20 147:1
operational 187:6	183:16 189:7	239:17 299:13	143:12 251:9	333:2,8 339:10
213:6 214:6,9	231:21 260:22	output 172:9	paint 250:13	342:6 345:2
215:13,14,16	267:19 271:5,10	outputs 22:14	Palace 236:17	349:10,16 354:11
219:21	271:22 272:7,22	outrageously 63:13	Palms 360:5,13	357:16 368:5,12
operationalize	277:18 280:5	outreach 100:21	pandemic 189:3	participant's 19:16
215:17	284:18 289:17	101:7 103:9 104:3	paper 13:13 347:5	355:7
Operations 183:19	309:17 315:19	119:2 120:9	papers 256:3	participate 102:22
opinion 348:15	316:3 326:16	140:13 141:21	paperwork 129:17	285:6 339:14,21
359:17	329:2,4 344:2	168:21 169:19	paramount 199:21	342:10 351:17
opinions 365:4,5	organizations	170:5 261:11	paranoidly 345:2	participated 15:19
opportunities	29:16 69:21	outside 109:21	paraphrase 339:7	26:17 119:20

participating 341:18 352:1 361:17	60:22 74:16 75:6 82:15,22 83:5 84:5,8 90:15	210:7 211:3 212:19,22 214:5 216:12 217:5,5	performing 81:22 period 42:8,12 59:3 59:4,11 64:17 70:6 72:17 83:17 106:4 195:4 197:2 283:18 374:1	330:20 348:22 364:20 365:8
participation 25:3 106:7 167:21	pays 120:22,22 121:2,3 294:19 295:8	220:15,19 221:7 222:19,20 223:7 226:20 227:1 242:3,8 243:12 249:15 256:15 261:22 263:6 264:6 265:15,17 266:11,13,13,14 289:1 301:10 305:15 336:3 341:5,12,13 347:21 350:9 357:2 361:17 363:12 371:7	periodic 187:17,21 216:11 periodically 148:17 periods 70:21 71:2 permanently 45:15 295:7 permission 19:17 185:17,19 permissive 346:15 347:16,18,20 349:1 person 50:7 54:6 82:2 97:11 122:10 177:3,4 179:5 182:10 226:17 254:16 266:8 277:2 283:9 287:6 344:10,11,12 350:7 355:2 356:19 358:7,17 366:21 371:18	pet 267:18 phase 125:7 phases 125:13 239:15 299:11 Phillips 1:22 4:18 4:18 12:20 17:5 21:5,17 25:14,18 31:17 32:11,14 35:4 147:14 166:21 167:17 168:7 169:19 170:6
particular 167:9 190:6 220:9 231:9 234:19 241:21 264:7,8 267:14 273:21 284:2 291:5,8,19 292:11 296:5 297:6,9 303:11 310:14,17 318:2,5 319:11,16 324:6 326:14	PCM 313:14 PCs 222:4 PDA's 115:15 PDHRA 102:22 peace 60:7 279:21 PEB 132:3,15,15 132:21,21 peer 183:10 263:21 Pendleton 273:5 276:16 penetrating 262:6 pennies 73:3 Pennsylvania 315:16 pension 58:9,12 60:15 68:17,21 75:5,19 76:22 82:12 83:10 pensioned 56:1,1 pensions 58:19 59:19 68:19 69:5 72:13,19 73:10 74:19 75:2,14,17 76:13,18 84:1 98:10	people's 39:20 percent 8:17 48:4 49:12 68:21 69:1 69:2 71:9,11,13 71:19,22 72:4 84:15 105:3,8,17 105:20 108:19 121:17 122:20 135:5,7 140:19,22 169:16,17 194:19 249:10 257:8 279:18 280:1 281:7,9 300:20 301:1 302:15 303:20 308:5 percentage 160:19 169:14 278:20 283:11 percentages 123:2 160:2 194:21 perception 337:2 perceptions 346:14 347:8 percolating 347:13 perfect 219:20 perform 81:9 performance 67:4 68:11 129:18 167:20 168:10 176:3	permissible 346:15 347:16,18,20 349:1 person 50:7 54:6 82:2 97:11 122:10 177:3,4 179:5 182:10 226:17 254:16 266:8 277:2 283:9 287:6 344:10,11,12 350:7 355:2 356:19 358:7,17 366:21 371:18 personal 9:20 10:1 10:3 20:3 73:17 167:10 318:13 personality 290:4 personally 26:15 370:12 personnel 41:17 185:5 188:13 222:4,9 226:17 245:8 326:20 337:18 persons 338:20 340:3 person's 234:4 365:7 perspective 131:22 132:1 158:21 164:7 208:17 213:6 220:12 322:19,20 330:18	phone 7:11 24:21 25:6 26:4,8,12,13 26:18 27:14,17 122:8 140:9 237:18 240:2 244:21 267:7 physical 69:11 92:6 92:6 192:11 251:21 254:20 290:2 physically 269:4 physician 95:17 190:18 196:11 200:21 physicians 49:17 53:8 67:14 207:8 Ph.D 265:3 pick 244:4 303:1 313:16 Pickett's 79:14 picking 276:2,3 picture 36:1 119:7 185:8,9 250:14 pictures 188:12 pie 146:13,20 piece 18:2,10 116:2 126:19 155:4 157:8,11 253:1 275:13 310:7 319:5,12 320:4 345:15 347:5 pieces 154:5 156:6 273:13 310:6
particularly 17:22 46:1 55:16 63:14 68:4 337:22 352:14 353:2 364:2,3,4 366:3 366:13	peer 183:10 263:21 Pendleton 273:5 276:16 penetrating 262:6 pennies 73:3 Pennsylvania 315:16 pension 58:9,12 60:15 68:17,21 75:5,19 76:22 82:12 83:10 pensioned 56:1,1 pensions 58:19 59:19 68:19 69:5 72:13,19 73:10 74:19 75:2,14,17 76:13,18 84:1 98:10	people's 39:20 percent 8:17 48:4 49:12 68:21 69:1 69:2 71:9,11,13 71:19,22 72:4 84:15 105:3,8,17 105:20 108:19 121:17 122:20 135:5,7 140:19,22 169:16,17 194:19 249:10 257:8 279:18 280:1 281:7,9 300:20 301:1 302:15 303:20 308:5 percentage 160:19 169:14 278:20 283:11 percentages 123:2 160:2 194:21 perception 337:2 perceptions 346:14 347:8 percolating 347:13 perfect 219:20 perform 81:9 performance 67:4 68:11 129:18 167:20 168:10 176:3	permission 19:17 185:17,19 permissive 346:15 347:16,18,20 349:1 person 50:7 54:6 82:2 97:11 122:10 177:3,4 179:5 182:10 226:17 254:16 266:8 277:2 283:9 287:6 344:10,11,12 350:7 355:2 356:19 358:7,17 366:21 371:18 personal 9:20 10:1 10:3 20:3 73:17 167:10 318:13 personality 290:4 personally 26:15 370:12 personnel 41:17 185:5 188:13 222:4,9 226:17 245:8 326:20 337:18 persons 338:20 340:3 person's 234:4 365:7 perspective 131:22 132:1 158:21 164:7 208:17 213:6 220:12 322:19,20 330:18	physical 69:11 92:6 92:6 192:11 251:21 254:20 290:2 physically 269:4 physician 95:17 190:18 196:11 200:21 physicians 49:17 53:8 67:14 207:8 Ph.D 265:3 pick 244:4 303:1 313:16 Pickett's 79:14 picking 276:2,3 picture 36:1 119:7 185:8,9 250:14 pictures 188:12 pie 146:13,20 piece 18:2,10 116:2 126:19 155:4 157:8,11 253:1 275:13 310:7 319:5,12 320:4 345:15 347:5 pieces 154:5 156:6 273:13 310:6
parties 219:3 partner 136:22 partnering 137:6 partners 184:12 parts 188:19 364:1 part-time 171:7 passed 68:16 90:20 121:21 308:7 319:4 passion 270:4 patch 54:14 pause 195:14 366:19 pay 49:12 60:8,17 61:18 64:9,17 73:1,22 76:1,3 82:19 113:9,11,12 113:13 116:16 147:7 198:5 paying 51:3,15 73:16 76:13,17 120:17 372:18 payment 58:16,17 82:14 83:6 payments 44:22 50:22 51:6,9,18	people 15:20 16:9 20:15,18 29:15 32:3 36:14 37:9 49:21 60:13 65:9 79:8 92:12 94:11 97:16 98:5 128:3 129:19 130:1,2 141:22 158:9 171:18 185:17,18 186:2,20 190:9 192:10 193:19,22 194:10,12 195:6 197:3,5 199:22 202:14,20 203:20 204:5 206:12 207:1,2,8 208:3	people's 39:20 percent 8:17 48:4 49:12 68:21 69:1 69:2 71:9,11,13 71:19,22 72:4 84:15 105:3,8,17 105:20 108:19 121:17 122:20 135:5,7 140:19,22 169:16,17 194:19 249:10 257:8 279:18 280:1 281:7,9 300:20 301:1 302:15 303:20 308:5 percentage 160:19 169:14 278:20 283:11 percentages 123:2 160:2 194:21 perception 337:2 perceptions 346:14 347:8 percolating 347:13 perfect 219:20 perform 81:9 performance 67:4 68:11 129:18 167:20 168:10 176:3	performing 81:22 period 42:8,12 59:3 59:4,11 64:17 70:6 72:17 83:17 106:4 195:4 197:2 283:18 374:1 periodic 187:17,21 216:11 periodically 148:17 periods 70:21 71:2 permanently 45:15 295:7 permission 19:17 185:17,19 permissive 346:15 347:16,18,20 349:1 person 50:7 54:6 82:2 97:11 122:10 177:3,4 179:5 182:10 226:17 254:16 266:8 277:2 283:9 287:6 344:10,11,12 350:7 355:2 356:19 358:7,17 366:21 371:18 personal 9:20 10:1 10:3 20:3 73:17 167:10 318:13 personality 290:4 personally 26:15 370:12 personnel 41:17 185:5 188:13 222:4,9 226:17 245:8 326:20 337:18 persons 338:20 340:3 person's 234:4 365:7 perspective 131:22 132:1 158:21 164:7 208:17 213:6 220:12 322:19,20 330:18	pet 267:18 phase 125:7 phases 125:13 239:15 299:11 Phillips 1:22 4:18 4:18 12:20 17:5 21:5,17 25:14,18 31:17 32:11,14 35:4 147:14 166:21 167:17 168:7 169:19 170:6 phone 7:11 24:21 25:6 26:4,8,12,13 26:18 27:14,17 122:8 140:9 237:18 240:2 244:21 267:7 physical 69:11 92:6 92:6 192:11 251:21 254:20 290:2 physically 269:4 physician 95:17 190:18 196:11 200:21 physicians 49:17 53:8 67:14 207:8 Ph.D 265:3 pick 244:4 303:1 313:16 Pickett's 79:14 picking 276:2,3 picture 36:1 119:7 185:8,9 250:14 pictures 188:12 pie 146:13,20 piece 18:2,10 116:2 126:19 155:4 157:8,11 253:1 275:13 310:7 319:5,12 320:4 345:15 347:5 pieces 154:5 156:6 273:13 310:6

PII 159:1	23:13 25:22 42:3	209:18	159:2 328:5	predominantly 316:5
pillars 183:20	45:4 106:13	policymakers 209:13,16 215:2	postdeployment 210:19 221:1,3	preface 228:9
184:1,3	127:10 175:18	policymaking 212:22 213:2	postdischarge 101:21	prefer 26:6
pilot 125:2 126:14	227:5,19 240:18	Polytrauma 253:19	posted 145:12	pregnant 283:20
137:15,15 141:18	241:6,22 340:6,9	260:11 328:1	149:2	366:19
254:12	354:1 362:1	poor 60:13 78:19	postemployment 160:1	preliminary 344:21
piloted 136:5	pleased 176:3	79:16	posting 149:14,15	prep 11:4
piloting 374:8	pleasure 99:16	poorly 38:7	posttraumatic 308:5 312:17	preparation 39:13
pink 117:12	plugged 265:16	popped 198:18	post-DD-214 229:11 309:6	prepare 13:16
pique 139:9	plus 352:21	population 95:17	328:8 334:6	162:22 175:21
piqued 227:14	POC 222:18,22	181:6,19 185:20	post-9/11 120:12	329:16 344:19
PL 319:6	223:4	185:21 192:21	120:14 156:2	prepared 38:8 86:7
place 14:12 33:17	pocket 151:22	199:7 205:13	166:3 170:19	229:14
44:22 58:13,16,20	152:2	209:22 219:15	potential 189:7	preparedness 85:1
63:22 88:15 91:14	point 24:9,11,12	224:7,7 225:10,13	194:6 333:16	preparing 229:6
93:18 104:6	38:5 43:13 45:6	225:19 226:5	potentially 145:4	prescribed 47:17
130:11 141:4	68:10 72:10 91:4	234:8,19 257:12	210:22 220:15	prescription
157:21 225:1,2	106:16,16 107:6	259:9 278:22	345:9	249:20 254:6,8
240:5 287:21	108:1 117:22,22	296:4 321:9	Potomac 80:4	presence 143:18
290:22 297:3	118:7,9 120:11	populations 180:21	powder 56:16,21	present 1:16 2:1
303:8 342:1 343:1	126:20 132:2,4	populationwide 218:7	58:2	48:16 191:4
343:3	133:8 134:4 135:7	population-wide 210:12	power 84:3	199:16 341:5
placed 133:20	140:16 176:7	portal 130:7 141:3	PowerPoint 11:12	presentation 99:11
placement 118:21	180:11 196:2,17	portion 51:4	11:20 127:14	99:17 128:1 154:6
placements 146:15	206:14,20 207:4	position 196:14	154:13 158:15	177:6 229:20
146:17,19	207:11 208:14	200:22 215:9	practical 59:20	242:22 268:11
places 64:13	213:3 219:19	241:8 348:18	245:14	341:7
129:19 360:17	222:16 225:6	372:8	practically 25:16	presentations 12:1
placing 69:5	251:15,21 256:5	positions 43:20	practice 181:13,15	12:2,3 153:8
plan 110:5 111:2,3	304:16 310:14,17	213:1	182:3 361:5,6	presented 33:1
134:8,20 164:8	314:11,22 318:2	positive 172:9	practices 243:5	135:12 309:2
168:15 169:13	321:15 336:16	348:7	337:22 338:1,5	presenting 208:18
175:7,8 302:6	349:3 358:4,9,16	possibility 188:15	practitioners 63:19	presents 326:20
303:7	362:22 365:2,16	333:19	precede 339:3	327:7
planned 303:13	366:2	possible 26:7 42:1	precipitously 202:7	preserve 333:16,18
346:13,21 347:6	pointed 202:12	102:22 140:6	preconceived 164:5	preserving 342:5
planning 67:17	214:1 225:16	163:10 333:17	precursor 55:16	president 48:22
plans 66:1 136:10	253:17	343:15 354:1	58:21 79:4	49:1 94:2 232:12
251:19 303:4	pointing 225:8	363:14 364:12	predicted 45:10	President's 135:11
311:9	points 328:4,7	373:3 374:17	predischarge 101:21	presiding 1:15
plasma 92:15	330:7 334:5	possibly 130:10		press 199:12
platform 206:4	policies 43:15,18	167:7		209:12
play 19:21 81:18	130:8 229:13	post 144:21 149:11		pretty 24:3,15
155:14 171:5	policy 162:6,7,8			29:11 37:17 38:9
played 43:11 46:3	215:9 226:17			123:18 132:5
playing 20:9	338:1,18 341:3			188:11 193:5
please 8:18 13:14	policymaker			

202:7 357:5 359:19 prevalent 49:5 57:21 prevent 181:8,16 preventative 314:6 320:3 preventive 183:14 190:18,21 298:20 preview 199:10 200:4 201:22 previous 69:14 86:13 89:1 91:2 111:12 previously 41:16 56:18 previous-year 11:5 prides 138:6 primarily 181:14 primary 181:15,21 196:13 200:22 209:7 322:9,12 principal 213:21 principles 268:17 338:17 342:18 print 190:14 prior 102:9 270:21 288:19 priority 257:21 300:16 prison 58:7 71:18 prisoners 63:21 privacy 159:7 318:20 342:5,7 345:2,17 350:6 361:9,16 privacy-protected 159:2 private 17:17 18:15 18:21 69:16,19,20 123:15 126:9 148:2 163:7,12 164:3 317:22 privately 17:8 pro 267:9 proactive 269:2 probably 19:9 27:2	35:9 132:5 153:14 182:14 199:21 212:7 215:6 242:3 243:7 265:14 281:2 315:8 336:8 345:13 364:18 373:20 374:14 probe 341:15 346:9 366:12,19 probing 49:3 problem 55:1 96:17 111:10 223:1 321:13 problems 13:1 93:12 122:11 172:21 180:22 191:1 198:17,17 201:9 procedural 130:8 162:8 procedures 47:17 141:6 361:9 process 7:10,13,19 8:10 10:5 14:18 21:2 22:18 27:17 31:19 33:12 34:18 42:8 78:21 118:2 127:11 128:15,21 129:1,7 132:8,22 136:9 139:20 141:12 169:1 173:18 175:8 182:6 221:11 296:21 306:6,17 306:18 307:15 336:1 338:10,22 350:19 361:15 363:18 372:1 374:7 processes 41:2 processing 363:8 prod 366:19 produce 163:4 187:5 product 16:21 23:21 26:20,20 29:18 40:2 108:17	268:5 productive 27:9,11 27:13 87:12 334:18 products 6:4,6 26:2 187:4 professional 20:16 47:5 51:20 54:8 62:21 63:6 122:21 227:12 371:20 professionalization 62:7 67:9 professionals 253:17 373:6 professions 222:21 program 44:2 54:3 68:17 69:4 82:12 90:16 91:9 99:19 99:20 100:9 101:7 101:11,13,15 102:10,12,14,20 103:2,4,4,15,21 104:5,9 105:1,11 105:15 106:7,15 106:19,21 109:16 109:21 110:2,6,14 114:20 116:4,22 119:1,3,7,17 120:8 121:2,11,19 122:2,3,6,13,19 126:17,18 128:16 128:17,17,18 130:9,10 131:16 132:11 133:12,17 134:2 136:16 137:1,10 139:13 139:18 140:5,6 142:7 143:21 146:2 147:2,5,6 147:11 150:18 152:5,9 157:2 159:12 166:22 167:9,15,16 168:16,16 170:10 171:8 173:15 175:15 236:16,18 236:20 237:5	243:9,11,20,21 244:8,10,11,14 247:19 253:21 256:2 259:16 260:8,13,19 265:9 266:7,14,17 295:13 300:1 307:9,12 309:1,5 309:7 310:13 312:14,16 programmed 19:7 programs 9:19 47:16 69:14 70:9 87:14 91:2,5 92:7 92:21 103:1 121:11 125:4 145:17 147:19 155:10,17 167:17 167:21,22 169:20 228:19 229:6 240:11 261:13 292:22 298:11,19 298:22 299:15 301:3 304:10 309:22 314:7 337:4 progress 9:5 26:19 139:15 251:18 progresses 40:21 Progressive 87:10 project 42:5 141:18 182:5 230:2 232:3 232:7,8,9 243:16 264:5 327:4 projects 184:18 187:11 ProMED 183:9 promise 20:14 49:18,22 50:1 promote 200:6 promoted 139:16 promotional 127:16 promulgated 105:12 prone 93:1 properly 218:12	property 76:2 proponent 327:14 proponents 326:15 327:15 328:3,8 330:6 proportionately 61:8 proposed 87:17 proscribes 361:14 prospective 54:22 224:9 322:20 prostheses 81:13 prosthesis 82:3 prosthetics 69:11 protect 149:4 345:11 protected 159:8 protection 179:1 179:11 216:1 361:19 protocol 331:8,10 331:12 332:14 334:12,13 341:11 351:9 353:16 357:13 363:6 366:15 367:7 protocols 330:12 357:21 361:8 proved 93:2 provide 14:11 54:10,16 56:6 58:18 59:14,19 64:17 72:9 82:8 84:11 102:3 104:13 111:14,16 113:21 116:7 117:12 118:13 129:3,9 138:1 165:18 209:15 211:2,2 213:20 216:8 236:8 238:10 242:21 251:19 253:14 254:18 258:11,13 265:20 266:19,20 267:9,12 268:20 296:16 299:21
---	---	---	--	--

307:18,21 316:8 317:1,2 321:1,4 322:19 342:9 355:19 362:1 provided 43:1 46:13,14 54:12 57:15 58:13 60:5 63:17,18 68:19 82:13,18,19 84:12 84:19 106:12 132:17 137:20 157:1 220:18 221:5 251:16 254:12 370:3 provider 250:1,9 313:14,15 318:1 providers 36:9 225:11 249:13,18 250:12,15,21 251:2,5 252:12 257:16 258:1 313:9,12 provides 85:18 105:14 106:20 214:3 providing 15:20 29:17 81:13 84:12 85:22 90:15 134:11 244:6 250:20 252:6 258:22 267:21 313:20 357:19,20 provision 64:18 75:11 82:10 90:20 98:10 provisions 75:10 95:5 psychiatric 42:22 92:21 93:1 96:17 96:20 psychiatrist 320:18 Psychiatrists 93:3 psychiatry 97:18 psychological 42:21 46:9 57:19 97:2 psychologically	97:11 psychology 138:22 PTSD 98:5 192:2 201:20 207:9 262:9 public 2:7 69:16 77:7,8 88:4 90:17 115:16 121:7 163:14 177:13 179:18 181:1,7,13 181:14 182:3 211:10 215:20 216:14,20 217:10 217:17 218:15,18 219:17,20,21 220:8,11 221:6,14 226:9,21 281:8 373:15 publication 12:12 190:14 publicity 161:13 publicize 140:5 published 48:21 204:17 239:8 371:3 pull 21:22 25:1 pulled 250:8 pump 22:3 purchase 136:17 137:11 275:11 Purple 273:16 275:8,19,21 276:4 280:6 285:4 289:18 purpose 93:8 102:18,19 104:22 126:1 193:18 209:18 323:7 331:8,9 332:17,18 332:22 purposeful 115:11 purposes 224:12 346:8,9 pursing 101:22 pursue 107:8 124:14 157:5 pursuing 104:15	138:10 151:21 152:3,5 156:14 purview 88:3 pus 48:14,15,19 53:19 push 214:16 254:8 318:22 pushed 222:1 319:14 put 6:3 10:21 12:9 23:2,5,22 28:2,5 30:16 37:13 110:16 125:16 140:8 145:1,9 148:5,16 183:1 187:16,18 188:6 189:11,13 193:7 223:1,1 239:7 243:1 269:7 355:17 puts 15:4 182:19 putting 18:22 29:20 130:11,17 153:20 154:21 157:12,19 275:2 341:16 P&R 42:5 P-R-O-C-E-E-D-... 4:1 P.K 1:21 p.m 176:11,12 228:2,3 321:22 322:1 375:4	quality 2:16 3:13 129:8 229:19 230:14 231:7,13 231:16 232:4 249:12 250:6,9,20 251:3 264:13,16 287:9 367:8 Quantico 244:3 quantifies 265:4 quantity 249:13 367:7 quarter 122:8 230:6 Queen 59:16,21 62:9 queries 209:13 213:12 214:5 question 23:11 108:10 112:17,22 136:15 150:15 155:8,18 158:1,1 158:5 159:14 160:17 166:21 208:9 211:6 214:10 218:17 297:10 335:4,21 336:3,5 337:10 359:3 366:16 367:4 371:14 372:17 questioning 332:3 332:4 351:8 353:15 questions 10:11,17 11:1 13:9 22:16 22:19 42:2 99:20 112:11 113:3 166:18,19 171:16 175:19 200:9,10 207:15 214:7 221:3 223:19 226:14 262:18 277:18 287:15 308:19 311:1 314:14 326:6 328:16 329:11,17 331:13 334:2,8,10	334:11,12,17,20 335:20 336:14 339:3 341:11 346:2,7 347:2,3 353:16 357:7 quick 159:21 185:19 quicker 20:11 204:6 quickly 128:5 134:15 182:4 quite 58:14 66:9 83:8 120:10 153:15 184:15 185:8 188:10 193:6 200:12 205:2 217:22 223:16 231:6 237:15 273:5 365:21 371:10 quote 52:3 161:14 303:20 quoting 204:15,16
R				
R 181:12 rabies 217:8,20 218:1 219:6,9,16 220:7 raise 60:6 275:15 rampant 78:21 ran 44:1 88:4 259:21 295:13 RAND 2:4 3:4 41:16 285:1,6 range 43:1 80:5 151:8 174:5 ranged 293:2 rank 67:15 rapid 30:8 88:6 111:17 rare 88:12 326:21 327:7 rate 56:22 93:5,5 121:13,16 137:16 137:18 150:13,16 150:22 151:9				

158:12 168:8,12 168:14 170:20 219:15 335:7,7,8 335:9,16,17 rated 103:17,18,19 rates 64:14 66:5 72:3 81:11 195:12 195:12 207:9 rating 102:17,18 103:11 104:21,22 105:6,8,10,12,17 106:6 107:13,13 107:15 132:17 133:6,7,13 142:10 142:12 173:2,8,14 305:16 ratings 101:4,5 105:20 ration 62:18 rationale 59:19 rationales 59:21 raw 174:3 reach 39:4 101:1 101:11,19 126:8,9 135:21 136:3 155:3,5 157:18 161:4 175:16 228:20 263:22 264:2 300:20 316:5 reaches 150:20 reaching 140:2 155:19 263:11 reaction 58:4 read 94:18 98:17 180:4 190:10 202:1 242:5 268:16 280:12 315:8 339:7 364:13 readdress 9:3 readily 262:15 Readiness 41:18 179:1 reading 20:1 35:12 readjust 204:2 ready 29:11 32:15	231:6 261:15 269:7,9 293:7 304:6 330:8 353:17 real 66:19 70:1 113:12 149:15 217:5 294:12 Realistically 343:9 reality 9:20 reality-test 27:12 realize 143:5 179:13 realizing 122:1 really 9:1 14:19 15:9,16 17:4 18:22 21:1 25:12 26:19 27:3,5,12 35:9,18 37:12 38:6 39:3,18 45:10 46:9 53:14 54:11 58:19 64:9 65:3,9,10 68:9 69:12 70:13 78:9 79:21 83:8 84:20 86:10 88:16 89:8 95:3 111:8 112:7 120:8 125:15 126:14 127:16,17 128:5,9,17,22 129:15,16,18,22 130:15,15 131:7 133:3,4 136:14 137:14,17 140:8 143:5,6 149:21 151:22 152:1,10 152:22 155:1 163:18 171:13,17 172:14 178:20 179:7 182:10 186:6 193:7 211:22 215:12 223:8 224:12 225:21 231:3,3 251:7 252:9 253:12,13,14 256:17 257:1 264:17 270:2	276:5 277:7 282:22 285:5 287:4 288:22 290:12,12 292:6,7 292:10,15 302:8 305:4 310:10 311:14 315:13 320:13 321:14 323:18 324:15 334:15 352:17 365:11 367:2 371:14,22 realm 318:5 realty 288:16 reappears 52:8 rear 87:8 reason 109:18 112:12 124:5 182:1 194:11 202:15 218:1 275:22 278:11 282:12 283:13 296:9 309:4 333:15 347:5 reasons 54:12 55:6 124:8 151:14 169:7 192:5 196:7 350:15 reassessments 160:1 rebuild 245:13 rebuilding 233:15 recall 235:16 receipts 76:6 receive 46:2 83:10 84:7 108:21 116:3 117:8 151:20 170:2 306:11 365:1 received 6:15 7:8 49:7,11 50:6 52:17 57:4,8 61:8 62:17 73:21 74:4 74:16 108:11 172:4 240:1 242:3 306:9 316:18 receiver 343:8	receives 103:10 receiving 101:4 152:6,7 173:14 201:16 recency 344:8 recipient 11:18 recipients 119:18 recognize 20:7 recognized 83:2 recognizing 245:10 recollection 205:21 206:2 recommend 202:1 recommendation 28:9 310:9 314:19 315:3 recommendations 7:20 11:3,5 12:14 12:15 24:18 28:8 28:19 29:4,13 31:12 40:19 167:13 268:15 271:4 308:20 314:16 315:3,12 331:3 recommended 312:21 reconfigure 286:2 reconnect 277:8 reconvene 176:9 record 16:12 19:4 19:15 20:17 21:7 41:11 99:5 176:11 200:22 228:2 321:22 355:21 360:19 375:4 recorder 19:21 recording 20:9,20 21:11 records 185:3 196:11 recover 245:1 recovering 1:4 330:13,17 337:3 337:12 349:7 recovery 237:4,17 239:13 240:8	243:21 265:9 266:1,17 268:22 293:19 294:4,8 299:11 327:18 328:4 335:8,9 336:1 recruit 52:7 recruited 63:5 recruiter 149:13 recruiting 54:21 55:7 337:12 recruits 54:22 62:17 rectified 73:8 recurring 51:5 Red 66:21 85:21 redeemed 73:5 redefine 286:3 redeploy 202:18 204:4 redeployed 203:14 221:7 redesigning 127:12 127:22 redirect 346:9 reduce 129:1 201:12 reduced 57:2,3 reducing 129:16 redundancy 129:2 redundant 265:20 334:19 Reed 9:15 233:1,5 235:11 238:7 291:3,3 294:2 reemerging 184:10 reemphasizes 209:20 Reemployment 111:8 reengage 27:5 reengineering 128:15,21 141:12 reestablished 93:2 reevaluated 60:19 refamiliarize 342:20
--	---	--	--	---

refer 118:21 212:2 215:4 265:11 266:12,14 345:11 356:12,15 358:14	registrants 158:12 regroup 233:13 regular 78:18 189:12,13 190:10 216:8,9,11 272:4 275:5 294:11 304:4	reintegrated 289:13 reintegration 285:22 286:5,10 289:11 292:21 293:11,15	264:10 291:15 301:21 318:7 324:20 334:1 335:22 336:2 339:1,1 353:9 354:2,7	239:8,10,11 240:14,22 241:14 241:16 243:8 268:18 278:1 314:17 315:4,13 323:5 331:6 333:3 333:4 334:4 336:12,13 356:10 356:11 358:2,12 359:5
reference 204:12 223:15	regularly 212:8 216:6	reiterate 244:13 reiterates 88:10 relate 206:7,11	remembered 14:21 remembering 70:5 remind 337:20 367:13 368:11	reportable 186:1 189:17 reported 174:13 221:8 354:22 reporting 148:2 181:5 189:18 333:6,7 346:9 reports 147:17,22 187:10,17 189:12 189:13 216:9,12 292:19 296:19
referrals 235:4	regulars 62:12	related 44:3 97:14 180:20 197:14 201:3,8 221:4	reminded 87:22 345:6 reminder 180:18 remote 135:17,21 remotely 136:3	repository 186:6 187:14 221:1 represent 5:14 representation 243:20 representative 5:4 5:5 243:18 315:15 represented 51:1 64:13 republic 65:2 70:6 Republicans 83:22
referred 109:20 131:10 132:3,15	regulations 130:7 rehab 101:14 103:13 104:10 107:19,19 117:3 118:14 120:2 121:2,11,19 122:4 124:17 128:16 130:17,18,22 131:10,22 138:9 138:12,15 139:5 139:11 141:8,19 142:13 143:1 147:1,5 152:5 153:17,20 156:8 157:10 161:14 162:1,9 164:8 166:1 167:22 172:12 174:16 251:12,20,20,22 252:6,12	relationships 285:18 relationship 118:18 337:11 relationships 285:18 relatively 56:20 88:11 183:11 relax 258:3 relaxed 32:3 release 98:17 released 87:18 relevant 180:6 214:14 reliable 250:20 relieves 75:3 religious 53:3 relocate 282:14 relocation 311:11 311:22 reluctant 296:1 rely 223:17 234:15 relying 222:18 224:11 remain 298:10 remainder 323:19 remaining 73:8 remarkable 62:7 remarks 344:19,20 remedial 341:4 remember 14:4,5 20:4 37:5 134:1 183:21 219:8 238:4 241:5	remove 313:5 316:10 removing 308:6 Renaissance 54:1 renovation 154:2,3 Rented 295:15 reorientation 323:8 323:10 reparations 83:18 repeat 192:3 194:1 197:8,13,21 202:14 368:8,17 repeated 56:9 59:21 76:16 190:1 191:7 194:10,17 196:21 210:8 repeating 49:20 repeats 75:4 replace 25:5 replaced 24:6,7 51:14 336:6 replication 210:1 report 5:19 6:8,14 7:3,15,17 8:9 12:12 13:16 14:13 19:18 20:10 24:18 28:2 30:11 31:16 34:6 35:12 39:15 111:10 146:8,15 147:12 176:19 183:2 189:1 212:16 216:5	reporting 148:2 181:5 189:18 333:6,7 346:9 reports 147:17,22 187:10,17 189:12 189:13 216:9,12 292:19 296:19 repository 186:6 187:14 221:1 represent 5:14 representation 243:20 representative 5:4 5:5 243:18 315:15 represented 51:1 64:13 republic 65:2 70:6 Republicans 83:22 reputable 163:4 request 226:20 361:8 362:13 requested 166:20 requests 212:9 require 244:17 247:20,21 262:9 262:11,12 required 25:11 338:6,13,13 352:7 354:5 355:4 361:11,12 requirement 130:21 313:11 requirements
referring 19:18 156:13 167:14 326:13 350:22	rehab 101:14 103:13 104:10 107:19,19 117:3 118:14 120:2 121:2,11,19 122:4 124:17 128:16 130:17,18,22 131:10,22 138:9 138:12,15 139:5 139:11 141:8,19 142:13 143:1 147:1,5 152:5 153:17,20 156:8 157:10 161:14 162:1,9 164:8 166:1 167:22 172:12 174:16 251:12,20,20,22 252:6,12	reintegrates 88:10 relate 206:7,11 related 44:3 97:14 180:20 197:14 201:3,8 221:4 relates 290:4 Relations 2:19 269:20 relationship 118:18 337:11 relationships 285:18 relatively 56:20 88:11 183:11 relax 258:3 relaxed 32:3 release 98:17 released 87:18 relevant 180:6 214:14 reliable 250:20 relieves 75:3 religious 53:3 relocate 282:14 relocation 311:11 311:22 reluctant 296:1 rely 223:17 234:15 relying 222:18 224:11 remain 298:10 remainder 323:19 remaining 73:8 remarkable 62:7 remarks 344:19,20 remedial 341:4 remember 14:4,5 20:4 37:5 134:1 183:21 219:8 238:4 241:5	reminded 87:22 345:6 reminder 180:18 remote 135:17,21 remotely 136:3 remove 313:5 316:10 removing 308:6 Renaissance 54:1 renovation 154:2,3 Rented 295:15 reorientation 323:8 323:10 reparations 83:18 repeat 192:3 194:1 197:8,13,21 202:14 368:8,17 repeated 56:9 59:21 76:16 190:1 191:7 194:10,17 196:21 210:8 repeating 49:20 repeats 75:4 replace 25:5 replaced 24:6,7 51:14 336:6 replication 210:1 report 5:19 6:8,14 7:3,15,17 8:9 12:12 13:16 14:13 19:18 20:10 24:18 28:2 30:11 31:16 34:6 35:12 39:15 111:10 146:8,15 147:12 176:19 183:2 189:1 212:16 216:5	reportable 186:1 189:17 reported 174:13 221:8 354:22 reporting 148:2 181:5 189:18 333:6,7 346:9 reports 147:17,22 187:10,17 189:12 189:13 216:9,12 292:19 296:19 repository 186:6 187:14 221:1 represent 5:14 representation 243:20 representative 5:4 5:5 243:18 315:15 represented 51:1 64:13 republic 65:2 70:6 Republicans 83:22 reputable 163:4 request 226:20 361:8 362:13 requested 166:20 requests 212:9 require 244:17 247:20,21 262:9 262:11,12 required 25:11 338:6,13,13 352:7 354:5 355:4 361:11,12 requirement 130:21 313:11 requirements
refers 266:11 refine 315:12 refined 214:10 reflected 335:3 336:17 367:19 reform 286:7 reformed 65:17 reforms 65:18 67:1 95:17 refraction 198:21 refresh 180:18 refugees 64:9 refused 60:10 regain 252:3 regained 254:21 regard 90:22 206:14 223:10 regarding 161:22 273:2 337:3 350:4 regardless 76:1 94:22 223:18 Regency 1:12,12 Regiment 236:22 regimental 78:3,10 regimented 252:16 regimes 54:19 region 274:19 regional 101:8 119:4,21 145:3 161:3,4 165:10 region-specific 166:11 registered 144:14 158:17 registering 158:7	rehabilitated 87:19 118:1 rehabilitation 2:5 3:6,8 69:8,10 87:11,14 88:2 92:7 94:12,20 98:11 99:10,19 107:5,17 116:17 117:9 124:18 138:13 168:11 175:7 336:1 rehabilitative 80:17 251:15 reign 62:9 reimburse 64:20 reinforce 256:18 342:14	reintegrates 88:10 relate 206:7,11 related 44:3 97:14 180:20 197:14 201:3,8 221:4 relates 290:4 Relations 2:19 269:20 relationship 118:18 337:11 relationships 285:18 relatively 56:20 88:11 183:11 relax 258:3 relaxed 32:3 release 98:17 released 87:18 relevant 180:6 214:14 reliable 250:20 relieves 75:3 religious 53:3 relocate 282:14 relocation 311:11 311:22 reluctant 296:1 rely 223:17 234:15 relying 222:18 224:11 remain 298:10 remainder 323:19 remaining 73:8 remarkable 62:7 remarks 344:19,20 remedial 341:4 remember 14:4,5 20:4 37:5 134:1 183:21 219:8 238:4 241:5	264:10 291:15 301:21 318:7 324:20 334:1 335:22 336:2 339:1,1 353:9 354:2,7 remembered 14:21 remembering 70:5 remind 337:20 367:13 368:11 reminded 87:22 345:6 reminder 180:18 remote 135:17,21 remotely 136:3 remove 313:5 316:10 removing 308:6 Renaissance 54:1 renovation 154:2,3 Rented 295:15 reorientation 323:8 323:10 reparations 83:18 repeat 192:3 194:1 197:8,13,21 202:14 368:8,17 repeated 56:9 59:21 76:16 190:1 191:7 194:10,17 196:21 210:8 repeating 49:20 repeats 75:4 replace 25:5 replaced 24:6,7 51:14 336:6 replication 210:1 report 5:19 6:8,14 7:3,15,17 8:9 12:12 13:16 14:13 19:18 20:10 24:18 28:2 30:11 31:16 34:6 35:12 39:15 111:10 146:8,15 147:12 176:19 183:2 189:1 212:16 216:5	239:8,10,11 240:14,22 241:14 241:16 243:8 268:18 278:1 314:17 315:4,13 323:5 331:6 333:3 333:4 334:4 336:12,13 356:10 356:11 358:2,12 359:5 reportable 186:1 189:17 reported 174:13 221:8 354:22 reporting 148:2 181:5 189:18 333:6,7 346:9 reports 147:17,22 187:10,17 189:12 189:13 216:9,12 292:19 296:19 repository 186:6 187:14 221:1 represent 5:14 representation 243:20 representative 5:4 5:5 243:18 315:15 represented 51:1 64:13 republic 65:2 70:6 Republicans 83:22 reputable 163:4 request 226:20 361:8 362:13 requested 166:20 requests 212:9 require 244:17 247:20,21 262:9 262:11,12 required 25:11 338:6,13,13 352:7 354:5 355:4 361:11,12 requirement 130:21 313:11 requirements

130:3 162:20 338:14 requires 249:8 reschedule 109:11 research 2:21,22 3:10 22:16,19 23:11,19,22 164:11 181:12,13 181:20 182:5 187:15 200:6 208:10,15 216:22 224:10 225:7,10 225:10 226:10 235:7,15 237:16 238:6 241:2,18 246:9 253:11,17 262:22 263:4 265:3 279:10 284:10 285:9 287:2 292:19 299:2 319:16 321:18 324:5 334:2,7,10 336:14 337:9 338:2,3 343:6 347:2,3 348:20 350:1 researched 164:12 236:4 researchers 13:21 19:17 resented 73:16 reserve 5:15 85:14 85:16,22 86:1 128:10 185:9 191:2 196:3,5 261:4,6 278:13,18 279:1,7,8,17 283:3 294:17 295:19 Reserves 155:3,11 160:16 Reservists 282:7 resident 187:11 residents 183:15 resilience 202:15 337:13 resistance 184:6	resisted 93:20 resolve 320:10 resolved 173:1 resort 91:15 resource 19:13 23:10,12 180:9 186:2,18,21 236:1 257:3 267:2 268:4 351:20 352:6 resources 44:18 141:5 166:15,15 178:20 179:5 184:21 225:22 234:15,18 238:12 254:19 261:15 265:17,18 351:21 356:17,17 358:17 370:3 resourcing 23:12 respect 338:20 340:3 348:14 respectively 325:5 respiratory 184:3 respite 258:1 respond 112:20,21 182:4 214:4 329:12 responding 11:7 response 12:15 28:22 30:19 39:6 178:15 188:20 217:11,20 267:1,1 267:10 268:3 276:17 277:20 282:4 287:17 311:3 328:17 329:17 335:7 responses 34:19 332:5,9 responsibilities 171:2,5 239:4 246:21 361:3,13 361:14,21 responsibility 51:21 52:20 61:11 61:14 70:2 75:2,3 81:13,19 215:6	258:6 354:18 responsible 47:1 257:8 302:19 responsive 254:15 rest 27:12 76:21 93:22 141:11 184:8 194:20 244:18 255:20 280:19 372:4 Restoration 61:10 restricted 196:8 205:17 restrictions 167:6 restructure 264:15 result 67:6,8 352:1 results 7:1 13:12,19 14:7,12 22:6 185:6 194:15 206:18 212:9 331:1,4,5 resume 112:6,7 145:10 resumed 41:12 99:6 176:12 228:3 322:1 resumes 145:5,12 retail 288:20 retained 334:21 retire 301:17 302:4 303:8 retired 5:4 50:11 203:8 230:15 231:5 300:13 301:5,6 retirees 312:13 retirement 49:8,11 50:7,20 51:4 73:20 74:11,13,15 94:15 247:14 303:4 retirements 49:9 50:13 retraining 69:21 110:17 114:13 134:22 retrains 117:18 Retreats 275:22	return 87:11 93:9 93:13 100:11,15 197:1 245:6 returned 52:14 197:4 353:17 returning 80:19 233:9 returns 53:2 return-to-battle 93:4 return-to-service 93:5 reunite 291:13 reveal 341:14 revelations 18:18 revenues 75:16 review 3:2,19 5:18 6:3 31:13 39:1 40:20 42:8 178:4 242:7 338:6,11 362:2 reviewed 28:17 183:11 235:14 reviewing 125:22 361:7 revisit 128:7 Revolution 56:10 62:11,13 64:10 70:5,18 71:20 76:5,14 revolutionary 59:4 73:9 76:12,22 revolutionize 80:6 rhythm 204:3 ribbon 103:1 155:10,16 159:22 160:17 Rich 5:13 Richard 1:14,18 Richelieu 55:20 Richmond 252:2 253:20,22 right 8:21 10:2,19 11:1 17:2 18:19 19:7 21:19 22:4 22:10 24:19,20 26:1 27:18 28:20	29:6 31:6 32:13 34:2 39:12 41:14 100:7 108:13,15 124:3 125:11 127:13 129:19,19 129:20 130:4 143:15 149:8 153:12,22 161:13 162:11 164:20 172:19 182:12,16 205:4 206:5 221:11 225:3,13 237:12 250:6 260:4 262:17 265:2,16,17 274:10,11,12 287:18 310:14 340:2,13 346:21 347:6 351:4,5 363:2 369:14 372:10 374:11 rightfully 333:15 rise 55:8 58:19 85:20 91:22 97:18 201:10 rises 57:12 rising 51:19,20 84:4 risk 191:15 194:6 210:19 218:11 220:19 270:18 282:1 283:2 285:11 287:16,20 301:22 314:3 354:19,20 358:11 road 160:15 162:14 355:20 roaming 59:10 robust 238:3 239:6 295:21 rocker 369:9 rode 260:1 role 36:6 40:18 46:12 53:2 85:21 98:9 231:3 245:7 308:9 343:2,5 345:18 346:4
---	---	---	---	---

roles 36:2 129:17 351:6 362:22	running 6:2 222:10 285:12 298:1,7 339:20	330:22 349:11	192:10,16	51:5,19 52:12 53:7 54:2,11,17 55:2,18 58:2 59:3 60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
roll 136:9 138:3	runs 232:14 275:12	saying 112:17 169:2 171:20 172:11 206:10 207:12 241:20 254:4 310:7 343:13 352:18 364:22 367:9 368:14 372:15 373:6,18	scribe 349:22 353:9 353:12,16,18 355:22 358:15 367:13 368:15,19	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
rolled 244:12 324:20	rural 136:1 249:17 321:8	scale 79:6	scribes 367:15 368:3 369:19	67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
rolls 75:21	rushed 366:14	scandal 66:9	scribe's 353:20 355:18 368:20	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
roll-back 96:2	Russell 182:8	scanning 196:10	script 342:19 352:12	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
Roman 47:9,13,15 48:2 49:7,10,16 49:19 50:11,11,15 50:17 51:10 56:14 72:17 81:3	rustling 30:7	schedule 11:22 89:11,14,21 107:16 204:7 324:16	scroll 22:6 23:10	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
Romans 48:7 49:13 49:16 50:3 53:18	Ruth 99:9	scheduled 89:6 172:11 330:2	scum 65:8	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
Rome 46:17,18 47:3,11 49:15 51:11	Ruthie 235:5 243:14 266:11	schedules 109:9	se 49:15	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
RONALD 1:20	S	scholarship 274:22 275:3	seamen 77:10,10 77:12	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
roof 189:16	sacrificed 52:4	school 62:19 86:4 114:16 116:11,14 161:17,20 162:4 164:17 165:5 170:14,16,22 175:10 248:12,22 281:20,21 289:5 291:16 298:5	seamless 309:21	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
room 16:18,18 98:4 128:19 190:9 237:21 248:5,13 248:14 249:2 259:1 315:6 317:22 371:15	sad 363:18	schools 95:19,20 157:15 161:22 162:21 163:3,8,10 280:17 281:9 289:3,4	Sean 1:21 4:15	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
room 16:18,18 98:4 128:19 190:9 237:21 248:5,13 248:14 249:2 259:1 315:6 317:22 371:15	safe 52:11 63:17 224:22 236:21	screen 92:22 141:2 148:8,10	search 145:11,14	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
Roosevelt 94:2	safeguard 345:1	screened 97:20	searching 148:14	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
root 151:10 152:11 152:15	safeguarding 361:9 361:17	screening 159:10	season 189:14	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
rooted 70:6	safeguards 342:6		seats 24:6 41:5	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
roots 43:17	safely 115:18 357:8		second 4:9 27:3 42:10 57:19 68:5 74:20 180:4 199:10 202:17 205:2 208:9 267:8 267:10 269:2 276:1 289:11 309:15 322:12 371:18	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
Rostker 2:4 3:4 41:15,22 89:3,4 89:13,21 90:2,6 90:10,13 98:21,22	safety 165:20,21 262:13 361:20		second-class 53:14	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
rotate 183:15	sailor 228:13		secret 290:10	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
rotated 208:3	sailors 51:7 62:1		secretaries 241:13	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11,18 201:19 202:5 203:2 206:13,21 208:15,16 210:13 212:13,20 216:7 222:9 223:22 237:9 256:20 257:22 278:15,20 280:12,13 310:10 314:13 325:18 332:13 333:13 365:17 367:22
rotation 204:6	salaries 62:18		Secretary 5:19 41:17 241:12	60:20 62:20 64:22 67:13,20 69:9 73:19 75:9 77:2 78:8,14,20 79:8 80:9 81:17 84:4 85:15 88:5 91:20 92:14,20 97:5,18 100:6 101:6 103:3 110:20 111:6 119:18,22 120:9 120:13 121:7,21 122:20 123:4,16 132:13 133:16 140:12 146:20 148:17 149:8 161:21 174:7 179:13 185:4 188:7,15 193:3 194:20 196:11

288:13 326:22 352:2 seen 29:5 30:5 38:12 95:10 96:13 209:22 210:3,10 223:21 261:5 324:5 347:2 349:17 sees 62:6 172:10 segment 99:22 segmented 36:5 select 66:12 selection 202:20 self 354:20 358:11 359:21 self-employment 113:6 114:2,5 124:4,7,14,21 125:11,17,18 self-help 263:17 Self-Management 125:20 self-report 145:21 174:15 self-reported 146:18,21 self-select 202:19 sell 73:2 260:10,15 260:16 297:19 Senate 241:15 273:1 315:21 Senator 94:13 315:20 319:2 send 10:17 174:19 174:21 209:11 222:8 senior 39:9 41:16 176:15 183:4 226:17 248:11,22 sense 102:7 113:16 163:18 219:16 221:13 223:9 341:19 350:10 sensitive 12:22 21:9 sent 5:19 10:11 66:14 93:10 94:4	94:16 204:5 241:16 253:20 254:2 282:8 329:10 sentence 57:5 separate 38:5 47:20,22 198:4 306:9 separated 158:9 300:8,18 303:18 separately 283:15 283:16 separation 102:9 306:11 September 5:20 127:7 309:3 sequence 13:6 sera 186:14 serf 52:7 serfs 51:15 Sergeant 4:19 325:11 345:11 series 47:22 61:19 62:18 63:12 107:21 serious 36:8 57:9 105:21 106:10 357:11 serum 186:5,10,17 187:14 188:6 servants 53:11 serve 38:6 51:16 72:16 230:19 236:10,11 271:20 367:11 served 43:20 49:10 70:17 230:16 278:10 server 159:5 service 2:5 3:8 17:9 50:8,19 56:6,6 64:12 68:19,20 70:10 72:19 75:19 77:7 81:21 83:12 85:3 86:2 88:4 90:22 91:21 93:9 93:10 94:22 95:18	96:5,5 101:1,19 102:13 104:20 106:6,20 107:2,7 109:3 110:8 114:13 115:21 119:12 127:18 130:20 131:9 133:4,15 135:6 141:15 142:16 153:1,16 161:15 161:19 162:1 172:15 173:13 175:14,20 177:13 179:18 192:14 202:19 213:16 216:14 219:20 221:19 226:21 229:2 231:10 232:16 236:16 237:2 240:18 243:19 245:22 259:12,15 261:4 262:4 266:7 267:13,14 268:5 278:4,9 279:12,15 282:6 283:10,22 286:3 288:14 289:6 290:5 292:3 294:14 300:3,17 301:14 304:3,5,8 304:21 306:7 307:16 308:7 309:5 311:11 317:12,16 319:14 serviced 236:5 services 11:18,22 13:7 38:6,13 43:1 43:9 45:22 47:13 51:19 55:20 58:18 62:14 66:16 80:17 98:12 99:11 106:12 109:14,21 111:2,3 114:10 116:4,8,12 117:11 123:2 129:4,5,8 134:11 138:21 142:20 152:8	157:10 168:15 169:13 205:1,15 206:20 208:11 215:20 216:11 232:18 234:6 236:7 266:19,20 267:22 268:7 271:21 275:19 279:14 295:22 299:14,22 301:3 306:2 307:13,17 307:20,22 311:6 313:5 356:13 358:14 service-connected 83:11 91:13 100:10 107:14 108:6 109:17 142:10 165:22 296:16 service-specific 220:2 Service/U.S 2:8 session 7:18,22 16:7,8 31:3,7 41:4 153:21 154:22 341:4 351:4 365:13 sessions 16:2 18:16 19:5 21:11 31:9 31:10,11 342:10 365:14 367:20 372:3 set 32:14 60:1 69:21 89:11,19 97:19 113:18 125:10 127:2,3,4 151:15 204:9 241:21 307:7,9 309:20 316:22 319:21,22 362:11 sets 79:3 95:21 setting 182:2 351:2 351:3 settings 163:13 settled 61:12 setup 114:7	seven 126:22 127:3 143:14 204:21 211:17 271:20 288:7 seven-year 288:3 seven-year-old 288:12 289:3 308:16 severe 100:14 113:8,22 116:10 124:11 126:15 260:6 310:2 severely 126:3 305:10 severely-injured 232:11 sexually 184:6 share 12:22 147:20 290:10 294:22 341:6 344:1 349:4 370:8 shared 135:3 234:1 357:6 sharing 343:20 Sharon 2:7 176:15 176:22 sharp 53:12 sharply 56:22 shattered 57:9 258:17 shaved 53:11 shaving 53:12 sheet 13:13 103:14 356:15 sheets 358:16 shell-shock 97:14 shifted 36:2 shifts 244:22 shop 23:18 113:15 113:18 shopping 256:22 shops 69:21 short 46:16 70:21 84:21 107:10 127:17 shortage 302:11,12 302:13
---	---	---	--	--

shot 97:12 141:2 148:10 258:15	312:8 328:20	170:7 231:10 269:8	143:12,22 145:14 146:13 149:18	93:13 97:5,6 218:10
shoulders 233:14	similarly 325:13	situations 26:7	165:2 179:12	Soldier's 77:13
show 37:9,9 39:20 54:21 144:20	327:2 335:1	170:8 341:17	198:2 199:9 215:5	sole 116:4
146:1 148:6 151:8	366:11	360:2	329:16 345:18	solely 104:22 264:22
160:22 179:12	simple 20:8	six 12:10 20:2	slides 104:12	solutions 234:21
204:22 218:2	simplest 108:5	35:11 101:20	122:17 127:8	solve 37:11,22
237:16 249:15	simplify 129:6	134:1 163:3	268:13 323:18	somebody 37:15
365:17	simply 84:19 106:1	183:17 205:2	slighted 37:7	38:1 145:8 161:9
showed 146:13	267:6 343:13,18	259:18 274:2	slightly 204:6	284:4 327:8 350:7
291:16	365:22	349:12	220:1 326:2	353:3 355:20
showing 192:1	simultaneously	size 83:14,15	slip 67:2,2	369:8
273:18	363:20	sized 48:3	slotted 259:20	someplace 294:17
shown 279:10	single 236:4,15	Skedaddle 309:2	small 14:20 31:10	somewhat 21:9
287:2 314:1	243:19 259:3	skill 114:3 145:7,13	245:4 278:21	78:19 185:9
shows 129:11	279:1 284:3 292:6	151:15	283:11	186:19 228:21
158:16 215:5	311:13	skilled 249:9,20	smaller 123:1,20	318:12 328:15
siblings 248:9,14	sir 41:9 89:20	skills 112:8,8	163:12 209:21	son 258:15 259:7
sick 52:5	246:7 264:21	114:17 118:11,21	224:6	308:16
side 9:20 21:5 64:2	316:16 340:8	123:6 364:12	smooth 269:11	soon 5:6 80:18
64:3 70:18 148:15	361:4 362:5	Skype 317:8,15	smoothly 298:2,7	sophisticated
214:9 233:9 237:2	370:13	320:7,21,22	372:2	364:16
239:2 259:14	sit 17:16 31:20 35:8	slang 369:10,15	snapshot 119:10	sorry 31:5 71:22
315:21 358:10	131:14	slashing 56:19	SOBOTA 2:3	74:13 140:21
sidebar 368:6	site 8:4 9:21 18:1	slate 364:21	social 59:12 82:1	179:15 183:22
sides 39:21 64:1	37:20 144:2 146:3	slates 343:10	138:21,22	246:12
241:15	148:14 149:2,10	sleep 197:19	societies 50:18	sort 32:16 36:14
sight 82:17	153:21 154:21	slide 44:5 45:4,16	society 65:10 87:13	42:14 56:14 96:12
sign 133:15 262:16	321:19 322:5,14	46:20 47:12 56:11	SOCOM 327:6	100:22 106:14
264:7 339:14	322:15,18 323:1,3	58:20 62:5 65:12	softened 319:17	111:4 119:6 120:5
350:17 351:15	323:4,9 324:10,16	66:22 68:12 70:2	soldier 44:12 46:1	120:6 124:9 125:5
356:1	324:16 325:10	72:11 75:13 77:1	46:2 47:13 49:7	127:14,18 129:12
signature 57:17	326:8,11,18	77:16 79:1 80:22	50:16 52:2,17	133:4 141:4 164:2
signed 131:1,4	327:10 328:15,19	82:9 84:16 85:1	54:7 56:15 61:15	170:6 181:2 191:3
175:8 358:20	328:21,22 329:20	88:7 91:3 92:19	64:7 65:5,7 68:14	191:9 192:4,11,19
370:21 371:2	336:22 337:22	93:14 94:17 95:5	68:21 71:7 73:15	193:13,14,17
significant 18:18	344:18 345:19	96:6,9 100:3,5,8	73:21 76:12 81:2	194:16 195:10,17
105:22 123:18	349:5 369:9,20	100:19,22 106:13	81:3,4 87:12	196:4,17 197:15
191:20 197:11	371:6	106:14 119:8	228:13	198:16 199:6,10
201:5 280:18	sites 131:5,5 135:9	120:4 122:13	soldiers 49:9 50:5	199:16 200:15
360:18	135:16 143:14,22	123:13,22 125:19	50:11,17 51:3	201:7,15 204:2
signing 226:22	184:11 324:6	126:21,22 127:1,3	52:14 53:21 55:3	210:4 211:6
256:3	325:18 326:2	127:10 128:14	56:2 61:18 62:21	214:10,15 215:1
similar 197:9	328:9 329:11	129:11 130:13	63:1,3 65:1 71:1	220:13,16 221:10
198:12 234:5	349:6	131:6 135:13	71:14,18 72:8	223:9 224:2,10
264:1 281:14	sitting 37:14	137:13 138:3	74:4 77:16 79:12	226:4 296:22
	182:12 271:7	140:21 141:1,13	86:20 87:18 93:10	
	situation 59:6			

307:19 360:11 sorting 332:7 sorts 184:17 190:22 sound 128:4 source 195:18 sources 333:2 south 71:3 73:12 83:18 141:17,20 342:15 spa 257:19 space 113:20 248:5 299:17 300:15 space-available 90:21 94:21 Spain 59:9 60:9 span 128:2 Spanish 55:13 86:8 Spanish-American 84:21 85:4 speak 230:5 257:10 328:11 344:13,13 357:3 365:16 368:5,6 speakers 89:18 speaking 237:14 345:7 372:6 373:15 speaks 106:14 122:17 123:13 129:16,18 special 63:18 187:13 236:20 259:8 283:1,9 288:6 301:19,22 303:6 specialist 105:9 specialized 93:16 specialties 156:9 specific 60:17 82:15 162:5 165:8 192:16 199:19,19 213:15 222:22 236:9 246:17 275:3 329:11 363:11 specifically 37:5 144:6,15 145:7	149:2,2 167:15 182:2 191:16 206:16 221:4 329:16 specificity 367:2 specified 180:20 specimens 186:10 speculators 73:6 speed 89:16 129:6 spend 31:21 59:17 167:1 247:3 343:4 346:11 spending 245:4 247:6 277:7 spent 233:1 235:1,6 spilling 53:7 spinal 253:19 258:16 split 239:14 304:20 374:12 splitting 334:19 374:4 spoken 39:12 spot 66:17 spouse 232:10,21 237:12 246:3 256:10 258:7 278:16 279:13 281:3 283:8,21 284:21 299:12 spouses 271:14 275:4,5 277:2 279:5,8 282:13 303:18 spread 120:4 Springs 277:12 spurs 219:17 squeaky 344:9 St 77:14 stab 226:4 stabbing 56:19 stabilize 117:15 stabilized 47:7 staff 17:6,12,15 24:11 32:2 35:8 39:13 85:6 96:2 130:4 179:20	214:18 350:12 staffed 317:3 staffer 272:22 staffers 213:14 staffing 129:21 232:15 staffs 67:10,11,11 stage 132:19 240:3 351:3 stages 239:20 stakeholders 243:3 stand 179:16 349:2 363:12 standard 68:22 69:1 74:21 79:4 87:11 121:6 198:16,22 199:1 standardized 47:7 standards 129:16 182:18 337:12 standing 79:13 standoff 60:12 standpoint 111:20 138:2,11 348:20 stands 103:3 183:21 start 4:10 6:7 20:15 36:9 41:6 42:16 44:6 46:15 54:1,9 54:9 55:10 67:2 69:9 75:9,21 81:1 92:20 97:3,4,5,13 97:17 113:9 124:1 125:3 133:9,13 134:10,22 139:17 169:13 228:8 261:7 306:7,17,19 306:20,21 312:15 321:18 323:21 346:21 347:6 352:16 373:16,20 374:16,19 started 8:20 35:19 100:2 120:13,16 125:2,12 140:16 143:13 178:12 190:17 206:3	263:1 271:6,11 272:21 273:16 274:2 276:1,6,8 276:10 277:9 291:2 306:14 311:16,18 starting 34:9 56:12 56:13 121:22 124:16 137:5 199:2 277:14 278:9 289:4 296:14 310:13 starts 22:21 54:20 55:21 62:8 84:10 85:2,3 94:7 95:11 106:5 306:16 start-up 113:11,13 113:13 125:7 state 46:4,12 54:20 57:15 59:15 61:17 75:3 84:12,15,20 85:16 98:9 111:5 123:19 150:2 163:9 165:7,9,11 165:13 166:10,15 179:17,21 205:7 313:6 315:16,17 325:4,9 statement 43:14 350:17 355:19 states 5:15 70:9,14 74:22,22 78:5,6 80:12 81:16 92:13 151:19 155:14,16 160:3,13 180:20 191:13,19 275:18 308:8 317:4 state-specific 166:10 stating 190:1 stationed 104:11 141:18 stations 136:6 186:13 statistic 140:20 statistics 20:3 80:9 146:1,7,11 153:7	160:7 168:10 status 82:1 117:17 239:1,3 284:14 299:9 300:2 306:13 307:16 309:9,15 337:6 statuses 119:11 159:18 stay 131:20 132:10 251:10 282:14 346:6 359:16 stayed 38:10 68:17 staying 170:10 stead 367:11 step 32:7 110:2 229:13 stepped 285:7 steps 240:7 stereotypical 250:14 Steve 4:20 Steven 1:19,22 4:18 6:7 8:13 13:14 21:22 23:9,13 25:1 370:19 Stewart 327:3 355:14 stick 36:3 318:15 sticking 363:5 stigma 201:12 stimulated 21:12 stimulation 253:2 stipend 120:15,15 170:18 stipulation 163:16 stole 250:12 Stone 1:14,18 5:1,8 5:12,13 11:2,11 11:16 12:13,21 15:13 19:2 20:13 26:16 28:15,21 29:2,7 30:4,15 38:4 40:5 41:3 89:3,5,14 90:8,12 99:7 136:12 145:15 146:12 150:12,17 175:12
--	---	---	--	---

176:7 204:10,14 204:20 205:5,19 206:2,6 207:14 208:2,7,9,22 211:8 215:18 216:20 217:2 218:10 226:14 227:8,21 229:16 314:15,19 315:10 315:22 316:12 321:10,15 322:2 341:1 360:22 361:19 362:6,18 362:20 367:17 371:5	strongly 11:16 29:19 struck 37:4 231:17 structural 123:3 structure 182:7 structured 136:17 struggling 142:21 146:10 stuck 34:12 Student 139:12 140:1 143:16 students 139:3,14 140:2 142:2 studies 187:13 191:19 192:3 204:22 206:1 209:21 235:8 338:8 study 53:15,16 171:7,8 180:18,21 188:6 204:11,13 214:11 254:12 284:19 285:1,3 299:5 333:2,5,8 333:11 339:10,11 357:19 stuff 15:15 30:12 160:10 211:11,21 222:11 227:10 340:10 stumbling 13:2 stymied 318:12 subanalyses 199:18 subcategories 208:20 subcommittee 242:17 subcommittees 28:19 29:8 subgroup 181:2 subgrouping 223:3 subgroups 27:10 subject 338:8 341:2 343:21 subjects 338:2 350:5 358:7 subject-specific	329:7 submissions 125:22 126:13 submit 371:19 373:2 submitted 338:10 subsequent 28:10 subset 205:12 subsets 209:21 subsistence 116:18 121:12 substance 279:12 substantial 15:19 91:22 93:4 109:19 217:12 substantially 26:20 substantiating 331:2 success 137:16,16 146:1 150:18 166:22 167:6,9 168:14 169:22 171:3 276:12 successful 104:16 122:6 126:4,16 136:7 141:16 142:2 163:15 168:2 171:1 364:3 364:5 successfully 169:15 sudden 283:5 293:10 suffer 202:16 suffered 61:5 sufficient 74:5 suggest 27:16 29:19 315:10 340:17 suggestion 35:5 216:17 suggestions 40:10 suicide 191:15 201:3 357:22 suitable 100:11 108:8 109:15,18 110:11,18 118:12 summarize 16:3	summary 35:13 96:12 summit 293:21 superficial 333:7 supplies 113:17 116:19 supply 251:2 support 11:17 66:1 84:1 130:4,5 137:21 138:1 162:1 175:17 180:15 187:7,15 213:1 215:11 231:3 232:15,16 232:17,20 233:8 238:1,3,11,13,14 238:17 239:6,12 239:19 240:3,16 240:19 242:1 243:9 244:5 259:10,15 261:22 262:3 282:21 312:17 315:17 316:1,14 321:2 327:17 356:14 367:14 368:3,3 supported 17:9 184:14 315:19 supports 163:13 235:17 240:2,5 262:15 264:22 supposed 37:21 135:15 256:14 299:21 322:11 339:9 Suppression 54:4 sure 13:21 19:3 37:12 98:2 106:18 131:5 133:3 142:19 147:14 152:18 154:6 155:20 156:14 174:8 175:21 176:2 200:8 204:14 217:21 218:13 220:17 230:8 259:5	265:19 268:21 270:14 274:9,13 274:16 297:15 301:16 304:5 305:4 307:21 309:11 314:11 331:12,21 347:19 347:20 354:5 355:2 362:3 Surgeon 5:14 80:1 87:16 92:9 179:19 213:15 241:4 surgeons 53:9 78:3 216:5,13 surgeries 53:6 surprise 222:3 surprised 26:17 285:6 surrounded 233:21 surveil 197:3 218:12 surveillance 2:11 2:14 3:9 176:18 176:19 177:2,15 178:5,15,19 179:2 179:4 180:14,16 181:1 183:2,18 186:4 187:6,10 195:19 197:2 208:16 209:1,9 211:7,7 212:16 214:3 219:22 220:1 224:12 225:12 278:1 survey 207:5 208:1 220:20 331:4 336:5 surveys 235:3 337:7 survived 44:20 survivor 271:8,12 survivors 312:9 sustained 234:10 Suzanne 1:13,17 2:21 5:12 230:4 321:17 322:2 349:18 356:16
---	--	--	---	---

362:7 373:10 sweep 44:3,9 swell 75:22 swollen 75:16 symptoms 96:20 syndrome 302:2 synergy 25:10 synthesization 22:17 synthesize 22:5 Syracuse 320:17 321:5 system 38:19 45:11 50:3 51:14,14,18 58:9,12,22 59:5 61:2 68:1,6,8 71:12 72:13 78:10 85:9,13 91:12 93:9,12,15 94:5,6 95:18 147:13 156:11 174:18 178:15 179:14 180:10 195:20 238:3 239:6 290:21 292:4 294:7,10 299:19 319:9 systematic 181:3 systematically 330:16 344:4 systems 87:4 264:11 303:8	34:18 68:9 70:1 76:20 83:1 84:7 87:21 89:22 92:17 99:1,2 104:17 164:6 169:1 182:21 183:12 209:9 211:22 219:5 226:4,8 227:21 240:9 245:6 257:17 271:19 272:9 284:7 290:17 303:9,22 313:2 315:11 321:12,16 321:20 322:3 330:8 355:1 369:19 taken 60:13 63:21 64:19 71:20 81:22 248:5 270:22 359:7 takes 75:1 81:12 85:21 95:17 109:2 211:9 249:17 274:7 287:21 304:20 talk 6:4,13,17,22 7:3,6 8:2 12:14 17:7 18:6 21:20 37:21 42:4 49:21 50:5 70:4 100:20 102:11 104:5,11 109:3 110:21 119:5 131:16 137:4,9 143:9 145:19 147:8 165:19 167:10 184:20 189:22 223:20 229:1 243:4 246:17 270:3,6,17 271:2 273:14 284:9,16 291:7 292:18 297:4 301:11 311:22,22 317:22 322:4,16 328:18 339:9 343:1	347:22 348:1 351:10 354:12 357:16 362:13,15 363:22 364:19 367:20 374:18 talked 9:14 65:7 68:13 81:21 155:8 155:9 167:19 236:15 237:1,4,6 257:15 258:5 289:21 290:18 292:20 316:19 318:21 332:7 talking 36:16 42:20 43:4 76:9,10 82:22 97:4 107:1 124:2 132:14 157:9 204:11 217:14 221:16 263:1 309:18 310:8 317:13 323:13 325:19 343:4 346:12 352:16 353:5 357:22 360:7 talks 88:8 137:14 148:13 358:7 Tallying 368:16 Tampa 260:3,11 tap 154:1,3,6 171:8 327:16 tape 19:21 tapped 363:15 tardy 74:22 target 169:16,18 170:3 331:21 targeted 10:9 targeting 334:11 tariffs 75:17 83:19 83:21 task 1:3,12 2:21,22 3:2 5:15 36:17,22 37:1,7 38:7 39:7 151:3 230:7 315:1 328:12 333:1 343:2,11 344:3 357:9 359:10	361:2 371:17,21 372:11 tax 60:8 taxes 51:19 taxpayers 60:4 Taylor 216:6 TBI 115:14 teaching 291:18 320:18 team 2:21,22 23:22 264:6 344:3,13 350:1 367:14 tease 194:9 196:18 200:7 225:15 teased 210:2 teasing 200:15 technical 122:22 138:2 technically 200:3 358:19 technology 67:3 79:10 126:6 318:10 teens 280:6,11 281:14 teeth 66:19 teleconferencing 136:4 telehealth 319:10 telemedicine 313:7 telemental 313:3 317:10 318:18 319:8,10,16 320:15 321:7 telephone 218:22 tell 12:16 20:17 29:2 43:19 74:9 100:16 144:19 145:16 146:16 151:2 168:5 199:12 209:11 239:20 250:11 251:5 315:8 340:9 352:10,15 358:8 telling 44:7 161:15 174:20 354:14 template 34:22	326:3 templates 326:4 328:19 temporary 102:18 104:22 ten 34:17 48:3 71:9 99:2 105:19 134:1 153:9 173:18 207:5 211:17 230:21 279:22 280:9 302:10 321:16,20 325:21 tend 68:22 147:8 tended 63:1 73:2 term 38:22 63:2 77:11 369:8,10 terms 46:11 60:12 62:4 108:5 119:6 129:13 132:9 197:20 200:4,17 208:20 214:11 351:1,2 terrible 59:11 test 185:6 tested 68:4 84:20 testify 242:16,18 testimony 15:20 16:4,10 testing 126:14 tests 125:2 thank 5:12 13:5 23:14 40:3 41:6,8 41:8 98:20,22 99:13,15 100:4 139:22 161:6 164:21 175:12 176:1,4,5,5,9 226:13 227:7,12 229:22 230:4,6,10 242:13 268:9,10 268:12 269:14,16 321:10,12,13 322:2 341:8 360:21 362:6 370:9 373:10,10 374:20,22 375:2 thankful 121:20
T				
tab 5:21 6:3 41:20 99:12 176:20 229:20 323:17,19 370:11 table 37:14 110:17 197:18 271:7 tables 264:15 tactical 216:21 tactics 45:19 tailored 117:9 137:21 take 6:12 8:22 17:2 19:19 24:21 29:14				

thanks 190:3 254:14	151:6 153:18 154:9 157:7	210:1,2,21 211:8 213:3,4,5,6 216:2	200:13 202:10 227:19 347:14	85:17 86:11 87:17 89:15 108:10,19
theater 92:11,11 204:5 223:2,10 224:4 308:8,9 317:13 320:6,10	158:19 165:12 167:11 168:1 169:4 180:11 185:7,15 187:9 189:8 197:14,18 200:4 202:3 209:20 210:3 211:14 212:10 214:14 215:10 224:6 225:17,18 226:5,6 228:14 230:11 235:8 237:3,15 242:15 245:3 250:1 254:18 256:13,20 257:1,18 264:7 265:14 271:1 275:16 280:9 284:22 297:5 298:6 315:14 331:15 340:21 354:15,22 356:17 364:8 365:15 368:9	216:20 217:2 220:6 223:15 225:9 229:22 230:16 233:17 237:7 240:20 241:10 250:15,17 255:11 256:16 257:10 264:11 286:16 290:18 296:20 311:19 312:21 324:13 330:22 331:11 337:21 341:1,6 346:20 358:21 362:7,8 364:2,14 366:5 367:11,15 367:15,18 372:9 372:20 373:2	thousand 255:17 thousands 79:9 three 31:9 32:20 80:10 86:11,11 88:9 94:14 124:3 125:1,3 131:4,5 135:8,16 178:8,13 184:21 189:5 224:19,20 248:8 249:21 266:22 275:7 276:22 288:2 289:3 305:4 309:8,16,17 325:6 325:18,19 326:1 329:19 338:17 345:22 349:17 366:21 374:4,12	109:2,4 115:8 117:13 141:19 144:16 150:9 158:12,17 167:1 170:15,17 171:16 171:22 187:18 189:12 200:10,12 203:13 204:1,2 206:20 230:5 232:2 233:17,19 233:20 234:11 235:16 236:16 238:8 241:5 249:18 255:1 256:19 263:19 277:7 280:19 283:18 286:17 289:14 296:5 304:13 306:20 308:9 309:6 318:2 320:20 329:19 343:4,14 346:12 348:12 349:14 362:14,16,17 368:7 373:18,19 374:18
thematic 15:4	think 6:13 9:10,12 11:2,3 16:1,4 18:18 24:14 26:13 27:1,2,7,8,9,19 29:13 30:5 32:6 32:19,20,21 35:7 35:18 38:4,16 39:2,16,16,16 46:16 76:7 99:2 131:17,18,20 135:14 142:12 148:10 153:6 154:21 157:8,16 163:21 165:12 167:20 168:9 176:7 182:12 186:20 188:1,2 189:2 190:20 194:4,13 195:17 196:3 200:5,14 203:7,22 206:11	thinking 16:16 27:4 132:9 200:12 203:22 364:6 371:13 372:17	three-hour 374:1 three-month 309:4 threshold 164:18 thrive 269:13 throw 17:18 31:17 58:6 throwback 72:16 throwing 370:4 thrown 314:9 tie 156:11,12,15 tied 257:7 tier 267:10 tiers 267:1 ties 31:21 till 6:11 28:16 374:2 time 4:7 6:13 10:17 22:8,21,22 28:12 30:14 31:15 33:5 34:3,11 35:6 37:18 39:21 43:16 43:16 46:4 51:17 56:4 57:18,21,22 62:10,20 64:15 67:10 70:19,22 72:14 74:1 76:2,5 81:19 82:13 83:5 83:5 84:9 85:15	timeliness 108:15 timely 41:6 180:6 181:7 214:15 times 34:1 49:12 51:16 61:7 66:8 78:16,16 88:9 114:12 138:17 168:21 171:6,12 194:11 195:7 197:5 202:21 203:2,3,11 245:2 248:2 259:18 262:3 274:11 283:3 288:17 290:17 294:22 295:1 304:9 311:7 317:2 350:13 357:2 timing 175:4 299:3
theory 25:15 48:13 53:19 203:18,19		third 103:10 123:16 184:19 201:21 202:6 210:11 268:3 269:6 289:11 337:1	three-month 309:4 threshold 164:18 thrive 269:13 throw 17:18 31:17 58:6 throwback 72:16 throwing 370:4 thrown 314:9 tie 156:11,12,15 tied 257:7 tier 267:10 tiers 267:1 ties 31:21 till 6:11 28:16 374:2 time 4:7 6:13 10:17 22:8,21,22 28:12 30:14 31:15 33:5 34:3,11 35:6 37:18 39:21 43:16 43:16 46:4 51:17 56:4 57:18,21,22 62:10,20 64:15 67:10 70:19,22 72:14 74:1 76:2,5 81:19 82:13 83:5 83:5 84:9 85:15	
therapist 321:3		third-party 372:21		
therapists 92:6		Thirty 28:7		
therapy 69:11 251:13,15,21 252:7,12,16		Thirty-nine 28:8		
thesis 48:22		Thompson 315:15		
they'd 76:19 233:17 273:5 374:8		thorough 106:19		
thick 323:18		thoroughness 332:4		
thing 9:1 13:16 27:3 71:7 88:13 103:8 106:22 112:13,14 115:19 151:18 183:11 219:8 226:16 230:9 243:7 252:21 257:5 261:17 280:22 286:6 288:14 308:17 313:22 314:10 365:19 369:1 372:15		thought 15:8,10 16:14,20 17:21 21:2 26:11,17,18 30:10 33:2,4 37:6 48:17 148:9 247:5 263:4 280:7,9,14 309:8 311:8 317:18 359:3 371:16		
things 11:13 32:3 34:1 37:3 40:13 45:13 54:1 56:12 62:15 68:13 71:16 86:11 104:19 113:13 115:13 118:20 124:19 129:20 130:2 137:22 138:6 143:2,12 144:20		thoughts 15:7		

tips 148:18	torso 57:5	307:8,9,12,15	238:20 294:16	186:3 194:9
today 5:8,9,17	total 37:17 84:15	308:22 312:18	296:11,17 300:11	201:12 228:22
43:18 44:8 49:8	touch 126:2 135:7	transcribers 16:5	313:17	312:4 337:5 348:6
49:21 51:6 61:21	145:2,10 182:17	19:5	treaty 63:15	364:11 367:6
64:6 66:22 73:20	188:22 328:3,7	transcription 14:19	tremendous 73:11	try-out 319:20
76:8 80:22 82:21	330:6 334:5 337:7	transcripts 369:22	86:17 87:2 92:18	tube 250:8
96:6 98:19 99:14	touched 195:17	transfer 211:11	tremendously	TUESDAY 1:9
176:4 178:21	touching 135:4	226:20 256:9	218:4	tuition 116:20
182:10 227:5	182:13	transferred 209:2	trenches 17:16	120:17,18 121:1,3
269:15 270:3	tough 170:7 227:4	transform 85:2,3	trend 36:14	121:17
278:2 315:7 322:9	tours 281:4	transformation	triage 87:4	turn 4:6 5:11 60:6
322:17 324:8	town 295:15	85:5	TRIApp 317:15	187:3 272:14
341:5 369:5	to-face 129:4 317:7	transition 1:4	TRICARE 246:5	280:19 322:4
token 38:9	trace 45:17 55:15	80:21 102:12	274:17,19 295:21	337:19 361:8
told 21:13 182:8	57:17	113:4 119:14	296:15 297:2	turned 94:10
233:4 242:11	traced 51:9 96:20	126:17,18 134:8	300:7,8,9,19	turning 45:5 373:5
250:7 251:4	track 100:16 102:6	135:1 165:3 173:9	301:19 312:8	turns 43:7
256:16 295:14	110:22 114:5	229:12 237:19	317:14 318:8	tutor 143:11
319:21	116:1,6,9 123:21	241:9 269:10	tried 39:14 57:16	TV 280:12
tomorrow 15:14	124:7,15 125:18	280:14 295:18	252:21	tweak 8:11 213:17
323:16 336:8	133:5 138:18,19	298:3 299:7	triggers 174:22	tweaked 335:18
345:8 371:4	139:6,19 143:6	309:21 329:6	trip 162:14 294:19	twelve 374:2
373:11,12,15	175:4 346:6	334:5 335:9	triplets 345:12	Twenty 59:9
374:18	tracked 108:17	transitional 102:17	troops 17:16 78:4	Twenty-nine 360:5
ton 262:22,22	tracking 140:15	110:13,15	138:4 205:18	360:13
tone 252:15 253:7	160:2	transitioned	206:15 207:1	twice 194:20
tool 7:16 34:5	tracks 111:7	134:21 239:16,17	210:17	two 13:18 14:20
125:8 128:6	115:20 116:15	transitioning 101:2	trouble 27:20	24:17 25:6 31:12
263:17 264:5	139:1 143:8	101:12 134:13	true 65:3 77:22	33:10,15 35:8,9
tools 8:7 13:15	170:14	135:5	264:16	38:5 42:7,15 53:8
113:17 115:16	trades 123:3,3	translate 112:8	truncated 195:7	57:17 79:21 86:4
130:4 224:9	tradesmen 64:11	transmitted 184:6	try 14:5 42:14	91:19 101:17
254:18 269:13	tradition 75:8	transpired 344:17	45:17 162:18	104:18 120:21
330:15,19 331:1	traditional 113:8	transport 222:21	214:13 223:14	141:22 144:20
top 197:20 218:8	124:11 162:3	transportation	225:18 254:8	168:22 179:20
280:9 289:15	tragedy 218:15	115:17	257:21 318:15	188:1 189:4 228:7
307:19 344:12	train 47:21 114:3	traumatic 224:3	332:2,3,5 341:15	228:10 243:12,14
346:21	142:13	233:3 248:7 262:5	342:8,16 354:1	243:14 244:2,9
topic 18:15 76:7	trained 59:13 63:6	278:5 290:3	364:11 367:10	248:9,21 254:10
182:13 193:6	117:19 124:18	travel 160:15	trying 20:5 34:14	265:14 267:7
326:6	282:9,10	239:16 299:12	79:12 131:20	277:11 281:4
topics 34:14 322:11	training 47:15,16	treasury 64:20	139:2 140:5 145:8	286:15,20 287:1
322:13 323:12	113:17 114:6	treat 181:8 314:11	146:1 147:12	289:4 292:14
326:5,22 336:15	116:19 125:9	treated 301:4	151:3,6,22 152:11	309:13,22 324:4
top-down 38:1	126:5 139:16	treatment 63:19	154:15,20 155:14	324:11,17,19
top-line 323:8	182:19 252:10	65:1 74:18 81:2	160:16 162:2	325:2,20 326:18
333:7	306:1,21,22 307:2	180:2 220:18	170:11 175:19	328:14 330:11,12

344:6 349:7,12,17 355:15 365:3 373:22 twofold 332:22 two-day 34:12 two-month-old 288:5 two-way 164:15 tying 156:22 type 19:20 22:21 34:18 40:13 127:17 145:7,13 150:18 156:21 170:20 207:22 326:8 334:20 336:5 365:19 372:3 types 122:17 123:13,22 124:19 157:2 199:19 229:10 254:18 265:4 275:16 302:2 325:18 326:2 328:3 332:5 332:8 354:22 typically 108:17 112:5 118:3,6 122:7 124:6 132:16,21 163:7 184:9 349:20 typing 368:21	86:21 undergraduate 139:4 underlords 51:15 understand 19:14 24:12 43:18 48:16 96:15 97:13 112:15 152:11,12 205:10 227:5 274:14,17 287:5 290:2 291:10 313:9 315:20 339:12,18 350:13 364:14,22 368:14 372:14 understanding 9:8 43:17 46:5,8 52:10 97:2 106:19 132:4 158:1 161:17 255:2,12 270:8 323:13 341:3 351:18 363:10 understands 287:4 understood 88:14 undertake 190:22 underutilized 124:6 186:19 undone 245:3 unduly 334:13 unemployed 152:7 unemployment 59:12 64:14 150:13,16,22 151:5,9,20 152:13 unequal 74:17 unfortunately 89:5 185:14 339:4 unhappily 339:2 unhealthy 197:15 uniform 316:13 361:20 uniformed 271:20 uniforms 62:18 Union 56:11 80:2 80:20 unique 43:7 47:14	103:4 208:4 234:14 322:19 326:11,12 327:10 361:2 unit 93:19 241:9 282:11 286:3,8 287:8 295:18 298:3 299:7 305:1 335:10 united 5:15 70:14 70:14 80:12 81:16 92:13 191:12,19 317:4 units 55:5 80:21 101:13 337:4 universities 140:8 university 22:12 141:17,20 162:4 320:17,19 321:6 unprepared 65:22 77:18 91:16 unquote 161:15 unrest 59:12 Unseen 262:2 unspecified 198:15 199:4 unsuccessful 364:4 upcoming 24:7 200:1 203:1 update 23:1,8 122:16 148:17 updated 23:4,7 127:7 upper 252:4 upwards 59:9 72:7 up-and-down 342:14,14 URIs 199:5 USA 134:16,18 usage 316:19 USAR 1:18,22 use 8:10 9:13 24:1 38:22 40:8 44:22 58:1 60:11 69:10 92:15,16 101:13 114:10 115:16 133:7 151:16	169:10 184:22 186:14,20 200:15 212:12 215:11 224:1 230:1 255:4 279:12 296:8,14 310:11,20,21 311:10 313:6 317:19 318:3 320:22 343:14 356:22 359:19 361:8,13,15 useable 208:11 211:11,12,19 367:3 useful 213:8 363:11 user 127:12 USERRA 111:8 369:5 users 36:8 user's 158:20 uses 212:12 253:2 319:10 USF 143:13 USMC 1:21 usually 118:4 123:9 192:21 214:9 261:19 utilization 204:21 205:1 207:16 360:22 utilize 7:13 361:5,7 utilized 280:5 utilizing 160:3 209:4 U-S-E-R-R-A 369:5 U.S 1:1 2:7	167:4 237:4,6 238:9 242:19 247:22 252:6,17 253:5,19 254:15 255:2 260:3,11 264:13,14 266:3 274:6 294:7 295:22 296:8,8,9 299:16,21 305:7,9 305:10,13,14 306:4,6 307:1,3,9 307:13,17,20 309:7 310:5 312:15 316:18,21 318:3 327:20,21 328:1,1,2 VAAP 103:2 vacation 295:14 vacations 257:20 vaccinations 86:16 88:11 validated 242:12 valuable 6:21 7:8 7:12,16,19 8:7 14:5,15 19:13 323:1 348:19 value 6:6 7:4 11:13 16:9 19:22 26:3 27:2 49:13 74:12 74:14 values 73:5 265:5 variation 326:5 variations 326:10 varied 25:3 varies 349:11 variety 187:7 325:21 various 184:17 212:10 216:12,12 219:2 vary 185:20 327:10 327:13 332:13 vast 206:6 VA's 310:10,12 VBA 126:9 138:6 141:1 142:15 vector-borne 184:5
<hr/> U <hr/>				
ugly 348:13 ultimate 93:12 unable 5:8 59:14 77:21 182:10 unaware 43:22 unbelievable 296:12 unbiased 343:7 unclean 49:3 uncomfortable 341:13,17 352:1 355:6 uncommon 71:1 uncontrollable				
			<hr/> V <hr/>	
			V 201:1,2 VA 74:17 90:21 91:1,8,16 94:6,10 94:16 95:6,10,12 95:15,22 96:3 103:3 105:1 131:2 139:4 142:14 165:8,9 166:14	

vehicle 212:11	300:2,19 301:14	VetSuccess 104:4,9	323:1 324:11,20	109:21 130:18
vehicles 87:5	306:13 307:16	140:4 141:14	325:3,7 327:10	164:18 171:19
venue 215:19	309:15 319:13	144:12 157:11	370:11,21 371:7	vulnerable 257:11
venues 180:12	veterans 2:6 3:7	vetsuccess.gov	visit-wise 323:9	321:9
verbatim 339:7	42:19 43:1,10	119:5 144:1,5,9	VITAL 143:21	
verbiage 342:21	45:12 46:11,14	144:21 147:3	voc 101:14 103:13	W
verify 149:11,14	51:9 55:7 59:10	148:6 152:17	104:10 107:18,19	wage 61:19 147:22
verifying 159:14	60:8 69:17 82:10	156:17 158:5	117:3 118:14	171:10
versa 310:6	84:2,14 90:19,20	166:6 167:15	120:2 121:2,11,19	wages 64:20
version 183:6	91:2,5 95:4,8	VETS's 150:3	122:4 124:17	wait 12:5 272:17
317:20	99:10 100:10,13	vetting 310:18	128:16 130:17,18	waited 172:16
versions 309:13	101:2,22 103:9	VHA 137:4 141:20	130:22 131:10,22	waiting 272:18
versus 225:10	104:14 105:16,19	143:20	138:8,12,15 139:5	310:16
278:6 286:21	114:13 115:22	viable 262:15	139:11 141:7,19	waived 106:12
299:16 301:9	119:2,11,12 120:3	vice 310:5	142:13 143:1	walk 40:2 336:8
vet 141:21 316:21	120:20 121:5	vicinity 326:16	147:1,5 152:5	338:19
317:4 318:4,13	122:1,5 123:4,12	327:4	153:17,20 156:8	walked 33:19
327:22	123:14 124:7	victorious 65:15	157:10 161:14,22	281:19
veteran 54:16,17	125:3,17 126:3,15	video 127:16,18	162:9 166:1	wall 275:14
68:15 82:19 83:1	129:1,4,9 130:5	136:3 148:13	172:12 174:16	Walter 9:15 233:1
84:6 87:15 91:15	135:20 136:7	videos 291:17	vocational 2:5 3:7	233:5 235:10
94:3,4,21 103:10	137:18 138:7,10	view 11:14 349:3	88:2 90:16 99:10	238:7 291:3,3
106:20 107:14,22	138:20 139:6,10	365:17	99:19 102:4 107:5	294:2
109:13 116:5,17	140:1,19 141:1,15	viewpoint 11:19	107:17 110:22	want 7:9 8:9,10 9:6
117:8 118:16,17	142:5 143:17	Views 285:2	124:18 162:3	12:7 13:21 14:1
121:10 125:6	144:3,4,6,16,22	vigilant 342:6	vociferous 344:10	31:16 35:16 36:11
130:10 136:13,18	145:11,13,16	vigilantly 345:2	voc/tech 157:15	59:16 89:18 107:8
136:22 138:15	146:4 147:4,4	VIII 54:3	voice 230:1 242:11	107:8 126:20
139:3 141:8 142:2	149:3,6 150:13	violation 255:9	257:9 270:4,9	128:7 133:3,15
142:15,17 144:18	152:18 153:1	Virginia 1:13 244:3	volume 34:19 42:7	134:5 137:1 139:9
144:18 145:6	156:13 157:4,17	vision 180:8	42:11,16 57:16	139:10,11 143:6
147:10 148:20	157:19 158:7,8,17	visit 3:19 8:3,3,4	70:15 96:9 98:17	144:18 147:8,8
149:5,9 152:13	164:1 165:3,4,4,5	30:22 34:7,8 35:7	volumes 42:7	149:1,4,4,5
159:13,15 161:16	165:12,19,21	36:15 37:20 38:8	voluntarily 17:14	154:10,11,13
162:10,18,22	168:14,21 169:12	39:19 195:13	voluntary 50:18	161:19 164:6
163:2,15 164:8,16	171:6,13 173:17	294:18 321:19	volunteer 115:8	177:10 187:1
166:7 168:17,18	241:12,12,14	323:3,4 324:16,17	volunteering	188:22 190:7
172:10 174:16,19	249:16 250:11	325:3,8,13 328:15	115:10	191:1 199:8,9
174:20,22 175:6	254:19 262:10	328:19,21,22	volunteers 78:5,17	200:9,18 211:1
244:7,15,22 245:1	263:22 264:1	329:22 337:15,17	78:20 272:2,15	213:16,18,18
247:19 249:8	277:13 296:6	337:22 369:10	273:10,22 274:4	215:6 218:13
251:13 252:2,11	297:9 309:9	371:3	vote 32:11,15	220:7 228:9 234:3
253:12 254:4,11	veteran's 3:6 84:5	visiting 243:15	votech 114:15	237:10 250:13
255:5,10 256:3	109:11 117:10	328:9	voted 74:19,21 84:2	251:10 252:18,18
257:9 258:7,11	248:3 249:3 250:4	visits 9:21 34:16	voting 7:18,22 31:3	253:14 257:14
260:5 268:20	268:22	35:16 36:13 37:4	31:7 32:12	259:5,6 266:15
284:14 299:9	VETS 119:1	40:15 322:5,14,18	VR&E 2:5 3:8	267:8 271:20

274:9,13,16,21	91:17,18,22 92:8	Watch 345:9	149:6 158:20	375:4
295:6,19 311:15	92:10,18 93:16,18	water 323:5	165:6 182:19	weren't 17:12
319:3 336:5	94:9 95:5,9,10,11	watershed 65:15	183:13 235:17	35:21 44:14
339:14 347:13,17	96:8 97:4,10,22	way 16:12 18:16,21	239:9 264:5	276:19 277:7
347:19,21 348:2,4	191:12 206:3	20:4,5,21 24:15	websites 299:1	282:9
348:10 352:17	207:21 217:8	27:11,13 30:21	web-based 128:6	west 39:8 51:11
354:3 356:18	273:3 279:22	32:21 40:8 45:2	185:16	72:10 160:20
359:5,18 362:12	280:2,11 284:20	46:7 59:15 61:20	Wednesday 199:14	we'll 4:4 6:11,11,18
362:22 363:22	302:10 308:3,15	62:10 86:6 87:7	week 34:10,11	9:4 13:6,7,8 20:21
365:15 367:12	warehousing 69:6	99:21 108:7,14	115:9 171:10	24:20 29:14 34:10
369:18 373:4	Warfare 96:12	112:21 136:16	267:18 275:10	46:4,12 47:11
374:12,18	warm 134:16	137:16 142:20	weekly 187:21	99:1,3 100:2,7
wanted 9:8 26:21	277:12	162:12 169:21	189:18 212:16	115:15 134:5,7
153:5 159:4	warm-up 6:16	177:5 179:16	weeks 133:22 169:1	144:19 176:8
199:15 203:2	warning 159:3	184:14 193:12	183:17 275:11,18	209:14 227:21
220:16 237:8	warrant 104:1	208:4 211:3,16	welcome 4:5,8	265:21 321:20
252:14 273:7	warrants 295:6	212:1,3 214:16	41:14 99:20	322:4 337:19
276:13 277:5,8	warrior 3:4 80:21	215:10 223:6,14	164:22 227:13	338:16 341:1
285:5,10 287:19	232:3,7 235:21	238:21 242:6,7	229:21 369:16	347:17 362:13
297:5,8,14 298:8	236:1,16,18,19,22	244:5 252:11	welfare 355:7	367:20,22 370:11
301:16 319:11,20	239:10 240:11	264:20 266:15	356:20	370:13 371:3
331:3 357:2	241:9 243:3,16,19	268:2 274:3	Wellington 65:6	373:21 374:16
wants 149:10	244:11 253:21	296:20 297:1	well-aware 329:8	we're 5:17 6:3,22
228:19 333:16	264:4 266:7	309:19 313:19	well-being 299:4	12:3 29:10,11,22
war 42:10,12,17	295:18 298:3	320:14 321:7	304:2 341:19	33:9 34:9 35:10
44:1,12 45:3,5,13	327:4,19 329:5	326:3 327:12	well-developed	42:4,14,20 43:4
45:14 47:18 56:11	330:17 335:11	334:16 339:8,11	150:19	45:17 56:13 60:17
57:6,7 59:9 60:9	337:4,12 349:8	341:11,15 342:22	well-known 59:1	70:3 76:9,10
61:3,3,6,6,7,8,9	warriors 38:14,19	350:5,18 351:5	well-meaning	79:11 82:21 89:6
63:21 64:16 65:14	236:6 260:14	353:20 357:11	350:6	100:1 104:7 107:1
65:14,21 66:21	271:3 328:4	360:6,19 362:9,17	well-received 242:2	107:2,3 125:15,21
67:5,7,17,22 68:5	330:13	372:7	well-reflected	126:12,13 127:15
68:6,7,9,18 69:12	wars 68:4 70:16	ways 45:9,9 100:22	374:11	127:15,22 128:20
69:20,22 71:6	77:17 78:5 92:19	125:3 186:20	well-trained	128:20 129:12,12
72:14 73:9 74:4,8	wash 49:4	191:6 200:6 209:8	124:20	131:8 132:4 133:1
74:10,12,20 75:2	Washington 73:18	209:20 213:22	went 6:20 16:14	133:3 135:4,8,12
76:12,17,17,22,22	74:3 77:13 80:15	214:22 220:8	28:17 36:12 41:11	135:18 136:8,10
77:22 78:1,9,13	wasn't 16:17 17:10	272:2 327:9 368:2	86:7 99:5 135:14	136:21 137:4,5,22
78:14,22 79:2,3,4	28:16 35:20 47:6	wealthy 82:2	167:18 176:3,11	139:2 140:3,9,14
79:6,7,11,14 80:8	47:7 82:5 86:18	weapons 45:19	195:5 224:19	143:20,21 144:19
80:11,13 81:2,16	103:13 231:5	79:11,12	228:2 231:7 241:3	145:1 146:10
81:18 82:10 83:5	248:19 249:2	wearing 316:13	241:4,11 242:12	151:6,21 152:10
83:18 84:2,6,17	252:5 253:8 281:5	web 28:5 128:10	247:9 248:20	152:21 153:19
84:21,21 85:4	297:15 336:3	webinar 155:4	276:21 281:20	154:2,15,20
86:2,3,7,9,10,12	371:12 372:8,16	website 28:3,18	293:20 295:12	157:14 159:19
86:18,22 87:4	372:18	29:12 119:6 144:2	304:13 315:7	160:9 161:16
88:6,15 91:8,14	waste 37:17 39:20	145:20 148:11,21	321:22 334:16	162:18 164:9

169:3,17 176:13	279:22 302:9	45:1 56:3 152:17	31:10,22 65:11	38:14,19 40:11
191:5 192:10	316:3 320:10	152:22 338:12	100:1 104:7 107:3	43:5 46:1 47:2,21
195:18 196:18	325:19 337:7	366:21	129:9 133:9,13	52:5 53:20 55:3
198:2,11,22 199:1	360:1	wording 363:6	136:10 137:22	63:13,17,22 64:2
199:17 200:7,19	wheel 344:9	words 48:15 180:5	143:15,16 151:3	69:7 71:8 94:3
201:4 208:20	wheelchair 291:17	346:18	153:15 154:4,15	231:11 232:3,6
209:4 212:1,21	303:15	word-of-mouth	162:9 164:15	235:20 236:6,16
214:11,15 215:12	white 76:4	235:3	173:7 212:1 229:8	236:18,19,22
215:13 217:14	Whoops 31:5	work 6:11 18:8	229:8 231:6,8	239:10 240:11,17
221:20 222:18	Whoopsie 178:16	20:21 23:22 25:8	240:16,19 253:22	243:3,16,19
225:12,15 228:4	178:16	25:16 26:14 27:4	262:13 265:13,16	244:11 253:21
228:21 229:17	wide 208:19 220:3	28:18 35:3 55:21	271:15 272:21	260:7,14,21 261:3
245:16 253:16	330:18	57:14 59:14 60:15	298:5 304:15	264:4 266:7 271:3
262:16 265:16,19	widespread 56:16	60:20 82:15	workload 119:9	275:4 276:14
270:9 272:13	58:1,2 216:19	100:15 101:10	120:6,10,13	277:1 280:3 299:6
276:1 277:10	widows 75:10,11	104:4 107:20	121:21 129:22	303:21 306:7
285:13 287:11,12	75:12 76:8,10,11	112:6 115:7	works 35:2 274:20	314:1 327:19
304:6,11,17 311:6	76:17 82:18 83:13	118:22 120:2,8	288:15 364:11	335:11
311:21 312:7	wife 203:8 231:2	126:4 138:22	world 42:10 44:12	wounds 44:15
319:22 321:16	259:22 298:5	146:6 162:12,18	45:3,5,13,14	45:21 49:2,3
324:1,1,2 329:12	wiggle 98:4	165:5 171:7,8	47:14,18 53:4	56:18,19,19,19,22
330:8 331:14	William 62:9 79:22	176:20 180:6	57:6 61:6,7,8,9	57:17,20 66:3,8
337:5,13 341:17	willing 12:5,6	188:20 201:12	67:17 68:6,9,18	71:10 88:21 262:2
346:11 347:8	209:10 254:7	203:17 204:15	69:12 74:8,10,12	write 20:5 254:7
348:6,8,9,9,12,12	263:6,13,22 264:2	205:10,11,19,22	79:4,6 81:18 86:2	275:16
366:13 369:22	willingness 321:11	207:13 214:22	86:3,10,12,18	write-up 333:6
370:4 373:9	wind 247:11,12	216:22 217:6	88:6,15 91:8,14	written 111:1,3
we've 5:3 11:2	wine 48:8	220:3 223:16	91:16,18,21,21	162:7 204:18
13:10 30:4 68:13	wiring 179:8	226:2 227:3,6	93:16 95:9 97:10	249:21 315:1
77:18 96:13	Wisconsin 22:13	230:7,10 231:7	97:22 112:6,9	wrong 93:2 178:16
107:11 117:18	wish 220:4	244:2 252:11	141:7 153:3	250:9 354:15,16
118:6,10 121:20	wives 63:3	254:5,21 257:22	184:13 186:6	368:11
124:22,22 125:14	woman 258:12	265:12 266:4,8,15	188:13 189:6	WTB 345:13
129:13 131:3	295:13 345:14	270:1 271:12	236:13 242:14	WWCTP 373:17
133:20 135:3,3	women 76:19,20	274:5,16 304:14	279:21 280:2	373:20 374:2
140:7,12 144:6	198:20 271:7	321:18 332:14	308:3,15 350:16	WWTCP 374:5
148:15 151:9	wonder 145:15	334:21 353:20	worried 289:13	
164:10,12 166:6	226:22 340:14	worked 32:22	worry 281:15,15,16	<hr/> X <hr/>
167:10 193:3,6	wondered 318:21	118:6 131:2 146:5	wouldn't 32:20	XV 58:4
199:11 200:16	250:16	147:13 156:21	33:6 203:18	<hr/> Y <hr/>
207:20,21 217:7	wonderful 186:18	252:2 264:10	278:16 312:12	year 4:10 5:18 6:5
217:19 227:14	250:16	265:8 273:1 305:4	wound 48:15 57:4	6:19 7:8,12,14 8:8
228:7 230:19	wondering 10:7,10	309:11	57:8,9 247:17	8:19 9:4 12:8,9
237:15 241:20,22	17:13 31:19	worker 192:8	248:15,20 256:3	17:21 22:2 24:4,7
249:11 250:6	158:11 174:11	workers 207:7	260:2 279:4	25:5 32:21 33:10
256:1,15 258:5	246:8	Workforce 150:2	289:15	33:13,16,18,20
265:10 275:17	Woodson 216:7	working 5:9 30:20	wounded 1:4 3:4	34:2,3,15 35:1

36:3 38:10 64:18 70:22 73:22 74:20 77:5 101:21 119:10,16 121:9 122:15,15,16 135:10 152:21 174:8 193:5 196:22 197:3,6 203:15 214:5 261:10,11 275:9 275:18 276:2 277:10 278:3 292:13 319:4 324:4,4,9,11,12 324:19 325:1,2,6 327:16 330:4,5,10 333:17,17 334:14 335:15 338:9,9 345:21,22 349:7 353:20 354:8 369:8 370:4,5 372:11 years 42:15 43:20 44:10 49:6,11 50:8 59:9 65:16 66:7 68:10,20 81:5 86:4,13 91:19 94:14 106:9 106:11,13 118:8 134:1,1 160:9 177:16,18 190:15 201:6 207:6 211:17 230:17,20 233:18 245:19 258:20,21 259:18 271:6 276:8 279:22 280:15 288:1,2,18 290:9 302:10 318:8 year's 27:17 315:4 333:14 year-old 288:12 yellow 103:1 110:21 155:10,16 159:22 160:16 York 71:17 303:17 young 76:19 84:6	258:12,12 259:2 younger 248:9 <hr/> Z <hr/> Zeiders 232:10,12 232:13 zone 92:12 <hr/> \$ <hr/> \$5 75:5 <hr/> 0 <hr/> 08033 23:6 <hr/> 1 <hr/> 1st 121:9 1.35 194:18 1.9 279:16 1:04 176:12 1:57 228:2 10 122:15 174:8 349:10 10-year 217:8 10:59 99:5 100 88:16 119:22 105 175:11 105,000 119:11 11 5:18 70:8 122:16 279:18,20 324:9 11,000 92:2 11:09 99:6 110 8:16 135:9 111 121:7 111-163 319:6 117 8:17 12 106:8,11,13 135:10 247:6 277:12 286:18 349:10,13 12-year 106:3,4 12:13 176:11 13 70:9 127:1 177:18 288:1,2 13th 53:5 1300 176:9 14 49:12,12 173:19 314:19 315:3 323:18	14,000 80:16 119:17 15 28:4 34:15,16 190:15 262:17 314:20 315:3 324:6,13,14 362:20 15th 28:3,6 15,000 72:7 15-minute 227:22 150 66:6 1500 187:16 216:11 285:4 1598 59:8,18 16 95:8,10 230:20 286:17,22 324:14 16.4 278:6 160 66:6 1633 55:20 1642 61:3 17 90:5 233:18 259:18 17,000 70:20 17-year 259:19 176 3:10 1798 77:3 18 90:5 95:8 117:16 118:1,14 151:8 280:20 18th 64:8 65:3 18,000 175:14 1800 144:14 1812 77:22 1818 75:17 1820 75:20 1828 73:7 1830 75:22 1831 68:16 1833 76:6 1836 76:8 1851 77:13 1855 77:14 1862 82:11 1866 82:19 1870s 67:20 68:1 1873 83:2 1879 83:3	1890 83:9 1893 83:14 19th 48:20 65:4,6 65:19 67:1 75:15 97:3 1901 85:4 1906 76:14 1908 85:14 1910 84:13 1911 76:15 1916 85:12 1921 90:18 1924 90:19 1930 91:1 1943 94:20 1944 94:2 1950s 76:18 1953 96:3 1974 338:4 1980 84:5 <hr/> 2 <hr/> 2 335:15 2nd 5:20 2.9 280:15 288:17 2:14 228:3 20 49:10 50:8 61:7 105:3,8,17 143:22 197:20 218:8 20-year 73:20 2000 49:5 2003 258:19 2004 275:17 2007 231:14,22 278:9 2008 120:7 178:8 232:2 235:10,18 238:5 2009 141:17 238:5 239:8 264:10 278:6 2010 43:14 119:10 122:21 123:15 146:15,17 242:22 243:13 244:13 278:4 2011 1:9 3:2 23:7	135:16 2012 143:15,22 152:22 214 239:3 22 28:11 229 3:14 24 151:8 205:3 247:6 286:20,21 289:7 24/7 245:6,7 258:6 258:22 261:9 25 135:5 275:18 269 3:17 27 205:3,5 2799 1:13 28 230:17 <hr/> 3 <hr/> 3 334:3 336:13 3,000 80:10,14 3.1 279:5 3.7 88:9 3:42 321:22 3:55 322:1 30 68:9,20,22 306:12,12 324:12 31 101:18 32,000 84:14 322 3:19 3500 275:9 36 101:13,18,19 102:2 107:3 119:16 133:10 365 261:9 373 3:22 377 121:8 38 28:6 39 28:19 29:4 92:2 <hr/> 4 <hr/> 4 1:9 4th 277:15 4:55 375:4 40 13:18 16:15 65:16 68:10 194:19 400,000 70:17 41 271:6 275:18
--	---	---	---	--

41,000 280:2**42** 3:5**44** 94:3**45** 92:3 109:1

171:20 172:3,7,17

173:12,21 323:7

47 71:22 96:1**48** 95:7**49** 61:3

5

5,000 230:11**50** 81:5 86:13

140:22

50-page 13:18

16:15

501(c)(3) 271:18**57** 101:8 119:4,21

6

6 3:2**6th** 277:15**60** 68:21 69:2 89:6

118:13 140:19

600 214:5**614.6** 278:4**65** 281:9**664,000** 92:4**67** 71:19 72:4

7

7,000 218:10**7.3** 278:6**70,000** 119:15**73** 279:17 280:1

302:14

76 122:20**77** 169:16,17

8

8:30 1:13 373:11,13

373:16 374:19

8:38 4:2**8:45** 373:20**8:50** 373:20**80** 249:10**800** 73:8**800,000** 59:10**85** 71:13 281:7

9

9/11/12 139:19**9:18** 41:11**9:30** 6:11**9:38** 41:12**9:40** 41:5**9:45** 41:4**90** 366:15**98** 108:19**99** 3:8

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This is to certify that the foregoing transcript

In the matter of: Care, Management and Transition of
Recovering Wounded Task Force

Before: US DoD

Date: 10-04-11

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