UNITED STATES 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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TUESDAY
FEBRUARY 21, 2012

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The Task Force met in the Washington Ballroom in the Crown Plaza Hotel, 901 N. Fairfax Street, Alexandria, Virginia, at 8:00 a.m., LG Charles Green, DoD Co-Chair, and Suzanne Crockett-Jones, non-DoD Co-Chair, presiding.

MEMBERS PRESENT
LG CHARLES GREEN, Co-Chair
SUZANNE CROCKETT-JONES, Co-Chair
JUSTIN CONSTANTINE
CSM STEVEN D. DeJONG

CAPT CONSTANCE EVANS
LTC SEAN P.K. KEANE
MSGT CHRISTIAN MacKENZIE
KAREN MALEBRANCHE
STEVEN PHILLIPS, MD
DAVID K. REHBEIN
MG RICHARD A. STONE, MD

RUSSELL A. TURNER, MD

ALSO PRESENT
NANCY ADAMS, WTC, G1 Career and Education Readiness Branch Chief
RICH BANNICK, Defense Health Cost Assessment and Program Evaluation

COL PRISCILLA BERRY, ASA(M&RA) MP, Assistant Director for Wounded Warrior Care and Transition

ALSO PRESENT (CONT'D)

PHILIP A. BRUDETTE, Principal Director, Office of Wounded Warrior Care and Transition Policy

MAJ TERESA CLARK, MPA, MA, Senior Health Benefits Analyst and Air Force Medical Operation Agency (AFMOA) Integrated Disability Evaluation Systems Operations Manager, Lackland Air Force Base

COL TODD POINDEXTER, USAF

COL HENRY SPRING, OTSG, Health Policy and Services Directorate, Medical Readiness and Standards Division

COL GREGORY SWANSON, Chief, IDES Task Force

CAROL A. WEESE, RN CNOR, Acting Executive Director of Federal Recovery Coordination Program

BG DARRYL WILLIAMS, WTC Commanding General and Assistant Surgeon General for Warrior Care and Transition

LTC MICHAEL C. WYATT, Chief of Air Force Warrior and Survivor Care

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

Site Visit Reviews and Administration 7

TRICARE Management Activity Telephone

Survey of Ill or Injured Service Members

Post-Operational Deployment 70

WWCTP - Evaluation of Task Force

Recommendations 131

Army WTC Briefing 229

Air Force Programs for Wounded, Ill and

Injured Briefing. 356

FRCP Update 438

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

2 8:14 a.m.

3 MS. DAILEY: Thank you, ladies and

4 gentlemen.

5 We've already sworn in our non-DoD

6 members, so that has been accomplished. And

7 so we're going to start with our 8:15 bullet

8 there on your scripts, Co-Chairs.

9 And again, welcome, everyone.

10 MS. CROCKETT-JONES: Thank you,

11 Ms. Dailey.

12 Welcome to the third business

13 meeting and our second year of effort. Our

14 last meeting was conducted in San Antonio, and

15 I'm sorry that I missed that.

16 We have two new members that I'm

17 happy to introduce to the Task Force.

18 Our new Veterans Affairs

19 representative is Ms. Karen Malebranche, a

20 retired Army Colonel. She's Acting Chief

21 Officer for Intergovernmental Affairs in the

22 Veterans Health Administration, and she's

already done some preliminary work with us.

LT GEN GREEN: Well, good morning, everybody.

We're also excited to have Captain Constance Evans from the Nurse Corps join us as our new Navy member. So Captain Evans is the Director of the Warrior Family Coordination Cell at Walter Reed National Medical Center.

MS. DAILEY: The research team has asked everyone to please check that you have filled out confidentiality agreements which can be found in the front pocket of your binders, for those who have not completed them yet. I know that some folks will have to do those. Yes.

Before we start, would each of the members introduce themselves? Can we start down here, Mr. Rehbein?

MR. REHBEIN: Excuse me. Dave Rehbein, National Commander of the American Legion Research Scientists, and just glad to

be back. Glad to be sworn in, even though I don't remember raising my hand.

CSM DeJONG: Commanding Sergeant Major Steve DeJong, National Guard Bureau.

MS. MALEBRANCHE: I'm hearing about the mute button a little bit earlier from my colleague there.

Karen Malebranche. I'm the Executive Director for Interagency Health Affairs, still the VA. We just reorganized, so the name changed.

Glad to be here after all this time.

MR. CONSTANTINE: Justin Constantine.

DR. PHILLIPS: Steve Phillips, Medical Doctor. I'm with NIH.

MG STONE: Rich Stone, Deputy Surgeon General, Army.

LT GEN GREEN: Bruce Green, Air Force Surgeon General. Your Co-Chair.

MS. CROCKETT-JONES: Suzanne

Crockett-Jones.

CAPT EVANS: Captain Constance Evans, Warrior Family Coordination Cell, Walter Reed Bethesda.

LTC KEANE: Lieutenant Colonel Sean Keane.

MSGT MacKENZIE: Master Sergeant Christian MacKenzie, USSOCOM, Superintendent, Community Outreach.

DR. TURNER: Russ Turner, physician, San Antonio and Newport News and points in between.

MS. CROCKETT-JONES: All right. We're going to begin today with a review of the installation visits we've attended since December with the Task Force visit to the Marine Corps Camp Lejeune and Fort Stewart in the past two months. Then we will have some time to talk about upcoming visits and business meetings and the timelines for this upcoming year which have been adjusted a little. We have some information at Tab B in

your briefing books.

Shall we start with Camp Lejeune?

Do you have anything you wanted to share about the visit to Camp Lejeune?

LT GEN GREEN: Yes. I actually truly enjoyed going down to Camp Lejeune. We saw some things down there that were probably the best seen anywhere. I'm trying to remember the name of the Lieutenant JG who was running their DES system -- Cook -- Lieutenant JG Cook.

But one of the things I was most impressed with as I visit sites is the amount of paper involved with the process. And they had actually streamlined that to where we need to make that model, I think, across DoD. Very impressive. And I've talked with multiple people since that time.

I'll let you guys comment. Mack?

MSGT MacKENZIE: Obviously, one of the things that we look at at many of the sites is the family programs. And it was

1 pretty inspired and got some real good
2 feedback on the family programs that they're
3 doing there at Camp Lejeune.
4 However, one of the things that I
5 was concerned with was the recovery care plan.
6 I think that the RCCPs -- we were being
7 briefed -- but that was used as a major tool
8 to effectively help in these guys' transition.
9 Yet we found that the Marine Corps in that
10 location was more reliant on their own six-
11 part folder. And when I was given, by one of
12 the company commanders, review, some of these
13 recovery care plans really were not complete
14 at all. If I was to look at them, they were
15 not an effective tool whatsoever. So we were
16 getting one bit of information but what we
17 were actually seeing was completely different.
18 MS. CROCKETT-JONES: Also, whereas
19 we have seen the CTP in other locations used
20 as an electronic format with lots of
21 interaction, the CRP at Camp Lejeune was only
22 accessible via paper and had to be requested

1 to be printed out. So it wasn't a very
2 dynamic tool, and it was pretty much unused by
3 the recovering warriors.
4 LT GEN GREEN: And I think in the
5 breakout groups, we also got from some of the
6 folks at least the same dichotomy in terms of
7 who's in the unit versus who's not in the WWR.
8 And so, there was still some -- I guess from
9 the members who talked with us at least -- how
10 do I get into the WWR and why am I still in
11 the unit versus someone else, which -- I don't
12 know -- Mack, that was my takeaway from one of
13 those -- or Dave.
14 MSGT MacKENZIE: No, sir. That's
15 definitely correct. And we've had some
16 discussion since then about that because there
17 was no real clear answer. Not nearly as bad
18 29 Palms, but even so, it was the same unclear
19 answer as to who's in, who's out and how do I
20 get there. And I really don't think that the
21 population needs to be asking how do I get
22 there. They should be there.

1 And so, I don't think it's
2 understood all the way down even to the
3 company level as to why that process is the
4 way it is.
5 MR. REHBEIN: I think it maybe
6 even goes a little beyond that focus group.
7 One or two participants that fall into the ill
8 and injured category that really feel --
9 really feel that they're not sure that they
10 should be there because that's the Wounded
11 Warrior Regiment. And so, there was something
12 of a why am I here in their minds.
13 But I want to go back to what
14 General Green said about the paper process
15 down there. I think that's the first time
16 that I have really seen, not only in this area
17 but in the VA experience that I've had, where
18 the people were really beginning to manage the
19 paper instead of the other way around. With
20 these kinds of medical records, it's awfully
21 easy for the paper to manage the people. And
22 I think that Lieutenant JG has really taken a

1 step that others can learn from outside of
2 DoD, maybe even into the VA.
3 LT GEN GREEN: I think the other
4 feedback that we gave them -- and actually
5 they were doing exceptionally well with a lot
6 of dynamics to keep families involved with
7 social events and different mechanisms for
8 getting communications out -- and yet as we
9 looked at some of the vocational stuff, they
10 were very active, had good vocational
11 counselors, et cetera. And yet when we talked
12 with people and talked with the individuals,
13 they really didn't feel as useful as they kind
14 of wanted to at that point, I think, is
15 probably the right way to say it.
16 That's a common problem when we go
17 to places where people are in the disability
18 process in terms of how much do they get for
19 their own personal processing and getting
20 through the system versus what do they do that
21 basically makes them feel valuable to the
22 system. And I don't think we've solved that

anywhere we've been in terms of how to basically find the right balance. I don't know that there is a right balance. But it's always an issue.

Denise, did we cover anything else that you saw that we brought up out there?

MS. DAILEY: Yes, sir. The only thought that I would like to bring to the table -- and it's something we should look at -- is the VR&E program had some miscommunications about how to get a letter rating so that they could refer people into the VR&E program, which was kind of the first place I had seen the VR&E program not be really well integrated. So that's something we should follow up on and talk to the VA about looking at their process down there for the letter rating.

LT GEN GREEN: Yes. I'm trying to think, though. Is that the same issue with the folks who were having trouble since they worked to get some vocational internships and

1 then were not able to proceed?
2 MS. DAILEY: No, sir. Part of
3 that was the geographical region in which TDY
4 kicks in. Some of the internships were
5 outside that geographical region which would
6 entail TDY and per diem being paid to
7 participants in those internship programs. So
8 we were all concerned that that might be a
9 constraint on people who've got good
10 opportunities to intern but the opportunities
11 are outside the geographical area. So that's
12 separate from letter ratings being generated
13 at the VR&E office down there.
14 MSGT MacKENZIE: Sir, that was one
15 of the big things was there was opportunities,
16 but number one, it was too far out and they
17 were being withheld. They were being held
18 back at Camp Lejeune because of the perceived
19 command and control complications.
20 And then the other thing too, as
21 Denise started to mention, was that it was
22 entirely too late in the process that VR&E was

1 being brought in. And by the time you get
2 your PEB rating is not the time to be looking
3 at education. If these service members are in
4 a position where they are leaving the service,
5 these types of things should be engaged much,
6 much earlier in the process. And when I
7 brought up the timeline, I kind of got that
8 look which was they were way too late in the
9 process in getting this VR&E access.
10 LT GEN GREEN: I think in
11 deference to the Lejeune program, I was
12 honestly very impressed. Although we're kind
13 of identifying some things that we think there
14 may be some areas for improvement, the reality
15 was it was a well run program and they had
16 their act together down there.
17 MS. CROCKETT-JONES: Yes. I'd
18 just to like to reiterate that their family
19 program was probably the first time we saw a
20 generally positive response from people who
21 had had access that we talked to. Family
22 members were way more pleased with the amount

1 of contact that they had than we have seen
2 anywhere else.
3 LT GEN GREEN: And even movement
4 through the program was good based on how they
5 had modernized their DES system. So they were
6 actually helping to get people through, which
7 I think played a little bit of a role in terms
8 of the VR&E and some of the folks who didn't
9 get some of the educational aspects because
10 they were moving through the system -- I
11 wouldn't say rapidly -- but they were moving
12 through the system in a timely manner.
13 MS. DAILEY: The other comment I
14 would like to make about the family programs
15 was it was policy within the battalion and
16 it's actually policy within the Wounded
17 Warrior Regiment that service members are
18 required to provide spouse information. And
19 if they do not provide it, they have to sit
20 down and have an interview with the battalion
21 commander.
22 That significantly empowered the

1 family service coordinators to reach out to
2 people. They had good information. They had
3 the support of the policy in the Wounded
4 Warrior Regiment to make contact with family
5 members.
6 LT GEN GREEN: Any other comments,
7 guys?
8 (No response.)
9 LT GEN GREEN: So overall, I think
10 a very good visit. Some things that I think
11 that we can take out and hopefully broaden.
12 I know I've talked with several people about
13 -- and even talked with Lieutenant JG Cook
14 again since that time -- about trying to get
15 some of the things that they have done into
16 other sites.
17 And so, clearly one of those
18 things we need to identify in the report is
19 the best practice, I think, eventually. But
20 we'll see where that goes.
21 Are there other site visits to
22 discuss?

1 Fort Stewart?
2 DR. PHILLIPS: Sean, do you want
3 me to go ahead? Do you want to go ahead?
4 LTC KEANE: I can start, sir, and
5 you can fix it.
6 One of the noticeable things was
7 that they were well prepared for us. The
8 briefs were well prepared.
9 We noticed some best practices.
10 They identified by name two MEB outreach
11 counsels as go-to people. Both of the service
12 focus groups mentioned them by name.
13 Again, a recurring theme, nurse
14 case managers, the majority were very
15 dependable. Those were their go-to people for
16 the case management. Occupational therapy was
17 also another noted best practice. And of
18 course, big kudos for the SFAC down there.
19 They had some concerns about --
20 and I think we've heard this before -- about
21 the CTP not often being read, not worthwhile.
22 However, if you didn't fill that out, you were

1 on someone's list.

2 There were some interesting

3 dynamics between the nurse case manager, the

4 specialties out in town and on base, and the

5 primary care physician. The primary care

6 physician often countermanded previous courses

7 of action by the specialties or what the nurse

8 case manager was working on which had some

9 conflict.

10 And spouses need to be informed as

11 early as possible -- kind of the reverse of

12 what's going on at Lejeune. It seemed that

13 the spouses weren't aware of what was going on

14 until much later. And we made one suggestion

15 which was to mail out to the spouses their

16 info lists, slip sheets and information early

17 on in the process.

18 Dr. Phillips?

19 DR. PHILLIPS: Yes. Let me just

20 add a few things and reemphasize that the

21 RSFAC was the center of their universe. It

22 really was. And the nurse case managers were

1 really the most helpful group.
2 There were some issues. And just
3 again not to be too repetitive, the
4 comprehensive transition plan was felt by
5 everyone that it was not very useful at all.
6 It was technically very difficult to use. And
7 again, the responses to the questions were not
8 responded to. We were even told in the focus
9 groups that people would put in outrageous
10 comments and they weren't even addressed. But
11 if you did not respond, you were in trouble.
12 Again, the families and spouses
13 were not involved. Major issues in the focus
14 groups. We didn't know what was going on. We
15 don't know what was happening. So that is
16 something that I think needs to be looked at.
17 And then as Lieutenant Colonel Keane
18 mentioned, that recommendation was made.
19 Focus group comments -- and these
20 were enlisted and officers -- not enough
21 education for the staffing cadre about how to
22 manage us; major issues again with being --

1 perhaps not major -- but issues with being in
2 a Warrior Transition Unit. Once you're in the
3 unit, all they want to do is push you out. An
4 example is that when you're in the unit -- and
5 there were a number of soldiers that were
6 telling us -- there was a directive from the
7 Vice Chief of the Army, no elective surgery,
8 only emergency, lifesaving, eye-saving or
9 limb-saving. Go to the VA for your surgery.
10 And so that was delaying the transition of
11 many of these folks.
12 If you missed an appointment --
13 again, we've heard this before -- there was a
14 punitive response to the point where they said
15 they've even got an Article 15 if you missed
16 your medical appointment.
17 Related to jobs, something I found
18 out that I wasn't aware of was that the only
19 job sites that you were allowed to be searched
20 were the federal job sites. You could not go
21 to the state or the city sites. That's some
22 sort of a rule. So that limits the transition

1 back into the civilian population.
2 And I may have this wrong, but for
3 the Reserve and Guard, tuition for further
4 education only covers college. It doesn't
5 cover vocational schools. And I think that
6 would be something that we should look at
7 because there are an awful lot of folks that
8 are not wanting to go to college. They just
9 want to learn a trade.
10 Basically I think that is it. The
11 two major issues were the spouses not being
12 involved and this issue about go to the VA.
13 You're done, so go to the VA.
14 MS. CROCKETT-JONES: Can I ask you
15 a question about the CTP confusion? Did
16 anyone ask if it was the same kind of
17 technical -- just not knowing how to use the
18 site? Remember we had -- or did we nail down
19 whether it was the training to use it properly
20 or if this was actual cadre response issues?
21 DR. PHILLIPS: It's multiple
22 levels, my impression was. Even the commander

1 and the staff said, well, the CTP will give
2 you a pulse of where the soldier is. It
3 doesn't serve the purpose of what it was
4 created for. And again, correct me if I'm
5 misstating this. But it does give us an
6 impression of what's going on.
7 Now, again I asked -- or someone
8 asked -- technically how difficult is it. Oh,
9 it's difficult to open. It's difficult to
10 load. If we're not in the office, it times
11 out. If I'm using my computer at home, we
12 can't connect. If you're not on by 6:00 in
13 the morning, there's not enough bandwidth.
14 Then people really just smirked even at the
15 officer-high level. No one ever responds to
16 what we put in. But if we don't check the
17 box, someone calls me.
18 MS. CROCKETT-JONES: Do you know
19 if they knew where to look for responses,
20 because that turned out to be an issue at one
21 place? We found out that some people actually
22 knew how to find the responses and some people

1 didn't. And it was more of a training issue
2 than it was an actual cadre response issue.
3 LTC KEANE: No, the cadre said
4 that they looked at it within 24 hours.
5 DR. PHILLIPS: And again, some of
6 the issues -- and sort of a paradox concerning
7 response. If they put down a behavioral
8 health problem, they were afraid they were
9 going to lose their three-day pass and things
10 like that. So it sort of became a game that
11 people were playing.
12 LT GEN GREEN: So the confusion
13 really is whether or not that's a
14 communication tool or if it's simply basically
15 a management tool.
16 DR. PHILLIPS: Yes. For dotting
17 the Is and crossing the Ts.
18 And again, universally at most
19 posts, we have not heard that this is helpful.
20 LT GEN GREEN: Just contrasting
21 the Active duty side versus the Reserve side
22 of this, so we were told very clearly at

1 Lejeune that when we talk with people, their
2 primary contact would be the platoon sergeant.
3 And that turned out to be true -- really very
4 true -- that whenever they needed anything --
5 I mean, yes, they had case managers. They had
6 RRCs. But really it was their platoon
7 sergeant that really was the person who was
8 their primary interface.
9 What would you say was the primary
10 interface for the reservists?
11 DR. PHILLIPS: Again, I think it
12 was their platoon sergeants. But there were
13 kudos given to responsive platoon sergeants.
14 Complaints about unresponsive and not really
15 related to anything except the lack of
16 understanding that they were injured or ill
17 and needed support.
18 Sean, I don't know if you have any
19 other thoughts on that.
20 Still, the nurse case managers or
21 the platoon sergeants, the one complaint the
22 officers had or some of them had -- we didn't

1 verify this -- was that I'm a major or
2 lieutenant colonel or whatever and I have to
3 respond to an E4 or an E5 who's yelling at me
4 about this or that. And that's causing some
5 trouble. And they don't understand I have two
6 dysfunctional hands or whatever.
7 MS. DAILEY: Sir, one of the
8 things that I saw at Fort Stewart that is --
9 and I don't know how it's being replicated --
10 I'll look for it at other installations. The
11 division surgeon and a team had a very good
12 process for identifying what I call the bow
13 wave coming into the IDES process. They had
14 everyone with a 30-day profile or a 30-day
15 limited duty paper identified, and they were
16 being case-managed. And they had a nurse case
17 manager. And these were people who were not
18 in the WTU which was everyone in the division
19 who was basically nondeployable. So everyone
20 had a nurse case manager. And then at a
21 certain time, there was a council of medical
22 doctors -- three doctors -- who reviewed the

1 long-term profiles or limited duties. And in
2 conjunction with the chain of command would
3 then move people, if required, into the IDES
4 system or would return them based on their
5 recovery to full duty.
6 So the whole division had a
7 pinpoint on who had the potential to move into
8 the IDES system. Additionally, that process
9 also afforded them visibility of high-risk
10 individuals in the division. So the complete
11 case management of profiles -- a nurse
12 assigned to everyone to move them through the
13 process, get them to their appointments -- and
14 then kind of an intermediary panel to either
15 move them into the IDES system in conjunction
16 with their chain of command or to return them
17 to full duty was a best practice that I would
18 like to look for at other units.
19 DR. PHILLIPS: I think that's an
20 excellent point. They were so precise
21 division-wise in the medical issues of the
22 soldiers that they even were able to say that

1 on this particular day, ten percent of the
2 division --
3 MG STONE: Let me walk through
4 this because the Army has had an escalating
5 problem with medical non-readiness.
6 We have tracked -- and this is not
7 publicly disclosable data -- escalating
8 percentages of our brigade combat teams that
9 are not medically ready. You'll find some
10 articles -- if you google it -- some
11 publications that have referenced it. And
12 we'll just leave it at that.
13 We instituted a year and a half
14 ago a soldier medical readiness campaign plan.
15 Part of that was to automate the process of
16 giving full visibility across the brigade
17 combat teams using an automated system called
18 e-profile that integrates with MEDPROS which
19 is our medical readiness system. But on any
20 given day, the brigade surgeon has full
21 visibility of every profile in the system and
22 is able to manage those subsets based on how

many days those electronic profiles have been out there so that our 10,000 that are in our wounded warrior command are really part of a larger population being managed that are not medically ready.

So we can share with you the profile system, the visibility of e-profile, the dashboards that gives the brigade commander. These are commanders' tools. But it's refreshing to hear that it was actually being used after we spent so much time. But it is a line commander's tool in order to really manage that non-ready population with the population we're paying attention to most closely which is a subset within that, but a true major initiative on the part of the Army in order to tackle the percentages of non-deployable because of medical problems.

DR. PHILLIPS: Thank you. I wasn't intending to be negative. I was being very positive about the fact that we have information that's very helpful in managing

1 this whole system.

2 MG STONE: I wonder if we can come

3 back to one other issue I think that would be

4 helpful for the Task Force.

5 We recently have had a lot of

6 contact with the First Lady's support team

7 about employment post-military service and

8 translating a number of our MOSs into

9 certified employment-related job qualifying

10 training.

11 The issue, especially in the Guard

12 and Reserve, of trade school, of educational

13 benefits. I would like us to take a look at

14 the First Lady's program and really make sure

15 that we in the Department of Defense are

16 aligned fully with what is a very high-

17 profile, very good program coming out of the

18 White House.

19 LT GEN GREEN: Actually, Rich, I'm

20 glad to hear that. I've been working for two

21 and a half years trying to get us to look at

22 how we train our enlisted to make certain that

they're giving them skills that will translate. For similar reasons though it's nice to hear that that's getting senior-level support. That's great. And obviously with METC, we have some opportunities. So this is a good thing.

MS. DAILEY: The other program at Fort Stewart that's worthy of note is they had 22 wounded warriors, not only from the wounded warrior battalion but also I think they said they had two individuals from the division who are participating out at a facility called FLETC which is their law enforcement program. It's about 15, 20 miles away. But they have over the years rotated a significant number of people through the FLETC program which had cooperated significantly with the wounded warrior battalion to create job sites and environments that the service members can serve in and can contribute. So we have a tape on it. We have a six-minute tape. I'll probably run it through one of the meetings --

through one of the intermissions. But the FLETC facility and the wounded warrior battalion for the internships have built a significant relationship.

MS. CROCKETT-JONES: Can I ask one more question about the SFAC?

Did you hear anything about a reduction in staffing? Were there any issues that the SFAC folks brought to you?

I know that they're being used well and providing a lot of services. But we had heard about some staff reductions in some places.

DR. TURNER: Without being very specific, there was concern about staff reduction, especially some key members and that the Director of the SFAC said she's working through that and hopefully it'll be solved. But there was concern.

LTC KEANE: And at the same time, they just received two legal assistants -- one lawyer and a paralegal. And I think they were

1 pending another paralegal. So on one hand,
2 they had lacking -- two people had left and
3 they hadn't filled the positions. So we're
4 concerned about that.
5 DR. TURNER: But this SFAC was one
6 of the best I've seen. It was a one-stop shop
7 for the soldiers and their families. They can
8 get everything from their ID card if they lost
9 it to legal advice, financial advice, helping
10 retrieve a DD-214 or any other types of
11 information, babysitting services or childcare
12 services. Really an excellent, excellent
13 organization.
14 MG STONE: Have we heard the
15 Soldier Family Assistance Centers are run by
16 installation management command? Has
17 installation management command actually
18 commented that they were intending to reduce
19 this asset in any way?
20 It seems like every place we go,
21 people say, oh, we're getting ready for cuts.
22 But when you talk to leadership of

installation management command, they say we have no plans to cut this. In fact, we're enhancing it. And I don't know whether it's a preemptive strike on behalf of the individual operating units to say, please, we're going to raise this to your level so that nobody can possibly cut us or whether we've actually heard that there is another lane of work going on.

LT GEN GREEN: I think there is some reality. I can't speak to the Army, but I know after we looked into this down with the San Antonio visit and talked with the Air Force, there are some cuts that are actually poised to occur. And so I verified that with A1 in our community looking at it.

And of course, there are plans in terms of how they're going to take care of the workload. But I can't speak to the other services. I do know we followed up on the San Antonio and verified there were some manpower cuts coming based on overarching budget issues

as the DoD now looks at this. So I think that it's realistic for us to expect that each of these programs may have impact from what's going on within the Department right now.

So a question on Fort Stewart. So can you give me any ideas on what's happening to numbers? So did they have any historical look at the numbers of people that have been there? Are the numbers coming down? Are the numbers staying stable? Just getting an idea.

We found that the Marine Corps, that their numbers had actually come down and that they were watching to see services available if the numbers continued to stay down. I think that's an accurate statement. But I don't know what is happening on the Army side. Did you get any sense of that at Stewart?

MS. DAILEY: Yes, sir. The numbers are down significantly. The impact of FRAGO-4 has brought the population of the Army's WTUs down significantly. Some of these

units at one time were 600, 500 people. Even as late as last spring, they were. The last few units we've gone to have been about somewhere ranging between 270, so to speak, or maybe 320, I believe was the highest we saw at Fort Knox last fall. So they are down significantly.

And generally what that means is that population is now outside the WTU being managed by the program that General Stone mentioned which is their management program for people who will not be deploying. Or they're in the IDES system. There was 300 people at the Warrior Transition Unit at Fort Carson. And there were 1700 in the IDES system on post. Similar at Fort Stewart, there was 265 people in the WTU. But there were 800 people in the IDES system on installation.

LT GEN GREEN: And the reason I ask -- and this is really for General Stone -- is to get an idea of, are we seeing a

transition. And I guess we can ask the Army program when they come in.

So it sounds like we're automating the tracking so you can actually track them in the unit. And that's what I wondered. Is the system that you're talking about so that you can keep more people in the unit?

MG STONE: I wouldn't say that the purpose is to keep more people in the unit. The purpose is to give commanders visibility so they can manage their non-readiness, so they can enhance readiness as we begin to bring down the Army, that we actually maximize however large an Army that Congress authorizes.

So I think the second piece of that is Henry Spring is coming in this afternoon who really manages these automated systems for us. And he should be able to talk to really the complexity of these systems and whether they're effective tools or not, as well as the relative use of these.

1 Certainly we've done well with the
2 implementation of these. We track each site
3 on a monthly basis. And you can give data on
4 the utilization of that. We have some areas
5 doing better than others. Some of our FORSCOM
6 institutions, our line institutions are doing
7 better than some of our TRADOC -- our training
8 and platforms. But he can talk to that. And
9 I would ask you to challenge him on the
10 utilization of that this afternoon.
11 LT GEN GREEN: Thanks, Rich.
12 Any other comments on recent
13 visits?
14 (No response.)
15 LT GEN GREEN: Okay. Denise?
16 MS. DAILEY: Thank you, sir.
17 Thank you, everybody.
18 If I can get you in Tab -- yes,
19 we're still in Tab B. If you would roll your
20 pages over.
21 What I would like to work on a
22 little bit -- we actually have an hour -- our

1 next briefer which will be Dr. Bannick from
2 Health Affairs will be here in an hour. So we
3 have some extra time to talk administratively
4 about our upcoming meetings and the report
5 that we'll be doing this spring and publish in
6 September.
7 So one of the first items you have
8 in front of you is a proposed timeline which
9 says as of February 6 -- no, not quite that
10 one, Phillip. That's it. That's the first
11 one in my book, if I could get everyone there.
12 There we go. Okay.
13 So this is kind of a proposed
14 timeline. We didn't have a January meeting.
15 I couldn't get the word out fast enough to do
16 a January meeting. So we rolled it into this
17 one, ladies and gentlemen, which makes this a
18 three-day meeting.
19 And the information I've put out
20 in an email -- two emails -- and I just kind
21 of wanted to kind of build the environment
22 here is that this was originally intended to

be the last data-gathering meeting. And the camp of 29 Palms was intended to be the last focus group -- set of focus groups and data gathered from an installation, that March into April would then be kind of a dark period so that the research staff could compile, synthesize, bring all this information together so that by the first of May, you all could get products, products that would allow you to start building and crafting recommendations, and have a couple of weeks in the first part of May to look at these instruments and to kind of get your head around the topics. And then the 15th of May -- 15th, 16th and 17th -- would in fact be a recommendation-building meeting. And the 15th of May would actually be what we did last year in those evening telephone calls.

Now, all best plans. We need to make up some installation visits. I originally planned 15. I only have 14 on the Statement of Work. I overbudgeted because

1 thinking I'd canceled at least one because of
2 weather.
3 We are making up one. We did not
4 go to the Indiana National Guard. Indiana
5 National Guard is coming to us. Excuse me.
6 Iowa. Iowa National Guard is going to come to
7 us tomorrow afternoon, and they're going to
8 brief us on readiness issues and resourcing
9 issues that they think are important for the
10 Task Force to hear.
11 I have re-scheduled Norfolk. And
12 the reason I re-scheduled Norfolk is because
13 I don't have any data on the Navy units at
14 all. And so, Norfolk is critical.
15 That leaves the Community-Based
16 Warrior Transition Unit in Iowa at Rock
17 Island. And it also leaves the Langley Air
18 Force Base.
19 It's my intention -- and I'm
20 looking for your feedback -- is to not do the
21 Community-Based Warrior Transition Unit in
22 Iowa for this report or Langley Air Force

Base. I've got good data on a Community-Based Warrior Transition Unit and we got a pretty good look at the Air Force Wounded Warrior Program. So I was going to hold off on those. I was going to do Norfolk on 12, 13 March. That is the absolute latest that I can collect data and get you a product in which you can get your arms around all of the data by the 1st of May so that you can synthesize it yourself and be ready on the 15th of May.

So that is what I'm proposing for getting our Navy material into the agenda and finishing up those touchpoints and then getting you your information so that by the 15th of May you can be on the ground and make good recommendations.

MG STONE: I would ask that we delay decision on the Iowa visit until you hear the report from the Iowa Guard. This is a brigade combat team that's been back I think about six months, though correct me if I'm wrong. They had over 1,000 line of duties.

They face some very unique challenges. And I would ask the committee to delay decision on whether you want to make a site visit until you hear what the TAG of Iowa is bringing to us by bringing his team out.

Thank you.

LT GEN GREEN: I guess the only hesitation I have is after hearing Rich tell us the scope of some of the things they're dealing with is that we get an awful lot of reports here but when we do the onsite, we get a lot of insight into the realities. And so, I'm not sure we wouldn't be wiser to go ahead and try and get that on the schedule for the visit so that we had that.

Right now, I think we have limited visibility in terms of the Reserve aspects of this, whether Guard or Reserve. And so, I think it might be beneficial to bring that into the report. But I don't know what the timing was or what the timing could be. So Denise, I have to rely on you to tell us when

1 that might be able to be scheduled.
2 MG STONE: One of my cautions here
3 is that when we went to St. Augustine to look
4 at the Florida BCT that had come back, we
5 found very substantial on-the-ground
6 disconnects. When we then went to the
7 community-based unit there in Florida -- I
8 think it was Orlando -- I'm not sure where we
9 were at that point -- but at that point, it
10 again was a huge disconnect where the Guard
11 was really struggling through policies and
12 programs that were not developed to support
13 the service member. The Iowa Guard gives us
14 an update to that from another BCT to really
15 judge the reality of this.
16 If in fact this can't be done as a
17 full visit, I think we need to look at
18 mitigating strategies. But I guess I don't
19 want to lead the committee down. I'd like you
20 to hear what Tim Orr's team from Iowa has to
21 say and then let you decide what you think is
22 the validity of their concerns.

1 But clearly, the community-based
2 WTU program needs a good hard look by this
3 committee on behalf of our COMPO-2 and COMPO-3
4 service members.
5 MS. DAILEY: Okay. Good. I'm
6 happy to have the discussion. I'll let you
7 look at it a little longer.
8 Let me get you to the next page
9 which is kind of a different timeline here, or
10 same timeline, just catching everybody up. We
11 are -- finished Fort Stewart. We're currently
12 at our business meeting. We're going out next
13 week to 29 Palms for kind of a follow-up visit
14 to last year.
15 Again, I have a three-day meeting
16 in May 15, 16 and 17. I'm adding more
17 installation visits in March and April. It's
18 going to be a product of your own memories
19 pretty much. It's going to be very difficult
20 for me to incorporate anything beyond the Navy
21 Norfolk visit on the 12th and 13th of March
22 into the products that you have. So your own

1 notes, your own recollections, those are going
2 to be the product that you'll bring to the
3 table for anything beyond that. I will not be
4 able to get products to you the first part of
5 May for the 15th meeting that would include
6 that material.
7 Next meeting would be in mid-June.
8 And that meeting, ladies and gentlemen, would
9 be pretty much -- it's my recommendation that
10 would be the meeting where --
11 LT GEN GREEN: Denise, we're just
12 a little worried. I'm just a little worried
13 that if we could get a meeting scheduled in
14 March that we couldn't have it by a mid-May
15 meeting. Really?
16 MS. DAILEY: Yes, sir. Look at
17 your books, ladies and gentlemen. You've got
18 two inches of material there that all have to
19 be incorporated into the effectiveness
20 documents that we provided you last year. The
21 focus group, we gave you a completely
22 synthesized focus group document both for

1 family members and for service members. It
2 takes a while to bring those products together
3 for you. And it takes us not having people
4 out on the road, the research assistants
5 getting their notes together and turned in.
6 This two months is critical.
7 And it is pretty similar to what
8 we did last year. We had kind of a dark
9 period before we gave you this material which
10 was the earliest -- I think we gave you
11 something at the end of May or mid-May -- mid-
12 May for the focus group products. And then it
13 wasn't until June I think that we were able to
14 get you a report -- or July.
15 Yes? Yes, ma'am?
16 LT GEN GREEN: So I guess the
17 question I would have is so what sites have we
18 visited. I just have to go back and look at
19 the calendar that gives us the CBTU visit or
20 vision -- yes, the community-based.
21 So what is it we're going to base
22 our report on then? Do we have a broad enough

1 spectrum to actually talk to the Reserve and
2 Guard issues associated with this?
3 MS. DAILEY: Yes, sir. We were
4 out at Boston -- Boston Joint Forces
5 Headquarters and then the downstream
6 community-based warrior transition at Boston.
7 We were at the Indiana Joint Forces
8 Headquarters. And we're bringing in for this
9 meeting the Iowa Joint Forces Headquarters.
10 So we really had three Joint Forces
11 Headquarters and one community-based warrior
12 transition unit.
13 We also looked at the Reserve
14 population at Fort Knox. Fort Knox was
15 primarily a Reserve component look.
16 MR. REHBEIN: Denise, with the
17 risk of sounding parochial because I am from
18 Iowa, I'm wondering and I'm agreeing with
19 General Stone here with that brigade combat
20 team just having returned so recently, I think
21 it would be a good idea for the Task Force to
22 get some eyes onto the process of just how a

1 community-based warrior transition unit
2 handled those numbers of people coming back
3 all at the same time. I mean, yes, I
4 understand and I was along on the CBWTU visit
5 in Massachusetts, but I think that process of
6 assimilating the numbers that they had all at
7 once and how well they handled that process,
8 I think that's something that would be good
9 for us to see.
10 DR. PHILLIPS: Again, being from
11 Iowa as well, I'm more than willing to wait
12 for the report tomorrow afternoon. But Iowa
13 is a little bit of a different place.
14 And this is just hearsay. I speak
15 with my colleagues and friends back in Iowa
16 and they are somewhat struggling with the
17 issues related to the return of these troops.
18 In a past life, I was voluntarily chief of the
19 VA surgical unit there. And so, I just hear
20 comments because folks know I'm on the Task
21 Force and they call me. So I think if we had
22 to choose whether or not to go based on time,

I certainly could find some time to try and go as well.

MS. CROCKETT-JONES: Well, I'd just like to point out that at least one thing we could get is a hard copy of the transcript of the focus groups which are a significant portion of our installation visits that reflect information we don't get from briefings. So that if we felt after we've heard from them that we need that balance to the information that we get, at least we can have the raw data of the transcript of the focus groups. That turnaround seems to be quicker. And we could get at least that to the members to include in the process even if it isn't collated in with the other data.

So if we do decide we need to make that visit, I think that we at least do have something we walk away from other than just the memory of those participating.

DR. PHILLIPS: I don't want to volunteer Dave, but I think between the two of

1 us if it's necessary, we can write up a more
2 formal report from what our impressions were
3 with the focus groups and then pass it on to
4 the staff, if that's helpful.
5 MR. REHBEIN: Yes, I'd be glad to
6 go along with what Dr. Phillips just said.
7 MS. DAILEY: Yes. There's a lot
8 of systematic work that goes on behind the
9 scenes to bring your focus groups into major
10 themes and then your subsidiary themes. I
11 mean, you saw the product last year. I know
12 it's hard to remember what it looked like, how
13 comprehensive it was, how it was synthesized.
14 A lot of stuff going on behind the scenes you
15 all don't see. So that makes it difficult to
16 give you comprehensive documents.
17 I know you don't see it so it's
18 hard for you to kind of value it. But it is
19 what gives your findings and recommendations
20 credibility because we can demonstrate a
21 systematic, comprehensive process of
22 evaluating all these documents.

1 LT GEN GREEN: At least what I'm
2 getting a little bit of consensus from the
3 group here is that we'd like for you to look
4 at what is possible in terms of a March visit,
5 whether we got the comprehensive information
6 back or not, or if that led to us having to
7 have a follow-on meeting later -- okay -- that
8 we could work with you. But I think if we
9 need to do some planning that we ought to be
10 ready to do that just because once they
11 present tomorrow, it would be very useful to
12 have a reality check of this is what they say
13 is happening and this is what we hear is
14 happening.
15 So if you wouldn't rule it out and
16 basically be able to plan that, we'll see
17 tomorrow. But I think that you're hearing a
18 little bit of leaning towards having it.
19 MS. DAILEY: Okay. And I would
20 like to truncate it somewhat. I'd be happy to
21 go to the community-based warrior transition
22 unit. I would have kind of checked the block

on the Joint Forces Headquarters having a full two-day review. So maybe just the community-based warrior transition unit after you all hear and see what the Joint Forces Headquarters says.

LT GEN GREEN: Can I get some head nods or thumbs up? Am I reading the group right?

Yes, Denise, that would serve us well. Thank you.

MS. DAILEY: Okay. Then let me also -- this is an iterative conversation. That's good. We'll take a look and we'll talk with Iowa Joint Forces Headquarters tomorrow and see what they have to say.

I want to highlight that we have moved your voting. Last year, you voted on the 15th of July -- excuse me -- late July -- 26th, 27th, 28th. We have kind of moved this process back to the middle of June. You're voting in the middle of June now.

LT GEN GREEN: There are a couple

of advantages to this. Last year, if you remember right, we ended up having to do a lot of phone work after the recommendations work. And so, trying to get the final report closer to June gives us July if we have to do some follow-up work. And so, we think that by doing this, it actually gets us a little bit closer, yet gives us time if we have to to do something into July.

And so, there's some other issues that are playing into this right now that I can't talk about as much. But I think the reality is that by doing it just a little earlier, it avoids what we ran into last year where we ran into some kind of time crunch, if you remember what happened.

So Denise, I appreciate you actually setting it up so we can get this a little earlier. And again, if we need to work in July, we shall.

MS. DAILEY: Okay.

So big meeting in May then. We're

1 going to be kind of crafting our
2 recommendations. And we'll talk again. We
3 have probably some time Wednesday morning --
4 tomorrow morning -- or Thursday morning to
5 kind of close out what you want the schedule
6 to look like and nail down any more visits.
7 I do need volunteers for Norfolk.
8 That's going to be the 12th and the 13th of
9 March. It is a Monday and a Tuesday five
10 weeks from now? Yes. So Monday and Tuesday
11 the 12th and 13th of March. Just let me know
12 if you're interested. We'll put you on that.
13 Okay. I would like in that
14 section, there's also -- if you'll turn the
15 page once more -- I do have some information.
16 You all had talked to us about social media.
17 I do have information in that same section
18 about efforts that we are working on to
19 outreach to the community, reference social
20 media. I'm going to give Steven -- Steven,
21 you want to give the Task Force like five
22 minutes about how we're outreaching in the

1 social media area?
2 MR. LU: Good morning.
3 We actually have two members --
4 Ms. Malebranche and Captain Evans. If you're
5 not familiar with me yet, my name is Steven.
6 I'm the web developer on the operations staff.
7 I wanted to talk to you guys today about the
8 social media development and our community
9 outreach efforts in this fiscal year.
10 The last fiscal year, we
11 established our Task Force website. It's our
12 primary conduit for sending out information
13 about our meetings, briefings. And it has all
14 the vital statistics about what we do -- our
15 charter.
16 We established our Facebook as
17 well last fiscal year, although we didn't
18 really focus on pushing it. So at the end of
19 our first year, I believe our participation
20 was around 40 members or 40 likes on our
21 Facebook. And we decided that it was prudent
22 to proliferate our social media efforts and

1 just try to focus more on involving the
2 community more.
3 In the last couple of months ever
4 since October 2011, our Facebook -- which I've
5 been pushing with the services, VSOs, MSOs --
6 we've swelled up from 40 likes up to around
7 650, 660 now. And our Twitter account, we
8 have over 120 or so followers. And these I
9 like to contrast against the passive nature of
10 our website because they are a much better way
11 to push information out. Once people follow
12 us, once people like us, the information that
13 we post gets published onto their feeds. And
14 they're able to receive information in a way
15 that doesn't require them to take the
16 initiative and go to our website to look it up
17 which makes it a lot easier for people.
18 We chose Facebook and Twitter only
19 because they are very, very common -- very
20 popular among the general public and the
21 community at large. I do believe the U.S.
22 Army has the largest Facebook community right

now. They're around 1.2 million members. And by tapping into these communities, getting our name out there, I think it's very important because they can't voice their concerns to us if they don't know that we exist.

With business meetings and installation visits, we also utilize Craigslist because it's just another way that we can get our name out there, let them know that events are being held in their area.

The one aspect of our push right now that I did want to speak to all of you about is the release of our blog. We do want to add this one extra dimension because we feel as though putting a more human face on the Task Force is a good way to get people to open up to us more. By getting more participation, we get better information, more participation of focus groups during our visits and during meetings for the public forum.

And that would require a bit of

1 participation on your part though. I do know
2 that Mr. Constantine, Mack and possibly Ms.
3 Crockett-Jones do have more experience with
4 just writing entries out or posts. But if we
5 can get some participation in that, we should
6 be able to get people more involved and just
7 get the word out concerning what we do and why
8 we're here to help and how we can do that.
9 So I was wondering I guess if I
10 could get any thoughts on that?
11 DR. TURNER: Could you tell us who
12 actually does the tweets and status updates?
13 MR. LU: That would be me. So
14 right now, I release Facebook updates, tweets
15 and Craigslist postings that coincide with all
16 of our activities.
17 Prior to installation visits, I
18 get in contact with base commanders -- their
19 public affairs offices, and I try to get the
20 word out.
21 The last fiscal year, our primary
22 way of getting participation in focus groups

1 was sending them PDF flyers and asking them to
2 post them up physically around the base. And
3 we think that we really do need to reach out
4 more to people. And with technology being
5 what it is, this really is the most effective
6 way because there are so many people out
7 there.
8 DR. TURNER: So if we wanted to
9 follow the tweets or the Facebook, what's the
10 account name?
11 MR. LU: It's just RW Task Force.
12 We actually do have quite a bit of
13 following only because I have been able to
14 network with the major service branches. So
15 one of the major pushes that we had was having
16 the U.S. Army, the Navy, Air Force, VA, the
17 marines -- all of them basically cooperating
18 with us and getting them on board. Because
19 when they recognize us or if they follow us,
20 their whole entire community -- like those
21 millions of people -- basically are given an
22 update. We're announcing that hey, we exist

1 and this is what we're doing. And it's a very
2 I guess easy way to do this compared to doing
3 it the conventional way which we're also
4 doing.
5 I spent a lot of time emailing and
6 calling MSOs, VSOs because that's the more
7 traditional approach to it. But we're trying
8 to push every way possible to get as much
9 participation and awareness out there.
10 MR. REHBEIN: Steven, what sort of
11 issues do you anticipate being discussed on
12 the blog?
13 MR. LU: With the blog, I am
14 hoping that I can have members just speak
15 about their experiences during the
16 installation visits -- your thoughts. The
17 thing is with most of these, we're hoping that
18 it won't go too much into opinions because I
19 can't have people speaking on behalf of the
20 Task Force in that capacity. But if I can
21 have just acknowledgments about either -- I
22 suppose you do get into some shaky territory

1 with anecdotal evidence. But it's just
2 important points that were the focus of these
3 visits and information that you've been able
4 to gather.
5 In order to put it into your own
6 voice and everything, I think that is a very
7 effective way of just connecting with people.
8 Because otherwise as it stands right now, all
9 of the communications that we have with the
10 general public that don't attend meetings or
11 these visits -- which is very small I guess
12 comparatively speaking compared to the
13 community at large -- the only way that they
14 hear anything from us is what we do online.
15 And I only post very official postings about
16 just our activities. And it really doesn't
17 have that human touch to it. And I'm hoping
18 to add that in.
19 MS. CROCKETT-JONES: So you're
20 looking for basically a personal reflection of
21 what would otherwise be public information
22 that we would share at the meetings?

1 MR. LU: Correct. And hopefully
2 done in a way I guess that integrates your own
3 personalities because we do want people to
4 realize that all of you are human, and you are
5 people that they can talk to and bring their
6 issues to because that is what we really need
7 to get good information at these visits.
8 DR. PHILLIPS: Steven, I want to
9 first commend you and the staff for doing
10 this. This is a tremendous tool. And all of
11 the government agencies are using, as you
12 know, these tools. And I can talk to you a
13 little bit offline about some of the things
14 that we're doing that might be helpful in my
15 division.
16 One thing about tweeting -- and
17 perhaps you are planning to do this -- if you
18 could capture someone that has a tremendous
19 following like an Ashton Kushner who has over
20 two million people following him, and if you
21 want to get a message out, that's what we do
22 responding to important issues.

1 MR. LU: Yes. I've actually been
2 very careful in my approach so far. And I'm
3 reaching out mostly to large established
4 organizations. So DoD organizations, I've
5 actually made contact with a lot of the
6 service academies as well because the issues
7 that we deal with affect all of them as well.
8 And networking with them is very important.
9 And also, the MSOs and VSOs, some of them are
10 active and others aren't. And right now,
11 we're just still trying to branch out as much
12 as possible. And it's a slow process, but
13 it's been pretty fruitful because our
14 participation has honestly just exponentially
15 been increased in the last couple of months
16 just through these efforts.
17 I will probably look into the
18 actual protocol of both the DoD and also our
19 status as a FACA committee in terms of trying
20 to reach out to just public figures. But yes,
21 I'll definitely look into that.
22 MR. REHBEIN: I'm intrigued by the

1 Craigslist entry. What is your plan there?
2 MR. LU: They do have an events
3 section where for example, the installation
4 visits. If we actually have an open focus
5 group, we'll actually announce it on
6 Craigslist because they have just general
7 event listings. And it's just one extra way
8 that we're trying to reach out to people
9 because there are a lot of people who use that
10 website. And it's just an extra conduit.
11 DR. PHILLIPS: One thing, it's a
12 bit more restrictive, but before perhaps we
13 get into an active blog, people would have to
14 sign up. But if we could get the information
15 out that we created a listserv, well, then
16 people can put bonafide information on that
17 listserv and sign up and spread it that way.
18 MR. LU: Yes. We've also been
19 looking into the possibility of an RSS feed.
20 But at this time, we're trying to take
21 everything step by step.
22 In terms of a listserv, the type

1 of information that we would actually
2 distribute through that would have to be
3 pretty carefully crafted. And yes, we'll
4 definitely look into that as well.
5 LT GEN GREEN: The other concern
6 that Congress has raised repetitively to at
7 least the surgeon generals is the numbers of
8 websites and the numbers of things that are
9 there. And so the other question would be
10 what efforts have you made to link this so
11 that there's kind of a single site so that
12 people can go and then come to our website
13 rather than having to try and re-establish the
14 entire marketing system, et cetera.
15 MR. LU: Correct. Actually with
16 the current executive administration, they did
17 mention an effort to consolidate the
18 government in general, at least in their
19 presence online.
20 For this Task Force, I primarily
21 use our official website as basically like the
22 home ground. All the social media points back

1 to it because for example, with Twitter, all
2 of the postings that I put on there are
3 limited to under 40 characters. So most of
4 the time, it's a small little blurb and a link
5 to either something on our website or to like
6 a Federal Register notice for a meeting.
7 Whereas with Facebook, I'm given a bit more
8 latitude, but at the same time I do reference
9 our primary website as the I guess preferred
10 method of information and just having it there
11 available for everybody.
12 LT GEN GREEN: The question I'm
13 kind of asking, so are you leaning towards can
14 they get to our website from one source or can
15 they get to our website from any of the other
16 major --
17 MR. LU: Yes. All of them feed to
18 the main website. And the others are pretty
19 much just methods to draw more participation.
20 LTC KEANE: So if I went on the
21 Marine Corps website, there would be a link?
22 MR. LU: No. Not the primary

1 Marine Corps website.
2 LTC KEANE: But the Marine Corps
3 OWR?
4 MR. LU: I actually have
5 connections with big Marine Corps. But the
6 Wounded Warrior Regiment, I don't believe they
7 actually returned that email. So yes, I'll
8 continue pursuing it.
9 MSGT MacKENZIE: So we can
10 obviously talk this round table quite a bit.
11 So I probably am going to want to interface
12 with you more, Steve, as we go through the
13 next couple of days I'm thinking, because I
14 think everybody's got some individual ideas
15 that need to be collated, and so certainly
16 more.
17 Thank you.
18 MR. LU: Of course.
19 MS. DAILEY: All right. Ladies
20 and gentlemen, there's one last page in Tab B
21 that I want to just let you know. It should
22 be the last page. It's the focus group and

one-on-one interview activity that you have done for the last four months now. So here's a compilation of all your efforts over the last four months -- five months now. We've been traveling since October. So keep that as a reference for you.

And it is a break time, ladies and gentlemen. We have 9:30. Please be back at 9:45. Dr. Richard Bannick from Health Affairs will be briefing us.

(Whereupon, at 9:29 a.m., the above-entitled matter went off the record and resumed at 9:49 a.m.)

MS. DAILEY: We are going to hit it pretty hot and heavy. I have a very compressed schedule between now and noon. So we'll go bam, bam, bam.

And I'm happy I'm catching you fresh for our first briefing from Dr. Bannick. This is probably some of the most comprehensive survey material available to the Department of Defense on individuals returning

1 from a theater and their care and their
2 transition through the process.
3 So I'll get Dr. Bannick up here.
4 I'm not sure which one of my co-chairs is
5 introducing him. But here we go.
6 MS. CROCKETT-JONES: Okay. We now
7 have Dr. Richard Bannick, the Director of
8 Performance Evaluations at OASD, HA. He's
9 been surveying recovering warriors since 2007.
10 His information is located in Tab C for
11 everyone to follow.
12 Thank you, Dr. Bannick. If you'd
13 like to take over.
14 DR. BANNICK: Thank you, ma'am.
15 If I can have the next one.
16 So I was asked today to present on
17 four different topics here, specifically to
18 look at our survey methodology that we have
19 been doing for just about five years now,
20 discuss some of the results that we have found
21 and discuss some of the significant
22 differences as far as within those results

1 what are we seeing. And that's what I'll do
2 today.
3 Next.
4 So, following the articles in
5 February 2007 in the Washington Post, the
6 Secretary of Defense initiated a number of
7 efforts to assess what was going on within the
8 military treatment facilities in military
9 health care. We were asked through our
10 deployment health office through OASD
11 personnel and readiness to health affairs,
12 finally to me, to develop quickly a survey,
13 field it, try to assess the extent to which
14 the things that were in the article were out
15 there and how extensive they were, whether it
16 was the medical hold or service members unable
17 to participate in their duties, whether or not
18 the lodging and the facilities were in as bad
19 a disrepair if that one facility sited
20 elsewhere, and to get this information,
21 quickly get it out and then work it with the
22 services and feed them information.

1 So we developed between February
2 17 and March and April timeframe this survey.
3 We worked with the services' survey
4 representatives. So we tried to make sure
5 that we created question sets that were worded
6 sufficient for each of the service members to
7 understand. One of the most interesting one
8 at the time was medical hold. This was just
9 at the time that warrior transition units were
10 being developed. Prior to that then when we
11 developed this, it was medical hold, medical
12 holdover, depending on if you were active duty
13 or reservist, awaiting medical board if you
14 were Air Force -- lots of different
15 terminology but all trying to get at the same
16 thing -- this thing called disability
17 evaluation system. So we worked with the
18 services, put the survey to field back in May
19 of 2007, and have been doing it monthly ever
20 since.
21 We are now at the point where I
22 will present today the 50th cumulative monthly

1 results. And I'll walk you through those to
2 help understand and take any questions if you
3 have any issues or questions with these data.
4 We're at our 50th month. We've
5 actually accomplished about 56. We reported
6 every month on a protected Internet site for
7 our service representatives to look at the
8 data. So we actually have about three or four
9 months beyond this right now. But we report
10 it quarterly to the surgeons general, to OASD
11 personnel and readiness, to a number of other
12 offices, including recently the Warrior Care
13 Transition Program Branch.
14 Next.
15 So the survey methodology. We're
16 trying to get at service members who we
17 understood were wounded warriors without
18 having a definition of what a wounded warrior
19 was. So the easiest place to get information
20 at that time was aeromedical evacuation.
21 So we were able to obtain
22 information about the number of service

1 members of all services being aeromedically
2 evacuated out of theater. It's doesn't mean
3 back to the states. Out of theater. So at
4 the time, we were surveying them within 30 to
5 45 days of being aerovacced out of theater.
6 It could be Landstuhl where many of them were.
7 Or they were being co-located at central
8 spots, especially at Walter Reed at that
9 particular time.
10 We presented these results through
11 Deployment Health, the office that we were
12 supporting at the time, who then presented
13 these results -- provided these results on a
14 monthly basis through their Deployment Health
15 report to the services. But it was focused
16 only on the aeromedical evacuees.
17 At the time, we were surveying
18 maybe 400, 500, 600 a month, getting about a
19 25 percent yield just raw -- how many we got
20 back versus how many we surveyed. But
21 actually even back then, 45, 50 percent down
22 to 42 percent overall -- a 42 percent response

1 rate. And the reason for that is a lot of the
2 aeromedical evacuees had already returned to
3 theater. They were pulled out of theater,
4 assessed, treated, returned to theater. We
5 excluded them. So we don't survey anyone
6 that's back deployed.
7 When they came back, we also
8 excluded those that were still in inpatient
9 facility. They were still in a hospital bed.
10 Didn't want to interrupt any treatment,
11 disturb them at all.
12 But aside from those two major
13 areas, we're getting a good response rate, but
14 really focused on individuals newly returned
15 from theater.
16 We reported this for about 12, 14
17 months. Dr. Chu at the time -- OASD -- OSD
18 Personnel and Readiness -- wanted us to expand
19 our perspective to try to cover more of the
20 service members' experience with the health
21 care system. Because again, our focus was
22 what's going on out there, how are they

1 experiencing the military health system, what
2 is their medical hold situation like. And
3 this was a worldwide telephone survey.
4 So we expanded it to four
5 additional cohorts to a group to a total of
6 five. So we continued with the aeromedical
7 evacuations. So if you think of a line going
8 along, every month we report the data up and
9 down on a particular question -- all
10 aeromedical evacuation within 30 to 45 days of
11 individuals coming out of theater.
12 Then between months 17, 18, 19, we
13 expanded it to the four additional cohorts you
14 see here -- those aeromedical evacuees one
15 year later. So this is the only group we
16 might survey again. All others are mutually
17 exclusive. But one year later to see how they
18 are doing.
19 Three other new groups, those that
20 we DoD referred to the VA for health care, and
21 they were treated. So we added some questions
22 so we can assess how DoD was helping our

1 service members transition for VA care. It
2 was not to assess VA care. It was are we
3 taking care of you, do you feel like you
4 received the support from DoD that you needed
5 to get this care, were your medical records
6 available. Those are the two principal
7 questions.
8 Then we looked at post-deployment
9 health assessments -- those forms that
10 individuals complete upon preparing to depart
11 theater or shortly after they arrive out of
12 theater into their units, very quickly coming
13 out of theater though to assess their health
14 care needs.
15 And in addition to an individual
16 self-reporting, we focused on where a provider
17 assessed that individual's self-reported
18 information and said yes, there is a medical
19 or spiritual condition that we recommend you
20 need care for. All right? Post-deployment
21 health assessment coming out of theater.
22 We also included those members 100

1 percent that completed a post-deployment
2 health reassessment. That's that reassessment
3 that occurs three to six months after
4 returning from theater back to your unit, back
5 to civilian life perhaps. But again, for
6 those medical issues -- those problems that
7 might surface after the individual is out of
8 theater.
9 So those are the five cohorts.
10 Next slide, please.
11 We have data sources, as I've said
12 there. So whether or not they're
13 aeromedically evacuated, whether or not
14 through medical surveillance records, these
15 PDHAs -- post-deployment health assessments,
16 post-deployment health reassessments -- were
17 completed whether or not there was a
18 recommendation. And finally, also we made
19 sure that we can find through our health
20 records system that the individual who was
21 recommended for care, was referred for care,
22 who was aeromedically evacuated for care,

1 subsequently touched the military health
2 system. And so we looked through inpatient
3 records and outpatient records to see if care
4 was actually rendered. So that would give us
5 five cohorts of individuals who were advised
6 to seek care and who received care.
7 I can't tell you. We never did
8 focus on did they receive care for what they
9 were advised to receive. It was just did they
10 touch the system. Therefore, are they
11 qualified to evaluate our system? In other
12 words, do they have something to say -- some
13 experiential reference point to say yes, I
14 don't like the system, I do like it, or it's
15 typically I liked it here, didn't like it
16 there.
17 Okay? Next slide, please.
18 So over all, we have sampled over
19 200,000 individuals, received complete
20 responses from over 50,000 -- 52,000, 53,000.
21 The breakdown of who we sampled is shown here
22 and the responses that we received.

1 And for the most part, with the
2 exception of officer enlisted, these are not
3 statistically different.
4 So you want to know that because
5 you want to worry about a nonresponse that's
6 going on. So you survey men and you get X
7 percent of men and you get a higher response
8 or a lower response. Do you need to look at
9 the data a little bit differently to offset
10 that -- to weight accordingly?
11 I said earlier that we for the
12 most part surveyed a census -- a 100 percent
13 of whatever the cohort was. We certainly did
14 it for the air evacs and have continued for
15 the follow-up air evacs. When we first
16 started around wave 17, it was not a complete
17 100 percent of the post-deployment health
18 assessments or the post-deployment health
19 reassessments -- one of those two. It lasted
20 about a month or two because we were capped at
21 how many surveys we can actually do. And the
22 numbers were actually exceeding what our

1 estimates were coming out of theater. But
2 it's been 100 percent since.
3 So the point is we're surveying
4 within these five cohorts -- these five groups
5 of people who have a health care need,
6 received health care services, touched the
7 system, haven't returned to deployment -- what
8 their experience is. That's both the extent
9 and the limitation of the survey.
10 It is worldwide. It's done by
11 telephone. When you do surveys, there are
12 modal effects whether you do a survey by phone
13 or you do it by mail or you do it by website.
14 Typically, a telephone survey is more
15 expedient. You get your information back.
16 Usually you get a higher response rate.
17 People tend not to drop off once you've got
18 them on the telephone. But they do. And
19 thirdly, oftentimes there's a slightly higher
20 modal effect. People tend to be a little bit
21 more happy, responsive, satisfied when they
22 answer a telephone versus those that might

1 answer it privately in the mail or on a
2 website.
3 I say that because this is all the
4 same mode. And where I'm going to show
5 trended data, it's the same question and the
6 same ratings. And for the most part, it's 100
7 percent of those that we were looking at, we
8 surveyed with a 42 percent response rate, and
9 the response rate was about equivalent to who
10 we were trying to survey. So we didn't see
11 any bias in the responses.
12 Yes, ma'am?
13 MS. MALEBRANCHE: I'm just curious
14 only because having done so many of these
15 survey things. How were you able to or what
16 was your numbers in terms of -- I mean, the
17 phone numbers? You had good phone numbers on
18 how many people that you're talking about?
19 DR. BANNICK: That is a really
20 good methodological question.
21 The answer is no, we didn't.
22 These young service members are coming out of

1 theater. When we first started this, they
2 were coming out of theater very quickly --
3 worldwide, coming out of theater. And when we
4 went to the standard repository of information
5 -- DEERS -- Defense Eligibility Enrollment
6 Reporting System -- a lot of the phone numbers
7 there were out of date.
8 What we found was a lot of these
9 individuals were carrying cell phones. And
10 they apparently were switching cell phones
11 even prior to going to theater and coming out
12 of theater. We saw that though when we were
13 starting to develop our methodology.
14 So what we did was -- I said that
15 we made sure that the individual touched the
16 system in some way. When we do that, we can
17 go back through some records and look for any
18 appointment logs where a phone number was
19 given for a follow-up appointment. So what we
20 found was we were able to provide up to three
21 phone numbers, more often than not cell phone
22 numbers, for these individuals.

1 Having said that, there was about
2 a third of who we tried to contact, we did not
3 have good phone numbers on them. Had we
4 relied on our typical system that we used with
5 addresses typically and phone numbers, it
6 would have been a lot higher.
7 MR. REHBEIN: Sir, I would have
8 guessed that the marines would be a higher
9 percentage of the sample. I'm surprised to
10 see the marine percentage less than the Air
11 Force, not that I think the Air Force is not
12 getting -- you understand what I'm saying?
13 DR. BANNICK: I do. I do. So
14 that's why I defined those five cohorts
15 because I figured we're going to get into that
16 discussion as time goes on. Do we have the
17 right mix of who's serving on operational
18 deployment and then coming out of theater in
19 some sort of ill, injured, wounded status?
20 What I can tell you is when we
21 first started the survey and it was
22 predominantly air evac and probably even when

1 we switched into the other four cohorts, the
2 marines were about 10 and 11 percent of who we
3 surveyed and who we received responses from.
4 And over time, the marine percentages have
5 dropped, and the Air Force numbers have
6 increased.
7 So we've gone back probably at
8 around the 30th month, we went back to the
9 post-deployment health assessment, post-
10 deployment health reassessment records, talked
11 to the offices and found that yes, there are
12 differential completion rates of by service as
13 to who completes these forms. I can't tell
14 you what they are, but there are different
15 ones. And there are differential definitions
16 of -- if you will -- boots on the ground to
17 define that they in fact are deployed in an
18 operational setting. So the Navy I understand
19 has a lot of forces afloat, but only a certain
20 group. And I'm going beyond my expertise now,
21 but has only a certain group of those then are
22 considered boots on the ground, have certain

1 type of deployment orders, and then are
2 required to complete a PDHA or PDHRA upon
3 return.
4 So I can tell you that this is as
5 good as our data is showing of those who we
6 survey. And we are taking a census, as I
7 said, of all that information.
8 MR. CONSTANTINE: Sir, what is the
9 percentage of marines who are airlifted -- not
10 who respond to the survey -- but of those who
11 are airlifted -- what's the percentage of
12 marines?
13 DR. BANNICK: I don't have that
14 right at my hand -- I could get it -- of that
15 information that we produced. I don't have it
16 at the moment. If I could have, Laura?
17 LT GEN GREEN: So Dr. Bannick,
18 just a couple of questions on methodologies
19 here.
20 So you say your overall sample is
21 205,000, if I'm reading this right. But
22 what's the total numbers of deployers from

1 '07? I mean, since you're talking PDHRA and
2 PDHA, since everyone that deploys is supposed
3 to fill those out, what's the number of people
4 who fill those out compared to your sample?
5 DR. BANNICK: Good. That's 100
6 percent of the PDHAs and the PDHRAs -- the
7 sample, 100 percent, except for that first
8 month or so that I was talking about where --
9 LT GEN GREEN: So the Air Force
10 sends roughly 30,000 to 35,000 people over on
11 now six-month rotations. So I would expect
12 60,000 times -- now this is 11 -- that'd be
13 four years. Four times 60,000 would be
14 240,000 just Air Force deployers.
15 DR. BANNICK: Yes, sir. Again,
16 it's 100 percent of the -- I actually ask for
17 the data every month and receive it from the
18 health deployment medical surveillance office.
19 So I get the number of PDHAs and RAs by
20 service.
21 LT GEN GREEN: But you understand
22 why your numbers are somewhat suspect right

1 now. As I look at this, it's not all the
2 deployers. If you're using PDH right now, I
3 don't know when you start to change your
4 methodology. So when did you start using PD
5 --
6 DR. BANNICK: Seventeenth month.
7 So for these data, about 33 months ago.
8 MS. CROCKETT-JONES: These aren't
9 all PDHRAs and PDHAs. They're only if they
10 have a referral.
11 DR. BANNICK: Yes. Okay. Good
12 point. Yes.
13 They had an indication by the
14 provider that -- they call it a
15 recommendational referral -- but it's not
16 mandatory. But yes. Any indication -- thank
17 you -- any indication that there was a medical
18 --
19 LT GEN GREEN: So it's a positive
20 finding that required follow-up?
21 DR. BANNICK: Right.
22 LT GEN GREEN: Okay. So that

1 helps.

2 So then the other question is was

3 there a reason why you're not working with the

4 services' WW2 programs to actually survey the

5 people who we know are in the program?

6 DR. BANNICK: This goes back to an

7 issue of when we started finding that -- I'm

8 jumping ahead on the data here -- but when we

9 found that there was one aspect of the

10 disability evaluation system, I've never had

11 access to a centralized database of those who

12 are -- sir, is this like a warrior transition

13 unit or a disability IDES -- the WW2?

14 CAPT EVANS: The WTU tracks all

15 their soldiers that are assigned. And they

16 track also the ones that are in the disability

17 system. So I'm not sure the survey and WWR

18 are the same. So when we sit down for a

19 meeting, we have a list of the one that's

20 assigned to the WTU or to the WWR. So I'm not

21 sure why the survey you didn't go back to

22 those units to survey the folks who are coming

1 out of theater. And I'm not sure why you used
2 a phone system because from Landstuhl, they're
3 either going to go to SAMC or Walter Reed-
4 Bethesda, San Diego. So you're able to survey
5 directly at those hospitals. Rarely do we
6 overfly to -- occasionally we do -- but rarely
7 do we overfly to one of the other hospitals
8 because the services are usually at one of the
9 tertiary centers. So I would think that your
10 survey would start there and then move out to
11 the transition at the units.
12 DR. BANNICK: So there's two
13 statements there. One is why didn't we obtain
14 this database? I'm not aware of a centralized
15 database that covers all services back when we
16 started this or when we modified it back on
17 the 17th through the 18th, 19th months. And
18 this was particularly acute with respect to
19 the disability evaluation system that then
20 became the integrated disability evaluation
21 system. Did not have access to a centralized
22 database.

1 If there is one, I would love to
2 add that, and depending on our ability -- the
3 resources to sample from that.
4 MR. CONSTANTINE: Each service has
5 one though, right? There is a central one.
6 There's four.
7 MS. DAILEY: Correct. Everybody.
8 Each service has a satisfaction survey for
9 their warrior in transition units in their
10 programs except the Air Force who has actually
11 hired RAND to come in and do a program
12 evaluation.
13 I was talking with my GAO cohort
14 over here. They did not validate the Army's
15 survey system in that they thought they needed
16 to go back and resolve the nonresponse, right?
17 The Navy's Safe Harbor program
18 only has a six percent return rate. And I
19 don't have any information on the Marine Corps
20 system.
21 The reason I brought Dr. Bannick
22 in is because it is the only comprehensive

1 cross-survey, cross-service, cross-program,
2 long-term survey out there. It is the one-
3 stop repository.
4 DR. BANNICK: Thank you. And I
5 would also say again, development of the
6 questions on the survey, looking at the data,
7 I've worked with the services survey
8 representatives. So coincidentally since the
9 very beginning, I've spent an awful lot of
10 time with the Army's Office of Surgeon
11 General's survey representative where we've
12 looked at the questions and facilities and to
13 see if we can kind of corroborate some of our
14 information.
15 Next slide.
16 This just is a pictorial of the
17 domains of the questions.
18 We ask approximately 34
19 questions. Some questions have little
20 subsections below them. Not everyone answers
21 these questions unless they participated in
22 the various domains that we're talking about.

1 So one of the very first set of questions are
2 on medical hold, hold-over, WTU, warrior
3 transition brigades -- anything related to
4 that. There's about seven questions on that.
5 So if an individual says no, then they don't
6 go onto those questions. Then we talk about
7 the VA -- support to the VA -- then outpatient
8 health care and your health status and any
9 other concluding comments.
10 The typical question is a five-
11 point Likert scale. One to five ratings --
12 and we say typically poor for one, five for
13 outstanding. And we let the service member
14 fill in what the two, three and four are. So
15 it's a five-point scale.
16 And then you'll see later on where
17 we'll talk about the bottom two ratings and
18 the top two ratings. The bottom two are those
19 that rate a one or a two on that five-point
20 scale. And we create a proportion. So if 100
21 people answer this particular question, 20 of
22 them rate a one or a two, then the bottom two

1 would be at 20 percent. And the top two would
2 be those that rate a four or a five. So that
3 would be eight percent there. And then we
4 compare these percentages for across time and
5 across services within these domains.
6 Next slide.
7 So there's a lot of text here.
8 You have a chance to read it.
9 For the most part, after we got
10 through the beginning year of this survey and
11 reporting this on a monthly basis, the lines
12 were going all up and down because they're
13 relatively small numbers -- 200 to 400 -- lots
14 of variation on a monthly basis. We collapsed
15 the data around the 17th to 20th month to
16 quarterly which tends to reduce the variation
17 a little bit across the system -- across the
18 MHS -- military health system.
19 And then depending on the service,
20 you may see a lot of variation or little
21 variation. And I have some slides in here
22 that are not meant as eye charts, but they are

1 meant for you to be able to stand back and
2 look at wow, look at these lines going up and
3 down -- and I'll talk to that in a little bit
4 -- whereas other lines are pretty stable.
5 I will say that approximately 80
6 percent of those who we survey and
7 approximately the same percentage of those who
8 respond are Army. So when you look at the
9 underlying data, truly how the service
10 members, how the soldiers respond to this
11 survey to a great extent influences the
12 overall military health systems ratings.
13 But we can look at individual
14 services, and especially over time where we
15 can accumulate enough responses, we can say to
16 the services, here are your facilities, here's
17 how your service is doing on this question,
18 and provide that information. Don't provide
19 recommendations. We do indicate this is where
20 we see of the questions that are being
21 responded to where there might be some
22 problems, or where we don't see any changes or

1 where we don't see any problems.
2 So there's a lot of verbiage here
3 that tells you the specific slides. And we
4 will discuss those.
5 Next slide.
6 But our focus has been since day
7 one on those areas that are problematic. And
8 so I'm showing them here on this slide.
9 Within the few questions we ask about the
10 disability evaluation systems, specifically
11 the Medical Evaluation Board and the Physical
12 Evaluation Board. Once we get through some
13 gate questions about you'll know if you're in
14 an MEB if or if you're in that situation, now
15 we'd like you to rate your MEB experience on
16 a one to five scale. What we have found that
17 those that rate the MEB unfavorably have been
18 in the 30 percent or almost a third of those
19 that are responding. Those that responded
20 that they were involved with an MEB rated
21 unfavorably for some time. But it has
22 declined. Those that rated it favorably was

1 at a certain level and have increased. And
2 I'll show you that next slide.
3 Sir?
4 DR. PHILLIPS: I'm just wondering
5 if you applied any statistics to that, ratings
6 continue to hover between 20 to 25 percent
7 compared to 30 percent. Is that statistically
8 significant?
9 DR. BANNICK: Yes. That phrase is
10 not statistically significant. The fact that
11 whether there was an increase or no increase
12 was statistically evaluated for an upward or
13 downward or no trend. So when I get to that
14 slide, I'll show you what we mean there. And
15 when I say it hovers between 20 to 25, that
16 seems to be where it is right now. It was at
17 30. So it's come down, and then it just
18 bounces along.
19 When I look at the whole trend
20 line, then I can tell you the whole line or
21 the part that we're talking, about whether or
22 not there was a statistically significant

1 difference from a zero slope. No change. And
2 we take all the data points in mind when we do
3 that through a regression.
4 DR. PHILLIPS: So you're looking
5 at percent change or actual numbers?
6 DR. BANNICK: It's actual numbers.
7 But it's all the data points -- the 50,000
8 data points -- fours, threes, twos, fives and
9 all that. You create a regression line, a
10 statistical line. And you try to plot it so
11 it fits all those points the best way. And
12 then you look for a positive or a negative
13 slope, and then statistically evaluate is it
14 significantly up or down.
15 Sir?
16 MG STONE: So since May of 2007
17 when the survey began, you've been at about
18 the same range. Can you give examples of
19 actions that have been taken based on these
20 surveys that have attempted to impact the
21 satisfaction level?
22 DR. BANNICK: I can give you

1 examples from what has been told to me. But
2 that's really for the services. Mine is to
3 provide the information to the services for
4 action.
5 MG STONE: And who in the services
6 are the action officers that you are turning
7 the data over to that we might look to to see
8 how they've responded to the utilization of t
9 his information?
10 DR. BANNICK: The survey
11 representatives from each of the services who
12 participate in a quarterly survey working
13 group with me are the survey experts that I
14 provide these data to monthly and quarterly
15 before it goes to the senior leaders. And
16 then on a quarterly basis, these reports go
17 from the Assistant Secretary of Defense for
18 Health Affairs -- now Dr. Woodson -- to the
19 services' surgeons general and to the other
20 medical components, as well as the Office of
21 Personnel Readiness. So the Personnel
22 Readiness used to be MPP -- now they're

1 Wounded Warrior Care Transition Policy Group
2 -- we give these data to them and that they
3 incorporate it into their decision making,
4 their analyses as well.
5 And what they do with it beyond
6 that, they usually don't tell me. I talk to
7 the survey reps about what's going on and what
8 our results are and what they're seeing.
9 MG STONE: It would be helpful to
10 understand who your liaison reps are, not
11 within this briefing, but afterward if you
12 could provide us who your reps are so that we
13 could take a look at how this data is being
14 used within the services.
15 DR. BANNICK: Certainly.
16 I will say -- and thank you for
17 the question -- the slide you're seeing here
18 with a few exceptions are exactly what we
19 report to the senior officers that I presented
20 in the third or fourth slide. I've rearranged
21 them a little bit to make sure I cover the
22 five points that were asked for for this

1 briefing. I've taken some slides that are
2 typically in the background, for example, the
3 methodology. The surgeons general don't need
4 to see the methodology slides every quarter.
5 So I've rearranged them a little bit. But
6 these are the data that are presented.
7 MS. MALEBRANCHE: I know this is
8 part of the Department of Defense that you
9 were commissioned to do this. But do you also
10 give the information for the VA back to
11 anybody at VA? Or is it the services then
12 that go back to the VA with all theirs?
13 Because we've been looking a lot in VA at VA
14 referrals and our response rate and how things
15 are going. So I just didn't know if that
16 information does not --
17 DR. BANNICK: I do not provide it.
18 And it's not transmitted in our memos from the
19 Assistant Secretary of Defense for Health
20 Affairs.
21 MS. MALEBRANCHE: Okay.
22 DR. BANNICK: Other offices may

1 then provide it to the VA.
2 When I first started this, I did
3 discuss this with the VA and carried the
4 discussion to the -- I want to say the HEC.
5 I can't remember. I think it was the HEC.
6 MS. MALEBRANCHE: That would be
7 the HEC. Yes.
8 DR. BANNICK: Looking at setting
9 up common questions in our respective surveys,
10 but nothing really materialized. I think the
11 VA was happy with their surveys and we're just
12 starting ours off.
13 MS. MALEBRANCHE: Okay. Thank
14 you.
15 MG STONE: I wonder if you could
16 share with us how many personnel are engaged
17 in your office in this, as well as what the
18 total budget is for the program.
19 DR. BANNICK: I am it for our
20 office. I use an analytic contractor to help
21 me develop the sample. I am involved in
22 obtaining pieces of the sample -- the PDHAs

1 and the PDHRAs.
2 The analytic contractor supports
3 me in developing the sample database,
4 analyzing the data when we get them back.
5 They have a subcontractor that actually does
6 the fielding and the telephone calling.
7 Total cost is I think it's $1.4
8 million. In the current year contract, we're
9 going to scrub it by about $400,000 this year.
10 So about a $1 million to do a worldwide, all-
11 service census survey.
12 MG STONE: Thank you.
13 DR. BANNICK: So this is the only
14 time I'm going to show this slide. But the
15 purpose here is to give you an example of
16 medical hold ratings by all service members
17 that responded. I've drawn a line here where
18 to this point it was all the aeromedical
19 evacuees. So we had one of those five
20 cohorts.
21 Then during this time period --
22 and we've stated them there -- we changed our

1 survey and expanded it both in extent --
2 broadened it to a large number of service
3 members that were self-identified and then
4 professionally identified as needing health
5 care. And over time, we backed off and
6 assessed those PDHAs which are one year ago.
7 So that gave the individual one year to deal
8 with the health care system -- one year to get
9 into or out of the disability evaluation
10 system.
11 I say that because there are other
12 weightings. I'm going to show them again.
13 But from that dashed line onward where you
14 have all five cohorts.
15 LT GEN GREEN: So, Rich, this is
16 the only longitudinal cross-service survey of
17 returning warriors, okay. I'm not sure we can
18 say recovering warriors, but people who have
19 a medical concern. Do you read this the same
20 as I do that in essence nothing the Department
21 has done since 2007 has changed satisfaction
22 with the program?

1 DR. BANNICK: I wouldn't read it
2 exactly the same way, General. But I see your
3 sense of a stable trend line. But I've
4 indicated where there are statistically
5 significant changes over time. So lodging,
6 managing duties, meeting basic needs have
7 increased during this period of time. So
8 those ones actually did increase.
9 And pardon me, I should have said
10 to begin with, I will typically show two types
11 of slides here. The bottom two ratings --
12 those that rate a one or a two on a five-point
13 scale. So down is better. Or the top two
14 ratings -- fours or fives -- where up is
15 better. So this particular example is up is
16 better. You're right. We'd love to see the
17 lines going all the way up. But that's why
18 I'm showing the slide is that there are some
19 changes and others are static.
20 So if I can have the next slide,
21 we'll see the same thing. But now I'm
22 starting from that one month or that one

1 quarter -- showing you quarterly results -- so
2 up down and all of that.
3 Favorable ratings for basic needs
4 have statistically increased.
5 Sir, your question about
6 statistical measurement -- there is a
7 statistically significant, positive slope to
8 the data for that line going back all the way.
9 And it's not just those quarterly points, not
10 just an average of those points. It's all the
11 data points comprising that particular line.
12 DR. PHILLIPS: Which technology
13 was used to statistically determine? I mean,
14 anything from --
15 DR. BANNICK: Laura, was it SPSS
16 or SAS? Out of North Carolina.
17 So these ask six basic questions.
18 How is your lodging, your ability to manage
19 your duties, your basic needs, overall
20 medical, health care and the medical hold, how
21 your non-medical attendees were supported, and
22 overall medical hold experience.

1 So what we have noted is that the
2 ability to manage duties -- the orange line at
3 the bottom -- hasn't changed. When we started
4 with this survey and we were showing this
5 monthly, it was high. It was not as high.
6 And the unfavorables were higher than the
7 rest, and it was not improving. But that was
8 on a monthly basis going up and down.
9 Now when we capture the five
10 cohorts over time, smooth it for the quarterly
11 results, we're not seeing any change in the
12 trend. That answers General Green's question
13 about is there anything positive on that
14 respect. It is still not as highly favorably
15 rated as the other areas. And the question is
16 is 60 percent favorable ratings good -- those
17 that rate a four or five?
18 Next.
19 These are the bottom two ratings.
20 So now down is preferred. The lower down, the
21 lower the percentage of those rating a one or
22 a two on a five-point scale.

1 Here we see managing duties. It's
2 not always the case. Five-point scale, you
3 can have a high percentage rating, a one or a
4 two, and a high percentage rating, a four or
5 a five, in which case you have very few in the
6 three -- that don't know, not sure, neutral-
7 kind of category.
8 But here, less than 20 percent are
9 rating their ability to manage their duties
10 unfavorably over time. And then a lot of the
11 others are down five percent, 10 percent.
12 Up above, we note that again
13 statistically significant downward slope in
14 meeting basic needs for unfavorable ratings.
15 Next slide.
16 One of the concerns that was
17 expressed to us up front in the survey was but
18 you're being unfair here. You're just showing
19 the negative which is what we are focusing on.
20 This slide here presents the
21 cumulative results over time. So the two
22 types of green are the fours and the fives.

1 And the pink and the reds are the ones and the
2 twos. And the three is that band where the
3 person may be just picking something in
4 between. They don't want to say something or
5 they're not concerned. How was your
6 experience? It was neither good or bad. It
7 was just it. All right?
8 So what we try to look for is not
9 a wide area in that three where it looks like
10 they don't want to tell us or they're not
11 concerned. And there's no magical number
12 here. But there are places where we were
13 seeing it. Looks like, again, most of the
14 ratings over time are favorable -- fours or
15 fives. But there are pockets where we said 18
16 percent here cumulative are saying -- so less
17 than one out of five are saying that their
18 ability to manage their duties was poor.
19 Next slide.
20 So quickly we've explained the
21 methodology. Not to repeat the methodology
22 now, this is the valuation of two questions

1 basically. Tell us about your experience with
2 the Medical Evaluation Board. And then if you
3 went into that question, those that said they
4 were somewhere in that process and those that
5 said they had completed the MEB, they were in
6 the Physical Evaluation Board process, they
7 thought, tell us about that experience on the
8 one to five scale.
9 This combines everything. So the
10 top two lines are those who rated a four or
11 five, MEB or PEB. And you can see, General
12 Green, again, early on there was a marked
13 change in the MEB ratings upwards -- favorable
14 ratings -- through quarter 3 in FY 10. The
15 MEB line -- green -- definitely up -- a
16 positive rating -- a positive increase.
17 I would say obviously it's been
18 flat for the last year ratings, downward from
19 a peak in either quarter 2 or quarter 3 FY 10.
20 So that is an example of an area that we're
21 worried about. It has improved for the upper
22 ratings. And for the lower ratings, those

1 that rate a bottom two -- one or two on a
2 five-point scale -- definitely had declined
3 and then leveled off for the last year.
4 And so, sir, when I make the
5 statement between 20 and 25 percent on the
6 line, I'm talking here about the hovering --
7 the data points, depending on which quarter I
8 respond to.
9 MG STONE: So can you overlay the
10 implementation of the IDES system over the
11 traditional sequential military DoD/VA system
12 in the improved satisfaction levels?
13 DR. BANNICK: I can't, for two
14 reasons. One, I don't know, other than the
15 reports that I've seen about the facilities
16 that have come on line. I don't know when I'm
17 doing the survey where that is. And
18 individually, by service member, I don't know
19 where they are -- where they are in the MEB
20 process -- physically, geographically, or in
21 time.
22 We've modified our survey the last

1 three months. We'll get results shortly. We
2 asked them where they are for the medical
3 hold. We asked them where they are when they
4 got most of their outpatient health care.
5 We've now starting asking where were you for
6 this disability evaluation system. And
7 because these are individuals who have been
8 back from operational deployment one year,
9 we'll look at the results, look at what those
10 IDES locations to see if we can map to an IDES
11 location that perhaps has matured -- maybe
12 give it six months to try to assess responses
13 from where we think our service members are in
14 IDES and where we think they are not.
15 But as others know more than I do
16 around here, IDES development occurred at
17 different facilities across a large long
18 period of time, I understand -- a year or
19 more.
20 LT GEN GREEN: Correct. So the
21 other question would be have you looked at it
22 all with relation to the overall ratings that

1 have been coming out of the disability system
2 -- not satisfaction ratings, which is what you
3 have here, but in terms of what the average
4 percentage of disability that people achieve
5 because there has been an increase with the
6 IDES. And so have you looked at all in terms
7 of what the average rating has been in terms
8 of how that's affected satisfaction?
9 DR. BANNICK: No, sir. We do not
10 get into that detail. Nor do we get into the
11 process.
12 LT GEN GREEN: So basically you
13 show us a positive trend here in terms of
14 overall satisfaction, but there's been no
15 analysis as to what's positive or why?
16 DR. BANNICK: Correct. We provide
17 a narrative to their responses to favorable
18 and unfavorable ratings. We provide those
19 answers to the services so they can see the
20 comments -- and I'll get into that in a little
21 bit -- what they're saying, what the service
22 members are saying positive or negative about

1 their MEB or PEB experience.
2 Again, this survey was a
3 worldwide, all-services for all health care.
4 Since day one, we've focused maybe two
5 questions each on the disability evaluation
6 system. But it's not a process-oriented
7 survey. And I have looked at the current DES
8 survey out there which is very detailed and
9 know specifically which members are in the
10 DES.
11 DR. PHILLIPS: Related to process,
12 I know it's not a process-oriented survey.
13 But is the raw data available that someone can
14 take a retrospective look to see what has
15 happened or get some more detailed
16 information?
17 An example, on page eight, you
18 mention that service members state that their
19 medical records are available at appointments
20 72 percent of the time. I don't want to
21 debate the 72 percent.
22 DR. BANNICK: That's a yes or no

1 question.

2 DR. PHILLIPS: Yes. But is it

3 possible to go back to that raw data and find

4 out -- because 72 percent is not great. Were

5 some of these emergencies that the records

6 weren't available or information like that

7 cannot be retrieved?

8 DR. BANNICK: It's not linked to a

9 specific treatment event. That's how we

10 define the -- just like the disability, it's

11 not linked to a specific geographic location.

12 I would be loathe to provide

13 detailed data to anyone since this is covered

14 under the Privacy Act. But would gladly

15 provide the aggregated percentages and the Ns

16 if someone would like to look at those sort of

17 data.

18 DR. PHILLIPS: No, thank you. I

19 understand it's a yes or no question. I can

20 see how that's not available.

21 DR. BANNICK: That one helps.

22 That is straight yes or no.

1 DR. TURNER: Sir, real quickly,
2 just to follow up on General Green's question.
3 I understand this is like which of these area
4 are there satisfaction and no satisfaction and
5 that's it. When you give this to the
6 services, how -- and you do no analysis on why
7 it's that way -- do you have any idea what the
8 services actually use this data for?
9 DR. BANNICK: No.
10 DR. TURNER: You don't? Okay.
11 DR. BANNICK: They receive it.
12 And they receive it at different levels.
13 MSGT MacKENZIE: So there's no
14 process whatsoever that favorable or
15 unfavorable -- to use one of the terms -- that
16 your information does anything for the
17 services?
18 DR. BANNICK: Correct. I can't
19 say that my information is taken and the Army
20 Surgeon General has changed access standards
21 for wounded warriors because of my survey as
22 opposed to his own survey or cumulative

1 experiences from different surveys.
2 MG STONE: So how do you refine
3 the value of the survey if you have no
4 feedback loop?
5 DR. BANNICK: I think that's a
6 good question. I, again, meet with the
7 services' survey representatives --
8 MG STONE: So give an example of
9 something you've changed that has allowed this
10 to be more valuable data in some manner. I
11 again come back to if there is no feedback
12 loop, how do you improve?
13 DR. BANNICK: Agreed. We've added
14 questions on pain management, which you don't
15 see here, because that was one specifically
16 that the services wanted to see with regard to
17 these people. We've added recently a set of
18 questions on case management, just for a one
19 time deal, just to understand how these
20 service members, if in fact they're being
21 assigned a case manager for their needs,
22 whether or not they understand who the case

1 manager is, whether or not the case manager
2 has helped them. So we've added some
3 questions in that regard.
4 We've modified questions for
5 deployment health to get more at -- and I'm
6 going to show you a slide shortly if we have
7 time -- on individuals who rate their
8 experience getting counseling for a personal
9 family problem and to ask questions like did
10 it help you, and would it have helped you
11 looking back on it? So we've added other
12 questions and modified questions for that.
13 MS. MALEBRANCHE: Rich, so I know
14 you've presented before to the Health
15 Executive Council, but as I'm listening to a
16 number of things, you actually touch all of us
17 -- the DoD and the VA on a number of different
18 areas or groups that we have. But with
19 disability evaluation being one of the high
20 ones at this point in time, and I see your
21 charge was to look at this, is there any plan
22 to or how would there, if there's not, to look

1 at exactly what General Green was talking
2 about -- the amount of disability satisfaction
3 and all that over time? Because if this is an
4 analysis and an evaluation itself, is that
5 some kind of information -- will that be
6 coming back to the Department of Defense to
7 look at like how these different programs have
8 worked? I mean, I see all the graphs. But in
9 some type of narrative form, is that a charge
10 that you have?
11 DR. BANNICK: I'm not sure I
12 understand the question. We do provide, like
13 I said, this information much more detailed
14 including when I get to it, the narrative is
15 to what people are saying about it -- the
16 individual comments the services can see. So
17 they can at least see favorable or unfavorable
18 -- what service members are saying about that
19 particular issue.
20 MS. MALEBRANCHE: So you tell the
21 services all these different things. But then
22 does Defense -- Department of Defense -- do

1 you go back to them to say here's the analysis
2 evaluation, here are possibilities or things
3 that you could do to improve or not over time,
4 especially I guess in relation to this
5 disability evaluation system?
6 DR. BANNICK: Yes, I do, I think.
7 My charter really is to provide the
8 information and where the problems areas are.
9 Mine isn't to recommend solutions. That's an
10 easy way out of things. But the services have
11 the wherewithal to identify what's important
12 to them, how to make the changes as they see
13 it. And I know they have them. I know
14 they've been struggling.
15 MG STONE: I think the broader
16 question -- and in fairness to Rich -- this is
17 a perfect example of in response to the Sec
18 Def's concern, we have the management agency
19 do a survey that's unconnected in any way to
20 the people really accountable for the care and
21 the processes given. And in fairness to Rich,
22 he puts a perfectly good survey together but

1 has no loop back to demand improvement in this
2 and no authority to improve the delivery
3 system.
4 We're talking in essence to the
5 wrong accountable agent. The person that
6 should be standing here is the person on each
7 of the services accountable for the delivery
8 of services. And then the back question is
9 how do you use this tool and is it responsive
10 to you.
11 DR. TURNER: I would agree with
12 that. What's the value of this? How are the
13 services actually getting value from this tool
14 would be my question as well.
15 MG STONE: So the base question
16 goes back to why in the world would we ask TMA
17 to do this, why would be asking the
18 accountable services to do this, and then fund
19 them in order to do that or let them come back
20 to TMA and say we need you to do this for us.
21 DR. PHILLIPS: One might also add
22 our recommendations that we recorded last year

in the same broad category. Survey what's happened. Do our recommendations.

DR. BANNICK: Next slide, please.

Now I have how much time left? Ten? Okay.

Cumulative on the disability evaluation ratings -- a lot of green.

Next.

It's not an eye chart. It's not meant to see the actual data, but we can certainly provide it. What this is meant to say is if you compare the Army's top two ratings for the MEB and the PEB in the bottom two to that previous slide, you'll see it's very similar. When you compare the Air Force's with a fourth, a fifth of the number of people responding about being in the MEB, it's very erratic because the few people that answer might in one month say it was perfect, give it 100 percent. That means you have 100 percent saying favorable ratings. Next month, there may be one person and that person did

1 not like it.

2 So this really is to at least

3 justify General Green's comments about the

4 applicability to each of the services. But

5 what I do say is that we do still provide the

6 data to the services -- the cumulative. And

7 each of the services can see how they stand

8 relative to the other services or to within

9 their facilities. And of course, you have to

10 compile enough responses over time to make it

11 valuable to them.

12 So the Walter Reeds of the world

13 have never had a problem in our survey having

14 enough responses -- or the Fort Braggs. But

15 the Spangdahlem in Germany Air Force Base

16 might not have sufficient numbers that General

17 Green and his staff can deal with.

18 LT GEN GREEN: So do you highlight

19 to the services when you have this small

20 number bias? I mean, what you're talking

21 about is really small number bias, right? And

22 so it's impossible just looking at this slide,

because you don't know the numbers, because everything's by percentage to know what this means or doesn't mean.

DR. BANNICK: Correct. Do I highlight --

LT GEN GREEN: So in other words, if you have under five or under ten or under 50 or whatever you consider to be a small number bias, do you highlight those points? Because you show these graphs, and in essence it looks like that you have small number bias for the Navy, Air Force and Marines. But I don't know because I don't have any idea what the actual numbers are.

MS. MALEBRANCHE: That's what I was thinking. Do you give the N somewhere?

DR. BANNICK: Yes.

MS. MALEBRANCHE: That's what I was looking for. I can't see it.

DR. BANNICK: It's not obfuscated. It's just I can't only get so much on it. The Ns are here.

1 When you blow it up or if you go
2 back to another graph, you'll see an N at the
3 bottom of each one. And it'll show you the
4 range of the responses for those questions.
5 So here I could read on the last
6 quarter for the Army 12 to 356 or something.
7 So the three will be unquestionably related to
8 the PEB for the Army unfavorable ratings. And
9 the larger number will be for the MEB because
10 I know that PEB has fewer people that we
11 surveyed that are involved in it.
12 But yes, we do provide that.
13 And in answer to General Green's
14 question, which again I think is good -- what
15 can the services do with this information? We
16 do provide, again, all this information on the
17 website. But on a monthly basis, they can see
18 how they compare for the current month, the
19 last three months, the last year and since
20 inception of the survey. And each service can
21 compare how it's doing relative to the DoD
22 overall.

1 So there's an cumulative effect of
2 trying to ameliorate for small numbers so they
3 can see. Then you start losing the trend
4 effect when you do that.
5 In addition, we do provide a
6 summary of these data to the service survey
7 reps at the MTF level so that they can see how
8 their facilities compare within their service
9 or across services and kind of indicate which
10 are doing very well, which are not.
11 So there are data where the
12 services can look at it and go, okay, this
13 facility here looks like for this question, we
14 need to figure out what's going on. But for
15 this set of questions, they're doing great.
16 MS. MALEBRANCHE: So General
17 Green, I just looked at the end on this bottom
18 one. It's one to nine compared to the
19 hundreds. So I'm like you. It's all over.
20 DR. BANNICK: Absolutely.
21 LT GEN GREEN: If you look at the
22 other three services, they tend to be under 20

1 across the board and the Army being in the
2 100s range. And so, it really does appear
3 that we have small number bias that's making
4 the slides not very meaningful for the other
5 services.
6 DR. BANNICK: For trending, sir,
7 yes.
8 MS. DAILEY: And when you say for
9 trending, you mean --
10 DR. BANNICK: Quarterly that you
11 see here.
12 MS. DAILEY: -- quarterly. But
13 over time, you're identifying trends?
14 DR. BANNICK: If you accept the --
15 MS. DAILEY: The cumulative.
16 DR. BANNICK: If you accept the
17 cumulative -- the accumulation of ratings --
18 and discount the time effect, then that might
19 give you something. It does. We can show
20 facilities with a minimum 50 reports or
21 whatever number that we do. We can also
22 compare to groups of time where you can

1 collapse some of these data to see if there's
2 been change.
3 MS. DAILEY: And we do need to
4 move ahead, ladies and gentlemen. I have
5 another briefer standing by, and we are a
6 little over time.
7 DR. BANNICK: We're over?
8 MS. DAILEY: Yes.
9 DR. BANNICK: Okay. That's it.
10 Thank you.
11 MS. DAILEY: We use this data,
12 ladies and gentlemen, to validate when you are
13 making recommendations. It's long-term data.
14 It shows trends. When you made a
15 recommendation and you want to say is this
16 assumption true, are we really moving in this
17 direction whether it be up or down, we like to
18 go back to this type of data to substantiate
19 your impressions and your perceptions that you
20 are getting in the field.
21 So this is helpful to us. And
22 that's one reason I like to bring it to the

1 public so that we can use this. And the other
2 reason is it might be an underutilized product
3 in the DoD that they could get more out of.
4 LT GEN GREEN: I guess I would ask
5 the question -- so because it's been so stable
6 in terms of what you're finding over long
7 periods of time, my question would be who is
8 the owner of this? So in other words, I mean,
9 it's been asked several times, but if the
10 services are the owners and then that's one
11 thing. If it's being used to basically say
12 things haven't gotten worse on my watch, I
13 guess there's some fidelity to that. But I
14 mean, I'm not certain who you're reporting
15 this to that actually is the ultimate owner of
16 the process. So when you say we, Denise,
17 you're talking about the Task Force can now
18 use this. But we don't own this survey. So
19 who owns this survey? Who pays for this? Who
20 do you give this to? Who's the decision
21 maker?
22 DR. BANNICK: So Health Affairs,

1 TRICARE Management Activity pays for the
2 survey, funds it. The contract as it current
3 stands expires at the end of the September of
4 this year. I've met with the surgeons general
5 and Health Affairs leaders to discuss are we
6 on the right track and whether or not we're
7 going to continue this. And at this point in
8 time, we're going to shift to a quarterly
9 survey. Instead of just a monthly survey
10 report quarterly, shift to a quarterly survey
11 and perhaps close this survey out at the end
12 of September. Whether or not TMA/HA wants to
13 continue the funding will depend on those
14 decision makers or the services.
15 LT GEN GREEN: Okay. Thanks,
16 Rich.
17 MS. CROCKETT-JONES: Thank you,
18 Dr. Bannick.
19 We have Mr. Phillip Burdette
20 coming to speak to us, the principal Director
21 for the Office of Wounded Warrior Care and
22 Transition Policy.

1 We have heard from the WWCTP at a
2 number of our previous meetings. They will be
3 specifically addressing the recommendations
4 listed in our report from 2011.
5 The DoD provided their evaluations
6 of the report on 3 December. Look at your
7 agenda for the specific questions. They are
8 in the agenda itself. But we also have
9 information at Tab D.
10 Thank you.
11 MR. BURDETTE: Good morning. And
12 thanks to the entire Task Force. Ms. Dailey,
13 thank you for your hospitality again in having
14 us back.
15 I've got to tell you I'm jumping
16 out of my seat in the back on the IDES. I
17 hope we can spend a couple minutes on that.
18 And I hate to make that a segue because I know
19 I have other things to talk about.
20 But in short answer to your,
21 General, I own the executive agent
22 responsibilities for the IDES. And so, I've

1 got a host of thoughts on things that we just
2 wrestled with.
3 As Health Affairs gives us that
4 data, it's so critical as we move that lever.
5 And I know it's sort of beyond my scope. If
6 I could just have a 90-second soapbox, and
7 I'll take any questions at any length.
8 The IDES is one of those issues
9 that -- and I'm just finishing my first year
10 back in the Pentagon -- I have never seen such
11 scrutiny at such high levels. And without the
12 data that we just saw on those charts, we
13 couldn't move the needle on a lot of things.
14 So from my seat, the feedback loop
15 is absolutely there. I'm totally blind and
16 ignorant on legacy DES and how much you really
17 liked it. But I can statistically show you
18 that we're 12 to 15 percentage points higher
19 in satisfaction. Not increasingly trend line
20 going up, but the granularity of data that we
21 have there -- and we meet every Thursday with
22 the services from policy makers to

1 practitioners to let's move the dial on the
2 MEB phase, let's move the dial on the PEB
3 phase, how can we invest better, how can we
4 make better decisions, get better resources,
5 people, and get better results from the
6 system.
7 And that data -- I brief
8 personally the Secretary of Defense -- and
9 it's a matter of topic between him and
10 Secretary Shinseki on their three annual
11 meetings -- so three times a year. It's item
12 two. And the things that we do within the DoD
13 and with our VA colleagues on remodel IDES and
14 whether we're going to do that and how we're
15 going to change things -- without the data
16 that we get off of those things, we'd be blind
17 as to how we're turning the ship.
18 LT GEN GREEN: So can we ask you
19 then? So what analysis have you done to
20 basically look at the association with the 12
21 to 15 percent increased satisfaction that
22 you're highlighting from the report?

1 MR. BURDETTE: So in the crawl-
2 walk-run continuum, General, the system came
3 on line with 139 sites in September -- which
4 we started in '07, finished in September of
5 2011 -- in the crawl-walk-run continuum, let's
6 field it first and then let's watch the levers
7 on satisfaction. But we're much more
8 concerned I think with making it service
9 member-centric so we seeing it moving up, and
10 then how can we get the timeliness monster
11 soft. Two hundred ninety-five days is the
12 goal, 540 the legacy benchmark executing today
13 at about 396, 397. What can we move as far as
14 those go?
15 So in the priority of work issues,
16 that's on there -- what accounts for this.
17 But at the same time when we look in the
18 analysis, this is sort of like how did your
19 divorce go, to be very honest with you,
20 because this is the first time we're
21 adversarial with a person. We love you as an
22 airman. We're taking care of you and your

1 family. And now we're going to fight over 20
2 percent or 30 percent.
3 So your satisfaction levels, we've
4 seen -- and I have a lot of analysis on this
5 -- should have determined whether you got what
6 you wanted. And so, with those trend lines,
7 it's like, okay, if you got what you wanted,
8 you're really happy with it. If you didn't,
9 you're really unhappy with it.
10 So we could spend a lot of time,
11 effort and money on that satisfaction piece.
12 But in the near-term, we've got to get the
13 timelines fixed.
14 LT GEN GREEN: So I have to ask,
15 so have you done any analysis on what goes
16 into satisfaction? You've mentioned timing.
17 You've mentioned some other things. But the
18 obvious one would be to look at what's
19 happened to the actual ratings themselves and
20 overlay it in time to see whether or not
21 there's any correlation with the 12 to 15
22 percent. Have you actually looked?

1 MR. BURDETTE: Have not chartered
2 or christened that work. It's on the priority
3 of work effort. We're so focused on fielding
4 the system and having it meet the system-wide
5 standards that we have not put heavy analysis
6 into moving those levers. We're really
7 worried about the MEB right now which we're
8 getting killed on, and the transition phase
9 from the DoD perspective which we're getting
10 killed on.
11 MG STONE: You began your comments
12 by saying you were jumping out of your chair
13 because this is absolutely essential to your
14 success in your work. Can you give an example
15 of how it's been so effective in your work?
16 MR. BURDETTE: Well, you can
17 answer that question, General, with the word
18 `benefits gap.' When we had the legacy system
19 and that benefits gap, we put veterans
20 absolutely into the breach, alone, solo,
21 depressed, upset with no lifelines.
22 MG STONE: So switching to the

1 IDES system, you then went back and measured
2 and have shown enhanced satisfaction when you
3 switched to the IDES system which took away
4 your benefits gap?
5 MR. BURDETTE: Statistically
6 significant and provable. Absolutely.
7 MG STONE: Okay.
8 MR. BURDETTE: But I will tell
9 you, with an asterisk within the family here,
10 the legacy DES data system, absolutely not as
11 exhaustive, absolutely not as scientific and
12 not as good as the new data we have. But 12
13 to 18 percent benchmark changes in improvement
14 and satisfaction, no doubt about that.
15 MG STONE: So if you are the
16 accountable agent for the implementation of
17 this, can you discuss with us how you interact
18 with the services if you don't have data based
19 on performance variation by site?
20 MR. BURDETTE: You bet. So we do
21 have that data. I have site-by-site and 139
22 sites. Every month we publish a phonebook --

1 for those of you that are as old as me and
2 remember phonebooks -- phonebooks worth of
3 data to the services, and we can go site-by-
4 site. General Chiarelli before his retirement
5 held a number of infamous
6 videoteleconferences. One I remember went
7 until 10:30 at night. One started Saturday
8 morning at 6:00 a.m. We went site-by-site
9 with the military treatment facility
10 commanders and said show us where you're
11 struggling, let's look at your data surveys at
12 your site and see where you're improving.
13 Two weeks ago, I was at Fort
14 Carson, Colorado where I sat with the MTF CO,
15 walked phase-by-phase through the IDES and
16 looked at all the data at every phase and said
17 how are moving the levers and how are we with
18 our VA colleagues making this a better system.
19 MG STONE: I'm familiar with the
20 Army-centric approach through the vice as I
21 had the opportunity to sit at those meetings.
22 Can you talk about how the

1 Department of Defense has supported that
2 process? Is it primarily from a funding,
3 primarily providing research?
4 MR. BURDETTE: You bet, General.
5 So I'm anxious to say that I own
6 it as the executive agent, but this is matrix
7 management 101. So I have no tasking
8 authority over the services. I have no budget
9 authority over the services. But I do write
10 the policy and put it out on behalf of the
11 Secretary of Defense that runs their systems,
12 for sure.
13 So we meet every Thursday, as I
14 mentioned, with the services for four or five
15 hours. With the services since the summer, we
16 designed what was called the remodeled IDES
17 concept which we thought was a service member
18 centric, a better way to field the IDES system
19 and then field those improvements.
20 It ended up we didn't implement an
21 awful lot of it. We went a different route.
22 I led two teams in the past ten weeks. There

1 are teams out this week at three other
2 locations nationwide looking at how we're
3 implementing. And then we can best practices
4 the national norm as far as those things are
5 happening.
6 When we learn what we learn on
7 these field visits, we come back every
8 Thursday. We meet for four or five hours.
9 And we talk about how each service can learn
10 from where we were at Fort Campbell or Fort
11 Carson or Camp Lejeune.
12 LT GEN GREEN: So let me ask a
13 couple more questions.
14 So when you say that you have
15 proof showing the 12 to 18 percentage, and
16 whether it's with IDES or not with IDES, my
17 real question is -- forget which system it is
18 -- do we know what makes people more satisfied
19 in terms of timing because it's a two-edged
20 sword. Is it too fast? Is it too slow? What
21 disability rating? Okay? Again, it may make
22 people happy if you give them all 100 percent

1 disability rating -- okay -- with health care
2 access. Even you were saying service member
3 centric, but you're comparing the data that
4 you're using to quote the 12 to 15 percent is
5 on people with positive findings on a PDHRA.
6 In other words, they had something they wanted
7 to followup on, but not necessarily the W2
8 identified people who are in the system
9 formally. And so, are we making an
10 overarching statement about the 12 to 18
11 percent to a population that it doesn't apply
12 to?
13 MR. BURDETTE: So I don't think
14 so, General. But I have to make macro
15 statements when I look at systemwide
16 performance. And we could go to bases, posts
17 and stations and find varying degrees of
18 excellence or nonexcellence. And that's why
19 we've chosen the sites that we visited and put
20 the teams together to go out there and visit
21 those, and then sit with the budget people and
22 the people that have to do this job day in and

1 day out and say are we investing correctly in
2 it.
3 For example, this year, across the
4 '13 to '17 budget years, we're going to invest
5 almost 700 more people we're going to purchase
6 to get into the system. We're talking about
7 PEBLOs. We're talking about PEBLO assistance.
8 These are not high skillset jobs.
9 People making copies, to be honest with you.
10 I mean, we've got to make copies of these
11 records and get them moving faster downstream.
12 But we found that was the bottleneck. So how
13 do you fix that? Well, we've got to invest in
14 these 700 PEBLO assistants, teams of lawyers
15 also to help some of the legal reviews get
16 going. And then we've got to buy more MEB
17 doctors.
18 So when we saw that, we sat with
19 the services and said how can we invest in
20 this, make it better, more timely and then
21 reach our 295 goals. So when we sit with the
22 services, that's a real result.

So General, to your point, what's the real result? How do you know it's working? When we meet and we look at the data -- base, post and station -- and then in the macro, we figure out what to invest in, and then we go invest in it. And then we chart those results and see how it's going.

To your point, I think it's a higher order ask, General. And I think that we owe that. And I'm eager to do that work. But right now, we've got to field this system, make sure that it maintains its service member centric. And we've got to get it near that 295-day goal that it was designed to get to.

I'm anxious to get into the quality work. But we're just not there yet.

LT GEN GREEN: So if you really don't have any idea from focus groups or whatever you would use as to what actually generates satisfaction, what are you going to do if you find out that the IDES when you maximize its efficiency makes people very

1 unhappy?

2 MR. BURDETTE: If I didn't see 12

3 to 18 percent trend up from the legacy system,

4 we could all stop right now and figure out why

5 our satisfaction ratings aren't trending in

6 the right direction.

7 LT GEN GREEN: Except that it may

8 well be. Do you know what the actual average

9 disability rating has happened since you put

10 in the IDES?

11 MR. BURDETTE: I know I have that.

12 I don't have it memorized, General. I do not.

13 MS. MALEBRANCHE: One of the

14 things I was wondering too as you're going

15 along this line, but you do know previously --

16 right -- the numbers of claimed conditions and

17 then now what that average has increased?

18 MR. BURDETTE: Significantly. The

19 number of multiple injuries, you're talking

20 about compression injuries, you're talking

21 about in 2004, '05, '06, we saw a single

22 amputee, and now we've got TBI, PTS,

1 compression injury and that amputee. The
2 number of claimed conditions is really up. I
3 don't have it memorized. I want to say it's
4 going to around ten. I think it was around
5 three in '03 or '04. I'm going to be close on
6 that.
7 MS. MALEBRANCHE: So some of that
8 I think plays into all of this. And you're
9 right, we don't have a big look at the entire
10 picture. And then, too, I think the number of
11 Reserve Guard versus Active Duty -- I mean,
12 those sorts of things would be significant to
13 look at over time too. Just mentioning that
14 because I know that's huge for --
15 MR. BURDETTE: Absolutely.
16 Absolutely on our scan. And as the General
17 pointed out, there's two types -- I hate to
18 generalize -- there's generally two types of
19 people in IDES. For one, it's working too
20 fast. And for one, it's working too slow.
21 So one of the things we've tried
22 to do is fast track an approach for those that

1 know they're going to go back to San Antonio
2 and have that job lined up and want to get out
3 as quick as they can.
4 We use the EDES -- the Expedited
5 Disability Evaluation System -- on the really
6 traumatically injured. That can get you out
7 in 30 days or so. We've only used that about
8 350 times. We think there's a way to maximize
9 that for that soldier, airman, marine, coast
10 quardsman or sailor that needs and wants to
11 get out quickly and doesn't want to make it an
12 adversarial process and drag us through that.
13 So we think we're going to get
14 there with that process. But the other type
15 of person is the person that has new claim
16 conditions that happened at day 350 which then
17 starts the evaluation process again which then
18 gets it going. So that's a challenge for us
19 to get our arms around.
20 But we're going to stay service
21 member centric which means that that person is
22 going to be in that system, taken care of,

1 full pay and benefits, family covered, no
2 benefits gap for as long as it takes.
3 LT GEN GREEN: So that brings me
4 right back to kind of where I started which is
5 what is the Department then basically
6 considered success. So you're quoting the 12
7 to 15 percent increased satisfaction as
8 successful. And so, I'll buy that.
9 And then my question to you is so
10 the Department doesn't care if the costs
11 escalates significantly regarding disability
12 as long as the people are happy with the
13 process.
14 MR. BURDETTE: I wouldn't say they
15 didn't care, General. And I would say another
16 correction would be this. This is Departments
17 with an "s." The word integrated is critical
18 here. This is VA/DoD -- six stages for us,
19 five for the VA.
20 If we don't do anything in
21 harmony, we're going to fail. The fact that
22 Chief of Staff Gingrich was at all of the vice

1 chief's VTCs at every hour I think was
2 critical to our success. If you look at the
3 VA charts, they're macked at about 120 days on
4 the goal and they're about 140 days. So
5 they're pretty close to making their bogey as
6 far as that goes.
7 If we don't do this together as a
8 team, we'll fail. If we just get focused on
9 one element of it -- satisfaction -- we'll
10 fail. We've got to stay service member
11 centric to cross all 11 phases, and we've got
12 to make sure that as we field it -- and we're
13 grading the system that's been in full
14 utilization for three months which is
15 difficult to do and is ramped up the number of
16 patients in the system from in '07 zero to we
17 probably have about 22,000 in the IDES today.
18 That's a big heavy lift that happened quickly.
19 And so I understand there's a real
20 emotional desire to grade it right now and say
21 why isn't it right where it needs to be. But
22 crawl-walk-run, we're going to get there. And

1 I think that we've got the schematic in place
2 to get us there.
3 LT GEN GREEN: Actually I'm not
4 trying to grade it. I'm trying to understand
5 how the two Departments will grade it.
6 There's a difference.
7 MR. BURDETTE: So I think -- did
8 we eliminate that benefits gaps is the first
9 thing. Did we take those service members and
10 new veterans out of that risky area where they
11 didn't have a lifeline, they didn't know how
12 to get their physical therapy and they weren't
13 connected to their VA benefits. So right
14 there, we have saved lives. No doubt in my
15 mind. And we've saved families untold amounts
16 of grief because now they know when they leave
17 IDES that they're going to on the first of the
18 next month get a check from the VA, they've
19 got a VA contact, they're in eBenefits, and
20 they know how to get any number of things that
21 they didn't know how to do until 2008, or many
22 didn't know until '11.

1 So right then and there, we're
2 taking care of people and saving lives. So
3 regardless of the costs, that's a great
4 investment.
5 The second thing is we thought --
6 and this is the best minds in the room -- in
7 '07 and '08 thought we could do it at 295
8 days. So let's see if that was the right
9 number. Still not sure it is. But it's going
10 to take as long as it takes to get each person
11 through.
12 If that person comes up with that
13 claimed condition on day 295, we'd better not
14 get so obsessed with that number that we don't
15 take care of that person and make sure let's
16 go back and look at that new claimed condition
17 and take care of you and your family. But at
18 the same time, there's an expectation that
19 when you put that number on the wall, you'd
20 better get to it at some point, way, shape or
21 form.
22 So we're committed to getting that

1 balance right. General, I don't think we know
2 what that balance is right now. But we
3 circled 295, and we keep doing analysis to see
4 whether that's the right number and the right
5 goal. But the satisfaction's a key element of
6 it. You can't have a service member-centric
7 thing without satisfaction.
8 MG STONE: What about the
9 disconnects that we continue to hear from
10 service members between VA disability ratings
11 and DoD ratings? How does that factor into
12 relative satisfaction or dissatisfaction?
13 MR. BURDETTE: Well, I think,
14 General, this is where the investment in the
15 PEBLO and in the MSC on the VA side has been
16 a really great investment. That level of
17 confusion -- and I usually carry my little
18 laminate -- I'm a former marine. Everything's
19 laminated that I own. So a little laminated
20 book on the process, and as much time as I've
21 spent with it -- the extras I've spent in it
22 -- I still am concerned that a young family

1 that studies this process for the first time,
2 even with a great PEBLO or a great MSC, is
3 going to be confused about wait a minute, the
4 VA pays me for this and the DoD pays me for
5 me. That's still a difficult thing.
6 One of the things we discussed
7 RIDES was let's go to single adjudication. So
8 if you have ten conditions, we're just going
9 to accept it. The government will write you
10 a check. Let's not worry about the rest of
11 that.
12 From a can we afford this
13 standpoint -- and this is my DoD hat on -- I'm
14 not sure we can do that. When NDA 2008
15 passed, that became a $963 million annual bill
16 to us in our personnel because we created a
17 whole new class of retirees by accepting
18 conditions without our ability to then make an
19 adjustment to it.
20 If we accept all the ratings that
21 are on that sheet, we're going to have a class
22 of retirees I'm not sure we can afford. We

1 are studying that with our costing folks to
2 see whether that's something that is
3 sustainable for us. But these are a number of
4 things --
5 MG STONE: So then you would
6 accept the continued differences between VA
7 and DoD ratings as a price tag too large to
8 pay? Is that what I just heard?
9 MR. BURDETTE: We're studying it
10 to see whether if we accept all the conditions
11 -- we're talking about the things that are not
12 typically -- your asthma, your sleep apnea,
13 things of that nature, allergies -- we
14 typically don't pay for. If we just decide as
15 a government let's just all cover that, is
16 there a way to figure out the DoD/VA piece and
17 then can we afford it?
18 MG STONE: But the cost to the
19 United States government is the same?
20 MR. BURDETTE: I would agree.
21 MG STONE: It's just which
22 department pays it. So the service member

1 therefore is the one who suffers through this
2 because the departments cannot come together.
3 It's the same amount of money to the United
4 States government. It is the Department of
5 Defense and the Department of Veterans Affairs
6 who have been unable to reconcile this. Is
7 this an area that you're prepared to go down
8 and reconcile as a U.S. government or as
9 bringing together the VA and the DoD? Or does
10 the service member continue to have to suffer
11 through that?
12 MR. BURDETTE: General, I don't
13 agree that they're suffering through it. I
14 agree it's a point of confusion and
15 frustration for them, though "suffering" to me
16 is not a verb I would associated with that.
17 But, yes, that work is being done right now.
18 It's being costed with CAPE. I forget the
19 acronym in our building. But CAPE is figuring
20 it out. It's Cost Assessment Program and
21 Execution, I think. They're figuring out
22 right now if we can afford it.

1 But I agree with you. The service
2 member should see one check from the U.S.
3 Government. If there's a mechanism and a way
4 that through the laws and there's laws that
5 says what VA can do and what DoD can do, and
6 if we get stuck at a law, then let's have some
7 legislative change ideas come forward. That
8 work is underway. I think it's important, and
9 I think it represents some real strategic
10 thinking in the buildings -- ours and VA's --
11 where we say, hey, can we get past this? And
12 maybe we need a new law to change it. The
13 Army's appetite for changing law has been
14 enormous and we're aggressively pursuing that.
15 MG STONE: So I would come back
16 again to your opening statement. Are you the
17 person who then advocates for this? Are you
18 sitting at the negotiating table with the VA?
19 MR. BURDETTE: I am. I am. I
20 serve right beside John Medve, the Executive
21 Director of the VA Collaboration Service. And
22 I work with him on this process and others.

1 Work with Larry Fink who runs it from the VA
2 standpoint, from the IDES implementation. Our
3 practitioners sit every Thursday afternoon
4 with VA practitioners and service
5 practitioners. Those people work for me and
6 Deputy Assistant Secretary Campbell. It's the
7 top issue on our plate.
8 DR. PHILLIPS: Quick question. In
9 the process of evaluating the rating system,
10 do you factor in how much it costs to
11 reevaluate from one to the other because that
12 might be helpful?
13 MR. BURDETTE: Well, we take that
14 first physical. The VA's in charge of the
15 physical. So when we get you into the system
16 and you're getting that first physical, the VA
17 pays for that physical. We're doing great on
18 timeliness. It's modeled at 50 to 45 days.
19 The VA's hitting it at like 47 days. Doing a
20 phenomenal job of getting that physical done.
21 That physical should find us
22 everything that's involved and should be one

1 time we pay for that. In the legacy system,
2 remember, if my knee was the issue, I went to
3 a DoD doctor and got that, and then I went to
4 the VA and had the doctor look at it again.
5 And they're like well, that's insane. So we
6 fixed that which is tremendous.
7 Now if you get really far
8 downstream and I say hey, I've got something
9 with the elbow, yes, we'll probably have to
10 back upstream and pay for another physical at
11 some point.
12 I haven't seen a solution to that
13 yet if the person then says I have a new
14 claimed condition to go back and get that
15 looked at again. We hope we catch it in the
16 first one. Obviously we don't because we see
17 people swimming back upstream in this process.
18 But that's the reason behind that holistic
19 physical at the beginning.
20 Did I answer your question?
21 DR. PHILLIPS: Well, sort of. I
22 was wondering because of the difference in the

1 rating systems, rated at one point by the DoD
2 and then you're re-rated it again by the VA.
3 And I understand that new things come up as
4 you go along. And then deciding as you
5 pointed out that perhaps one check should be
6 given to the service member. And as General
7 Stone pointed out that the government is
8 paying for it doesn't -- DoD/VA.
9 How much does it cost to go
10 through the process of re-rating -- not a new
11 condition? And is that factored in to the
12 whole evaluation that's going on right now?
13 MR. BURDETTE: The re-rating costs
14 are just going to have to go I guess back to
15 the Physical Evaluation Board. I don't think
16 it would be gigantic. And I don't think the
17 percentage of people that get re-rated would
18 have a gigantic effect across the system
19 that's costing this much in the macro.
20 Certainly worth looking at, and I hope it's in
21 algorithms that we see. But my instincts tell
22 me it's not gigantic.

1 LT GEN GREEN: Just one final
2 question. Is there any consistency across the
3 services with regards to the single physical
4 since you brought it up in terms of the
5 payment for disqualifying? In other words, VA
6 pays for a total disability. Services tend to
7 pay for what was disqualifying from duty. Is
8 that consistent across the services?
9 MR. BURDETTE: It is, General.
10 LT GEN GREEN: Okay. Thank you.
11 CAPT EVANS: And to tag onto that
12 question, a lot of the complaints I hear from
13 the warriors or the concerns -- the medical
14 record. We tried to transfer a marine to Camp
15 Lejeune and had a problem with just getting
16 warrior from Walter Reed, Georgia campus, to
17 Camp Lejeune because of records. So that's
18 the DoD system.
19 A lot of them are concerned when
20 they go to the VA, they have to have a hard
21 copy record. And in your statement you said
22 we're going to hire 700 PEBLOs for

1 administrative purposes to copy the records
2 and things. We need to have an electronic
3 record where that warrior can carry that
4 record with him instantly and there's no
5 copying of going back and forth. So I just
6 wonder how close are we to resolving that?
7 MS. DAILEY: We've got a briefing
8 this afternoon from IPO. During this time
9 period, we can talk about electronic records.
10 MR. BURDETTE: And is Dave
11 Wennergran coming in or is the new Director
12 coming in? Somebody?
13 MS. DAILEY: Yes.
14 MR. BURDETTE: So that's a great
15 question for Dave this afternoon. I follow
16 him around the halls all the time and scream
17 at him for two things. I need electronic case
18 file transfer, and I need better ability for
19 the services both at the macro level and the
20 base, post, and station to have case awareness
21 of where that person is.
22 So Captain, I'm an anxious person

1 that wants to see that. I know you've seen
2 where you've gone. We've got the smartest
3 young service members out there who have built
4 local systems. But it makes my heart warm
5 inside and it also terrifies me because I
6 cannot have 139 separate databases that don't
7 talk to each other and then how do you get
8 that to the VA. We've got to have a macro
9 solution. General Hickey over at the VA has
10 done tremendous work at writing standards for
11 us -- the DoD -- to give them a writable,
12 readable, searchable electronic record of some
13 sort.
14 So I think that we in this system
15 are really on the cutting edge of electronic
16 file transfer between the VA and the DoD. I
17 need the IPO to own that and to become really
18 the big brother and big sister of that process
19 and then help us get there. But I know that
20 if I had electronic file case transfer, I
21 could save 21 to 27 days in the process just
22 in mailing. And my FedEx bill would go down

to nothing.

I keep pictures on my office wall of those huge crates of things that are FedExed from places like Fort Gordon, Georgia, down to Pinellas Park in Florida, down to Balboa and San Diego. We've got to get out of that business. I used those pictures for the Secretary when I expressed the importance to him. And they make a good case. We need it.

Okay. I appreciate that 90 seconds. I promise to go quickly through the rest of it.

I'm here to talk and we asked at length -- you've made 21 recommendations. I thank you for all of them. And we've followed many of them. A couple of them are in place already.

The SOC -- Senior Oversight Committee -- no longer exists. So that was Commission 21. And it is now folded into the JEC. And I think March 17th represents our next JEC which will then have a new membership

in some part. But about 28 members will still be there. We took your advice. The senior uniform people, senior civilian people, and make sure that the VA is represented. So I think you'll really be pleased with the new JEC. And then we've got a wounded, ill and injured committee that's going to work directly for the JEC chairpeople to make sure that we don't lose our focus on the wounded, ill and injured -- just a critical thing.

A couple other things that I know we've done and we'll get to a couple of them.

Could I have this next slide, please?

And I know you just asked to talk about ten of them, and I'll go through them. And I promise I didn't stay up late working on the slides. I don't know if we were afraid of FACA or whatever. But there's nothing earth shattering or new in the slides. It's your recommendation and what we put in on behalf of the Secretary of Defense when we turned it

1 into the Congress in December and what we said
2 on it.
3 I think on March 3rd, we owe an
4 implementation plan which will be the next
5 phase of what we're going to do with your
6 recommendations. I'd love to make this a
7 dialogue-type thing so you could tell me what
8 you were thinking on each one and I'll tell
9 you what we said and then what we're going to
10 do. And then we can move forward from there.
11 We've got about a half an hour
12 between you and lunch, and so I'm happy to
13 stay after if I don't go deep enough on any of
14 them. But I can hit on the ten that you asked
15 me to talk about.
16 Okay? Great. Could I have the
17 next one, please?
18 The first one's a hard one. It's
19 you want some standardized terms, and I get
20 that. And as you look back on the history of
21 this program from '07 until today, you see
22 terms of art and terms of science and where

1 each one lives, resides, grew up or has become
2 either the way we do it or the way it's done
3 is difficult.
4 So you've endorsed Recovering
5 Warrior and ask us to do the same. I love the
6 idea of consistency. I'm terrified even
7 looking at you, Master Sergeant. I still
8 don't know all the Air Force ranks. So I wish
9 we could all just go with Lance Corporal,
10 Corporal and the ones I've already memorized.
11 That level of consistency is I think where
12 you're trying to drive us towards in the
13 Wounded Warrior, Recovering Warrior Community.
14 I don't think we're going to get
15 there to be quite frank with you. It's just
16 that difficult to put everything together and
17 say you shall now call everything X. It's
18 easy. Yes. OSD could certainly do an edict
19 of that variety.
20 MSGT MacKENZIE: Sir, the
21 challenge I have with this and part of why we
22 were making some of this recommendation is you

1 say that we don't want to use one term -- you
2 shall call them this -- but yet we continue to
3 use old terms and combine unlike groups within
4 those old terms.
5 As a wounded warrior, as a person
6 who is serving his country, when you use terms
7 that everybody in your neighborhood doesn't
8 understand, we have solved nothing. And the
9 fact of the matter is a new term or a more
10 correct term needs to be come up with because
11 as an individual who interfaces with a lot of
12 the civilian community, the SOC's definition
13 of a wounded warrior and the civilian
14 community's definition of a wounded warrior
15 are two entirely different things. But yet,
16 that seems to be the direction that you guys
17 have gone whereas we're trying to combine a
18 group that doesn't already have an
19 understanding.
20 MR. BURDETTE: And I think you
21 nailed it, Master Sergeant, with the challenge
22 that we face. And I'll hearken back to when

1 Secretary Gates was here. And he went to so
2 many Wounded Warrior events. And he said a
3 lot of the people that I meet at these events
4 say I'm not meeting people from Kandahar or
5 from Baghdad. I'm meeting people with the
6 heart attacks and the cancers. Still tragic.
7 Still terrible. Still part of our family.
8 But he challenged us to come up with platinum
9 care or some other terms that we kicked around
10 to give them something special. Everybody
11 gets the baseline of excellence. Give the
12 ones who've served down range something
13 special and different.
14 We didn't get there because
15 services already embracing their own have a
16 culture about it, have nomenclature about, and
17 have embraced the way they do it even in four
18 short years since the term Wounded Warrior
19 became sort of codified with the SOC. It's a
20 tall mountain to climb.
21 I'm not throwing in the towel.
22 I'm saying it's a real challenge. I think

1 that the way out represents you go to source
2 documents which is where we go. We go to the
3 SOC -- has an approved definition of X. The
4 law says X. The law we're dealing with now
5 calls it the recovering service member.
6 So if you want to go right back to
7 the term of art, I would even throw your
8 recovering warrior out and say the law says
9 recovering service member. That's what we're
10 going with.
11 Task Force commission is
12 interesting. Service branding interesting.
13 The carpets I have in our office, Wounded
14 Warrior Care -- interesting. Law dominant.
15 So that needs to be the
16 cornerstone. So your recommendation doesn't
17 even get me out of the woods.
18 But I recognize your intent there.
19 I share your intent to try to get there. I'm
20 being realistic, I'm not sure the
21 implementation plan is going to make you
22 happy. But I do want to lessen the number of

1 terms we have out there.
2 DR. PHILLIPS: May I suggest you
3 be very aggressive. And it should not be hard
4 one. I mean, in every discipline known to man
5 -- legal, medicine, science -- definitions are
6 the basis of moving along.
7 And this is our number one
8 recommendation. Or it was number one. So if
9 there's anything that we could do to push this
10 along. It really should not be difficult.
11 It's a personality and a cultural thing.
12 LT GEN GREEN: And if I may, we're
13 not tied to any term of art. Okay? So if
14 recovering service member is the right term
15 from the law, that's fine. Okay?
16 The harder part is that what we
17 see when we go out is that we don't know how
18 to answer when someone says why am I not in
19 this program versus that. Because it's not
20 just across services. It's within the same
21 service. Some people will be in a recovery
22 mode that are in a unit. And some will be in

1 a recovery mode that are in a warrior
2 transition unit or a WWR. And so, that makes
3 it impossible for planning purposes in terms
4 of how many of these centralized-type
5 activities are you going to have and whether
6 or not you're going to keep people within
7 units which is the way that in the past you
8 basically have manned your medical support.
9 So the absence of definition that
10 creates beyond what Max says makes it very
11 difficult to plan.
12 MR. BURDETTE: Agreed. And from
13 the macro from the Pentagon's standpoint, we
14 owe a standardized definition and then some
15 oversight to make sure and seeing how it's
16 executing. But as you visit the military
17 troop facilities as I do, well, why is
18 Jennifer in this and Billy's not. Well, we
19 had excess head room and since we invested so
20 much in '09, then we hadn't had anybody come
21 back in a while, so we had room. I mean,
22 there's local execution issues that drive

1 these. And I don't think they're anecdotal.
2 I think they're much more widespread than that
3 -- how we're executing locally. We owe a
4 consistent top level policy that says you
5 shall call it X.
6 But I want to be realistic with
7 you. If it was that easy, we'd all be using
8 Lance Corporal, Corporal, Gunnery Sergeant.
9 There's some service flavor to it that we just
10 can drop an edict. We've got to work with
11 everybody. But it's problematic.
12 CSM DeJONG: Correct me if I'm
13 wrong, sir. You kind of in a way have already
14 done it with your former statement about the
15 JEC. You said you just added a wounded, ill
16 and injured portion. So what are we going to
17 call it? If that's what you guys are going to
18 call it, then all we're asking for is tell us
19 what you're going to define it as so we can
20 define it as that.
21 MR. BURDETTE: Absolutely. And we
22 only have one DoDI out right now in the

1 Recovery Care Coordination Program. We call
2 it Recovering Service and throughout
3 consistent with the law. We need to drive the
4 services to some common nomenclature. I just
5 don't think it's going to happen overnight.
6 MR. REHBEIN: I want to touch on
7 -- go ahead. I'm sorry.
8 MR. BURDETTE: I'm sorry.
9 MR. REHBEIN: I want to touch on
10 something a little bit farther.
11 We've talked a lot about
12 consistency. And we've talked a lot about
13 terms. But in that second bullet there toward
14 the end, even in your own recommendation, you
15 recognize that differences in terms are
16 leading to differences in criteria for
17 inclusion in the program. And I'm wondering
18 as someone that hasn't worn the uniform for
19 quite a number of years now, why does Master
20 Sergeant MacKenzie's uniform color get him
21 treated different than Sergeant Major DeJong.
22 That's where I think we're really going to

1 with the consistency in terms leading to a
2 consistency end result for the recovery
3 service member.
4 MR. BURDETTE: I get that and I
5 appreciate that. And I think it is a common
6 goal that we all share. I'm just being very
7 pragmatic and realistic with you about the way
8 services have different admission criteria.
9 At six month complex care, what does complex
10 care mean in the Army, vis a vis what it means
11 in the Air Force?
12 It's difficult. It's work that
13 we're up for. It's work that we're continuing
14 to do with the services when we're working on
15 nomenclature. I just don't think it's going
16 to happen by edict or overnight. And if it
17 was, the backlash would be tangible.
18 CSM DeJONG: You mentioned
19 earlier, sir, that you do write the
20 legislation. So --
21 MR. BURDETTE: Well, we write the
22 policy.

1 CSM DeJONG: Policy.
2 MR. BURDETTE: Yes.
3 CSM DeJONG: But if you write the
4 policy at your level, I don't see how this
5 can't happen in a timely manner.
6 MR. BURDETTE: So I guess I would
7 take it from here.
8 I wrote a policy. I wrote the DoD
9 instruction in 2009. So grade me on how
10 that's going.
11 Not so good. So then I don't give
12 up there. So my job is to read the law, write
13 the policy and then have some oversight.
14 So crawl-walk-run continuum,
15 that's sort of the world I work in. That's
16 where we're going. We got to get with the
17 services. We've got to keep driving
18 consistency.
19 And I'll mention to you. Right
20 now, Deputy Assistant Secretary Campbell is
21 out in Camp Pendleton, California right now at
22 the Marine Corps Warrior Games Trials. And so

he's out there with the services, driving points home with them, learning about what the wounded warriors are going through in the Warriors Games Trials, and learning on the ground. So we've got to stay connected with the services. We do that. And that's how I think we get there in the long run across a spectrum of efforts.

MSGT MacKENZIE: So in your crawl-walk-run analogy, you're saying you write policy without oversight already in place?

MR. BURDETTE: No, not at all. I mean, oversight's inherent in it. But in crawl-walk-run, first you've got to write some policy before you can oversee it. So if I say do X, first I've got to write X and then put it out. I've got to train you to it. I've got to hold you accountable for it. And that's the oversight piece.

But until I publish it and give you a chance for that break-in period of hey, now we're doing things this way, then the

1 oversight kicks in. If I drop the hammer in
2 the policy and oversight all in the same day,
3 that's a little too authoritarian.
4 MSGT MacKENZIE: That's what I'm
5 trying to -- I mean, how in this standard
6 terminology deal, how long do you anticipate
7 before you can actually hold the services
8 accountable for using the same terminology?
9 MR. BURDETTE: Well, I mean, I
10 published it in 2009. So as far as I'm
11 concerned, there's a whole glossary in that
12 DoDI of all kinds of terms. Wounded warriors
13 is one of them. Recovering service members is
14 one of them. What an FRC does and an RCC
15 does. I mean, we laid it out. I think it's
16 an okay DoDI. It could be better. But we
17 need to get more aggressive in that. No doubt
18 about it. And I'm up for that work.
19 MR. CONSTANTINE: Phil, this kind
20 of reminds me of when we met with you guys
21 last time we were talking about the transition
22 assistance program. Similar in that, you were

1 struggling with well, you have policy what you
2 wanted to do first in individual services and
3 we kept saying well, why is the Marine Corps
4 the only one that makes everyone go through
5 TAP. Why can't you tell hey, Army, hey,
6 everyone is going to go through TAP? And your
7 answer was this is something for each service.
8 And it sounds like -- I'm not saying you're
9 defaulting to the services on this, but what
10 is precluding you from saying this is how it's
11 going to be at some point? This is how it's
12 going to be and get your stuff in line to deal
13 with that.
14 MR. BURDETTE: So I was much
15 younger in the portfolio then. So just
16 finishing my first year now.
17 So I think we have some strategies
18 that are going to bear some fruit on that as
19 far as that goes. And we're working on that.
20 I mean, I'm not giving up the towel. I mean,
21 there is some service-specific. They want to
22 take care of their own. They want to do their

1 own thing.

2 At the same time, the services

3 work for the Secretary of Defense. And we're

4 making that clear through a number of forums.

5 And I think you'll see some better results on

6 that. And they want to do the right thing

7 too.

8 And we've increased our interface

9 with them directly. I know they're briefing

10 you. Each wounded warrior program is going to

11 brief you at length, I think. And General

12 Williams, in particular, has been great about

13 coming around on some things.

14 And we've seen real progress in

15 the area of RCCs in the Army, for example. So

16 as you all know, they didn't use them forever.

17 But now the AW2 program is hiring them. And

18 now they're all going to get trained at RCC

19 training that DoDI requires.

20 So are we aggressively moving down

21 the tracks? I mean, I'm a hard grader. So

22 okay wise. But now you're seeing a

1 breakthrough. And that's I think one of many
2 breakthroughs. And that's a tangible
3 breakthrough with the Army in particular. And
4 I think that there's other areas of
5 positiveness. And the language and the
6 linguistics is another one.
7 MG STONE: If your DoDIs are
8 unenforceable, are you seeking legislative
9 relief for that?
10 MR. BURDETTE: No, I didn't say
11 they were unenforceable, General. I just said
12 oversight was the next step of putting a DoDI
13 out. And I was being very frank with you that
14 compliance especially in the nomenclature area
15 has not been widespread. But I don't consider
16 it a) unenforceable or b) work that we can't
17 get done with existing understanding of how --
18 MG STONE: How much more time do
19 you need to enforce the DoDI that you issued
20 in 2009?
21 MR. BURDETTE: Well, I mean, I
22 think that the RCP DoDI is largely being

followed in the areas of some local nomenclature. Like for example, if the U.S. Army wants to call RCC squad leaders --

MG STONE: So if there's a uniform standard and we don't see it enforced and we're being told that virtually all sites that we go to that it's not enforced in a uniform manner, how should we interpret that?

DR. BANNICK: Well, I'll be the first one to go to the wall on whatever's not being enforced.

But I would say this, General. If the Army is calling an RCC who does duties A, B and C a squad leader, I'm okay with that. And I'm okay with telling the Secretary of Defense the spirit of the law which requires an RCC to do duties A, B and C is being met by someone they're calling a squad leader. I think we've got more important work to do than to figure out what the nomenclature is at this point in our maturity as a program.

But if we've got noncompliance on

1 an issue of real importance like there's
2 nobody doing this critical function for the
3 family, we'll fix that by dinnertime.
4 MG STONE: So although it's my
5 impression in what I'm hearing that this isn't
6 that important from your standpoint, what the
7 committee is saying to you is it is the key to
8 access to care and to services. The
9 definition of how we view these service
10 members is the key to access.
11 So I would respectfully ask you to
12 take a step back from this and recognize the
13 fact that what we're really talking about is
14 access. And if in fact that you feel that we
15 have reached appropriate access, then please
16 come back and tell us so.
17 But I would ask you to take a step
18 back and really examine your position on this.
19 Thank you.
20 MR. BURDETTE: You bet. I think
21 that's fair, General.
22 MS. CROCKETT-JONES: And I'm going

1 to just jump in a little bit on that.
2 For instance, just on the thing
3 you cited, if the squad leader's doing the
4 same job as an RCC. So a service member who's
5 not getting his needs met, a service member
6 who's really feeling completely lost is told
7 that the RCC is the person who's overwatching
8 his CPT or CRP. But he doesn't have an RCC.
9 Do you see how this gives him pretty much the
10 idea that he has no avenue by which he is
11 supposed to get his needs met? If he's told
12 on the one hand in literature that he needs to
13 go to his RCC but he doesn't have one, and
14 locally this place he's just gotten to calls
15 it a squad leader, but he doesn't have that
16 information because there is no consistency.
17 And maybe he was in a unit somewhere else and
18 now he's been transferred. Now we have robbed
19 him of getting his needs met by not saying no,
20 we are going to call people who do the job the
21 same thing.
22 And I can guarantee you

1 anecdotally, this exact situation exists right
2 now. So while it may not be significant if
3 you think someone's getting their needs met,
4 but this is a stumbling block to people
5 getting their needs met.
6 DR. PHILLIPS: May I add that the
7 designated squad leader RCC in a lot of places
8 that we visit and we hear they are not even
9 trained to meet these. So to me, that
10 emphasizes the more importance of having a
11 definition so people can be trained to respond
12 to the needs.
13 MR. BURDETTE: So excellent point.
14 I think General Williams has done phenomenal
15 work in October when they published their
16 brand new entire program, definitions
17 included, training included, lays it out for
18 everyone from civilian to service member to
19 family member to taxpayer as to how he runs
20 his outfit. Terrific work. Happy when we
21 went over and met with the British Wounded
22 Warriors in October. Took that with us. They

1 loved it and incorporated it into some of the
2 training that they're doing.
3 So that document, revising that,
4 and then making a national standard and then
5 eliminating these pockets of excellence and
6 less than excellence has been a fantastic and
7 phenomenal step, and General Williams deserves
8 a ton of credit for doing that.
9 He also deserves a ton of credit
10 for now hiring RCCs. And I recognize that
11 they're part of the 1200 AW2s, not the 9,000-
12 some wounded warriors at large. But it's a
13 step in the right direction. We're getting
14 there. They like many of us in '07 ran
15 forward, hearts first, not necessarily heads
16 first, and let's do the right thing. And now
17 heads got to follow hearts and get us behind
18 on making sure that the Ts are crossed and the
19 Is are dotted and that our policy is
20 consistent and that we're delivering for that
21 service member nationwide.
22 But we've got important work to

1 do. If that squad leader does what the law
2 intends that RCC to do, good. Let's check
3 that and go to the really big stuff -- the
4 alligators that are in the boat closer to us.
5 We'll come back to fixing the nomenclature.
6 But to your point well, does that
7 mean that someone's not getting serviced, I
8 think those two steps -- a) publishing a
9 national WTU training program and what have
10 you and policy and doctrine I think will
11 eradicate a lot of that, not all. And I think
12 that have they've revamped their San Antonio
13 two-week training to your point, sir. The
14 squad leaders are all picked and go to that
15 training now. And if you've seen it, it's
16 good. And I looked them over carefully. It's
17 good. It can be better. And it's consistent
18 at national, and they're training their people
19 to a high standard down there and holding them
20 accountable for delivering. So if a solder
21 doesn't have a CRP, I think there's a
22 mechanism in place for that person to learn

about that and then ask the right questions through a variety of channels at their base, post and station and then hold everyone from me down to General Williams accountable for that.

MS. CROCKETT-JONES: While I know you think that there is a mechanism in place, I'm not sure that with the inconsistencies in language and with sort of the in-process way we change things that service members have access to understanding that mechanism. From my installation visit experience, this is very inconsistent. The information and understanding that service members have is quite inconsistent. And I really think the language issue fuels some of that.

MR. BURDETTE: Got it. Got it.

MS. DAILEY: Ladies and gentlemen, I only have Mr. Burdette technically for 15 more minutes. We're only on recommendation 1. This is it. We've got to move through this.

MG STONE: Respectfully, Denise --

1 MS. DAILEY: Although we've
2 covered three.
3 MG STONE: Denise?
4 MS. DAILEY: Yes, sir?
5 MG STONE: I would ask that the
6 committee be given time to work its way
7 through this. And this may be uncomfortable
8 and laborious. But how we understand the
9 Department response to the recommendations of
10 the committee in each of these areas helps
11 drive our future work. And if we need
12 additional time in a future session, I'm quite
13 sure that Phil will be kind enough to give us
14 some more time.
15 MR. BURDETTE: You bet. And I'm
16 happy to stay as long as you want or come back
17 for another session.
18 I will only say this -- and it's
19 just because of the importance -- I do need to
20 leave at noon because for the state visit,
21 there's a big wounded warrior aspect to the
22 Prime Minister Cameron's visit when he comes

on March 13th. So that's terrific for our community. That's the only reason I mention it. And I'm happy to help represent and put together a really special thing for wounded warriors when that happens. But I'd come back any time outside of that.

Thanks.

LT GEN GREEN: Okay, folks. Let's move on to number 2.

MR. BURDETTE: Okay. So this one I think the point you're trying to tell me is this comes from the expansion of what we said on the first one is let's make sure that everybody's getting same thing at the bases, posts, and stations and that it's driven by business rules that are from a national level.

Do I have that sort of correct? Is that what you're trying to tell me there?

LT GEN GREEN: There's a secondary part of it which is actually about maintaining the continuity of these types of efforts. So as the numbers of casualties come down and the

1 numbers of recovering service members come
2 down, are you going to let this all just
3 dissipate, or how are we going to capture this
4 in terms of what are the centers you bring up
5 first? And that's where the population base
6 comes in.
7 MR. BURDETTE: So I've think we've
8 chartered some work, General, to get after
9 this and really it's to figure out what it
10 costs us in the long term. So I mentioned
11 earlier the PEBLOs and the PEBLOs' assistants
12 and the lawyers and the MEB doctors that we
13 are investing in to help make this go better.
14 At the same time, we don't want to
15 buy PEBLO assistants as a full-time government
16 employee that four years from now has nothing
17 to do. So we've put a commission together to
18 get some work. What's the work model look
19 like our investments-wise? And I think that
20 gets right to your population base standards
21 on what's your mix of contractors, what's your
22 mix of government people, what's your mix of

1 uniformed people and the Reserve element that
2 we're also using to try to help, especially at
3 the MEBs and other phases. And let's make
4 sure that that labor mix and that resource mix
5 is appropriate for the densities we're seeing
6 now through the pipeline and what we're
7 expecting in the outyears.
8 I can also foreshadow in this way
9 we've done extensive work with the VA. And I
10 really credit Deputy Secretary Gould for
11 asking the question is how many are coming
12 back to my VA polytrauma centers so that I can
13 staff those correctly? I think this
14 represents sort of the first time where we've
15 sent that data over to the VA -- and I can
16 sort of tell you nothing's off the record --
17 so it's classified a lot of times. It's not
18 a well exercised mechanism between the VA and
19 the DoD -- classified numbers. So in other
20 words, if Fort A in State Y is deploying, we
21 don't always say that way out ahead of time.
22 But if you don't tell the VA way ahead of

1 time, they can't resource it correctly.
2 So that mechanism is now working.
3 There are secret binders now going that didn't
4 go before with data as far as getting
5 population-based standards for our VA
6 colleagues. And we're glad to do that. And
7 it also happens in an unclassified manner.
8 But I think we get it. I think we
9 want to do that both to be good stewards of
10 taxpayer money, make sure these people are
11 adequately utilized and make sure that the
12 people in the pipeline have what they need.
13 LT GEN GREEN: And I would just
14 add one more thing to that which is there's
15 been a lot of military construction, a lot of
16 dormitory, a lot of handicapped housing that's
17 gone into WTUs, WWR. And so the big question
18 will be all of that will be used for other
19 things --
20 MR. BURDETTE: Yes.
21 LT GEN GREEN: -- once you no
22 longer have the flow. And so if you don't

have a plan for which ones you're going to bring up first or how you're going to go about this, then essentially you will lose all of these assets as well as the expertise.

MR. BURDETTE: Prime example, Building 62 at Bethesda. They've already got a plan for how each wing will then become whatever it becomes in the next phase which is fantastic. The Fort Carson one is a stunning 96-room wounded warrior barracks, ADA-compliant from top to bottom.

But I had the same concern too. What about in 2017? What does this become? The base commander had a plan for it to make sure it gets utilized. We invested correctly there. I agree completely.

DR. PHILLIPS: My additional thought and being part of this recommendation was that some bases are so remote like 29 Palms that you cannot provide all the goods and services. And perhaps my message didn't get through was that perhaps some bases should

1 not have a WTU, that you should look at low-
2 hanging fruit and perhaps concentrate them on
3 the places that do have the available
4 services.
5 MR. BURDETTE: Agreed. And I
6 think that sort of comes back to the
7 definition of what's the price of admission
8 here. So if the word complex medical care
9 means that you don't get a 29 Palms, you've
10 got to go to Balboa, then let's PCS you and
11 let's get you over there to where you're
12 needed. And that's good for you and your
13 family. And it's probably a better investment
14 for us. But we've got to make sure that those
15 definitions -- right back to the Master
16 Sergeant's point -- definitions will drive
17 better policy which will drive better use of
18 resources which I think will drive a better
19 experience for the family and the service
20 member. I get it.
21 CSM DeJONG: And along with what
22 General Green said real quick, sir, is that

1 how do we expand and contract this and how do
2 we keep the level of training where we're
3 after ten or eleven years of building this.
4 What historically seems to be the services
5 being reactive to us going into a conflict and
6 having wounded, ill, and injured, we're
7 looking at making it more of a proactive. How
8 do we maintain where we're at along with
9 expanding and contracting this model to where
10 we don't lose the continuity and consistency?
11 MR. BURDETTE: I think Health
12 Affairs has done a tremendous job. And I
13 really General Robb, the surgeon for the Joint
14 Chiefs of Staff, of just really thinking
15 forward and putting stuff on the shelf --
16 binders of when our next conflict, send
17 behavior health, embed the physical
18 therapists, send the physician assistants
19 forward with them, make sure there's a way to
20 do this. Those types of things are going to
21 pay such good dividends for us in any type of
22 scalable conflict that we get into that I

1 think those lessons learned will be tremendous
2 for us.
3 And we learned a lot from the
4 British too. I mean, the Task Force that the
5 President announced that I've been pleased to
6 be a part of all summer, we learned a lot from
7 them - their decompression stops in Cyprus,
8 for example, how they approach the mental
9 health part of the equation. And we've
10 incorporated their doctors into our joint
11 mental health assessment teams and others. So
12 I think there's good work in that.
13 Can we go to the next one, please?
14 Okay. I think this builds on the
15 last one. What are the final outcomes? I
16 think you're trying to drive me to some
17 scientific business processes and business
18 rules at the very top as far as who gets in
19 and then what happens -- how long they stay,
20 where they stay, and then how that person's
21 informed and ensured of that.
22 Do I have your theme there?

1 LT GEN GREEN: Yes. This is a
2 little different. I think what we're really
3 trying to get you to understand here is that
4 we have enough experience now that we can
5 leverage the data if you listen in vague
6 terms. With a single amputation, you really
7 have certain expectations at the six-month
8 level, which if they haven't reached that, you
9 need to be thinking about are they going to be
10 able to -- same thing if you have a double
11 amputee or a triple amputee. That's probably
12 the easiest one. But the idea would be that
13 you capture some of the clinical data that
14 gives both patients and the system
15 expectations of when Medical Board will be
16 started, how this is going to go.
17 And all of the services when we
18 talked with them, no one was actually
19 collating that data.
20 MR. BURDETTE: And I think this is
21 part of educating the practitioners in the
22 IDES process as to expectations, whether it's

1 NARSUMs or predicted outcomes or how long can
2 we expect and those types of things. And we
3 have some work to do there, and I think Health
4 Affairs can lead us in that as far as helping
5 us on the practitioner side of making sure
6 that we have understandable goals and
7 milestones built in. So agreed.
8 LT GEN GREEN: Even when we talked
9 with the VA, or when I have talked with the
10 VA, it's always individualized. We understand
11 that. But if you give people kind of an
12 understanding of what the expectation would
13 be, it helps them understand and then you can
14 make decisions on the margin whether or not
15 they are making progress that should be
16 expected or not and then basically set it up.
17 But if you don't give expectations, then
18 essentially people linger.
19 MR. BURDETTE: Agreed. And that's
20 why I think the PEBLO assistant investment is
21 so smart and so good because instead of PEBLOs
22 making copies of files and sending that stuff

1 down, they can talk to families and to
2 patients and recovering warriors to make sure
3 that they understand what's next for them in
4 the process. I think that'll free up a lot of
5 bandwidth for our PEBLOs and our MSCs who can
6 then go back doing what they should be doing
7 which is keeping people informed.
8 MG STONE: This is really directed
9 more at population, really academic review,
10 looking at disease processes, establishing
11 milestones and creation. Yes, you're talking
12 about the right implementers of that data.
13 But we did not find anyplace within the DoD or
14 in the services where the data on this now
15 large population is being accumulated to do
16 predictive outcomes so that we know that a
17 single above-the-knee amputee patient with no
18 other comorbidities ought to be at four months
19 at X point.
20 Now if some of your individual
21 practitioners at your large centers do
22 understand where they think people ought to be

1 but there are no triggers when people fall off
2 track of recovery -- when should I be fit for
3 my prosthesis, when should I be ambulatory,
4 when should I be moving off of my pain
5 medicine, what are the triggers. And our
6 strong recommendation then was that we really
7 do a population dynamic study through one of
8 your research arms so that your PEBLOs, your
9 practitioners have a database to go to. That
10 is not currently being created.
11 MR. BURDETTE: General, I couldn't
12 agree more. And we're going to get to it in
13 a minute. But I think that's what the DECOs
14 do for us, especially with some of the
15 signature injuries that we're seeing here with
16 the TBIs and with the prosthetics. I mean, I
17 want to be a very demanding customer of that
18 substantial investment and really say help us.
19 That's why you're there. I think that they're
20 resourced correctly, and the tremendous volume
21 of resource they could give to that I think
22 represents real opportunity.

1 Anything else on this one?
2 (No response.)
3 MR. BURDETTE: Could we go to the
4 next one, please?
5 Okay. Back to the Comprehensive
6 Recovery Plan.
7 So I think what you're telling me
8 here is when you visited places like I do, I
9 always ask two questions -- who's your RCC and
10 where's your Comprehensive Recovery Plan. And
11 you either get blank looks or stares or what
12 does that mean. And then sometimes you want
13 to hug the person who says well, it's Jennifer
14 Adams and here's my CRP, right?
15 But then when you look at the CRP,
16 sometimes it's a photographed one-pager that
17 says get better, go home by Christmas -- that
18 type of thing.
19 I think that General Williams on
20 behalf of the Army, I think theirs is much
21 better now. I think their training is better
22 for the squad leaders who oversee the CRP. I

1 think they call it something different in the
2 Army. CTP?
3 And so I think the training is
4 better as far as squad leaders' expectations
5 for filling one out. And then I also think
6 that it's more coached to the family as to
7 hey, this is really your critical document.
8 We've made some investments. And
9 I'm insisting that we standardize across the
10 services an ability to electronically look at
11 these. So far we've seen each service do it
12 differently. And frankly, DoD OSD-level, we
13 did it differently as well. We invested in
14 our own type of thing. And everybody wanted
15 to bring a shiny penny to the table and say
16 look at mine. We're doing better now on
17 driving that to one single CRP. We call it
18 RCPSS. I don't care whose shiny penny we use,
19 but we all have to use one in my estimation.
20 And I think we'll get there in this calendar
21 year. And that way we'll all have a standard
22 baseline for it. And then we train to it.

1 And then we just hold people accountable.
2 They do report how many CRPs are
3 out there. So when the services look at me
4 and say 100 percent of my wounded warriors
5 have CRPs, that's good. But Master Sergeant,
6 I know you're going to jump at me. Well,
7 how's that oversight going?
8 So I took yes. I got it. But
9 then we got going further and say well, what's
10 the quality of that and is it that good and
11 are we feeling it that it's being felt
12 downstream or is it just anecdotal that the
13 occasional person doesn't have one. So --
14 MSGT MacKENZIE: One of the things
15 that we find, sir, is that -- we'll go back to
16 my comment the last time we met over the whole
17 Internet thing. I mean, here we are again
18 where it's like okay, everybody will have a
19 CRP.
20 MR. BURDETTE: Yes.
21 MSGT MacKENZIE: Great. I could
22 fill out a CRP for everybody in the room and

1 say everybody has a CRP.
2 MR. BURDETTE: Got it.
3 MSGT MacKENZIE: The purpose of
4 the CRP is not being accountable. You're not
5 being accountable to the purpose of the CRP,
6 only the fact that you have a piece of paper
7 that says CRP on it.
8 MR. BURDETTE: Got it.
9 MSGT MacKENZIE: Okay? When we go
10 to these sites and we talk to these folks,
11 it's almost of no value to them. When we see
12 people who have processed out of the military,
13 we see completed CRPs, and they're worthless.
14 It sounds to me that the level of
15 accountability to this product where you say
16 everybody must have one is not achieving any
17 purpose whatsoever that the warrior other than
18 another moment in time of paperwork fill-out
19 that doesn't do them any good.
20 DR. TURNER: I'm just going to
21 add, I would like to hear based on what Mack
22 said, what specifically plans DoD has for

1 accountability and oversight with this.
2 MR. BURDETTE: So the first thing
3 is we ask all the services does everybody have
4 one. So we can yes, and I can testify to that
5 all day long that we had it. But to the
6 Master Sergeant's point, how good are they?
7 So then, we go back to the General
8 Williams and we say, well, what chapter of
9 your training teaches your squad leader to do
10 a good one, and then to make sure that it's
11 overseen by not only the squad leader but
12 perhaps a platoon leader or someone else who
13 has experience with this. You sort of build
14 a hierarchy of people that understand those.
15 So we've gone back and said the
16 training has increased for better ones. The
17 forms they're using are different and better
18 as a result of the new Army policy that came
19 out in October or November. And then we're
20 going to go out and look service-wide to make
21 sure that there's a baseline of excellence for
22 these CRPs. And it's my goal, as I've

1 mentioned with the four different independent
2 electronic versions to have them all in some
3 place where they're resident somewhere that
4 each service is using a consistent electronic
5 form and that we can have some visibility on.
6 MSGT MacKENZIE: What is your plan
7 for judging its effectiveness then? I mean,
8 are you planning a survey of the folks? Once
9 again, it comes down to the warrior at the
10 user level. What is your plan for making sure
11 that they're getting a good product?
12 MR. BURDETTE: So crawl-walk-run.
13 Let's make sure they have them. Let's make
14 sure that from what policy people think are
15 good ones that have been set up. Let's make
16 sure people that have managed these through to
17 completion with good effect have signed off on
18 those and said they're good. And then let's
19 make sure that we're asking all audiences --
20 the people that implement them, the people
21 that have to type them into the system and the
22 people that are using them. And I think that

1 that drives what you need to improve. For
2 example, hey, there was nothing on there about
3 my resume prep. And that needs to improve.
4 So then how do you know it's doing
5 well? Well then we see that feedback and we
6 add a resume section. I'm just making this
7 up. I think there is a resume section on
8 there. Or are you using the GI Bill section?
9 Or with the new TAP that's coming out, have
10 you availed yourself of all the new TAP
11 opportunities. So that's going to take a
12 revision to the CRP to make sure that that
13 person knows hey, entrepreneurship open to me,
14 or I can go education, or I can go and get a
15 job -- that type of thing.
16 DR. PHILLIPS: Would you know how
17 much the CRP or the CTP -- again definitions
18 -- program is costing? Any idea?
19 MR. BURDETTE: I would not. I can
20 only tell you some of the electronic systems
21 that have been invested in. I could get those
22 numbers. I'm not sure that answers your

1 question.

2 DR. PHILLIPS: Again, I don't want

3 to expound and beat on you related to from

4 what we've heard, or what I've heard, how

5 useless this whole system is on both sides.

6 Complaints from the cadre and the staff is at

7 we can't even download the pages, it takes two

8 minutes to download each page, and I have 30

9 or 40 to review every week.

10 MR. BURDETTE: Right.

11 DR. PHILLIPS: And then from the

12 soldiers' side, again technically, it's very

13 difficult. They can't get online. They can't

14 connect.

15 So there's a major strike against

16 the system right there. So technically, the

17 whole system has to be improved if it's going

18 to go ahead, and I assume it will be.

19 And the other is again, response

20 to what is put on the CRP. If I don't fill it

21 out, I get a call. If I put something

22 outrageous on it, no one even notices it. And

1 you've heard this before.
2 MR. BURDETTE: Got it.
3 So I think a) It's going to
4 continue because it's in the law; b) I've
5 heard the same technical issues. When I speak
6 to my shiny penny syndrome, I want a shiny
7 penny that works for everybody and is
8 downloadable and usable for the family and for
9 the person who has to implement it and for the
10 squad leader that has to put it together for
11 that person. So that's a real goal. I think
12 we're driving that towards conclusion.
13 Then improving quality through
14 training, and I think the new Army one
15 represents a step forward.
16 MSGT MacKENZIE: Just to add a
17 positive note to some of my comments, when
18 this is done correctly way down at the user
19 level, it's a great tool. The problem is
20 there's not standardization or enforcement to
21 use it at that level across the services.
22 So it is a very, very good tool.

1 It's a communication tool. It's a mentoring
2 tool. It is certainly a great tool. The
3 problem is we have to dig far and wide to find
4 those occasional superstars that are using it
5 the way you designed it and are actually being
6 accountable to their warriors -- their
7 recovering service members -- to provide them
8 a good product. The problem is that there's
9 no enforcement to operate it at that level
10 across the services.
11 MR. BURDETTE: I think you're
12 absolutely right. And when the TAP people
13 come in and talk to you about what TAP is now
14 -- for every service member, not just a
15 wounded warrior -- every service member is now
16 going to have a career transition plan. So
17 it's not a CRP, but it's a career transition
18 plan which is going to read an awful lot like
19 this. And this was the model for it when used
20 correctly.
21 DR. PHILLIPS: And the reason I
22 asked about the costs again is that I work in

1 this area, and I can guarantee probably that
2 a Google or a Microsoft or one of those big
3 firms could probably fix this very quickly
4 related to bandwidth and simplicity. And I
5 would extend that to the electronic health
6 record that we've been struggling with
7 forever. It's just thinking out of the box a
8 little bit and getting somebody else who knows
9 how to do this involved.
10 LT GEN GREEN: Yes. And I think
11 we're going to hear about that this afternoon.
12 And I'm fairly involved with exactly trying to
13 do that.
14 So in respect for this gentleman's
15 time, we're on number 4, and we've got like
16 14. And so I don't know if there's some that
17 are of more criticality to the members. Is
18 there one that somebody really wants to go to?
19 Because we've got the Department's answer. Is
20 there something we'd like clarity on?
21 DR. TURNER: Just number 7, just
22 to make sure -- recommendation 7, the next one

1 -- just to make sure I understand kind of what
2 you're saying.
3 So DoD basically agrees on the
4 need for acuity-based medical standards, but
5 it feels that it's really more of a service-
6 specific -- the services' responsibility to
7 determine those standards. Is that what
8 you're saying?
9 MR. BURDETTE: Well, we write the
10 doctrine that puts the ratios out. So we need
11 to write the ratios. We don't actually --
12 DR. TURNER: So you do agree that
13 DoD needs to set the standard --
14 MR. BURDETTE: It has.
15 DR. TURNER: -- for the service?
16 MR. BURDETTE: It has. In our
17 DoDI. The 2009 DoDI does.
18 Now the services actually hire
19 those people. So --
20 DR. TURNER: What's your thoughts
21 about oversight and resourcing and
22 accountability?

1 MR. BURDETTE: Well, that's three
2 huge and different things.
3 DR. TURNER: Right.
4 MR. BURDETTE: So accountability?
5 Absolutely. They're accountable to the
6 Secretary of Defense who writes the policy.
7 He says do X. You better do X.
8 Accountability? That's the
9 accountability resourcing. Now they come up
10 with their own resourcing plans. And when
11 they can't meet it, it's their obligation to
12 say hey, you told me to do this. I can't get
13 there. And then we have those discussions.
14 And I think to a good end in the
15 IDES which we opened talking about, that
16 yielded a discussion where we found money to
17 hire 700 more people to put into the IDES.
18 And that was a significant investment across
19 four years.
20 So I think that's how that starts.
21 That's how that machine works. I think it
22 worked well in IDES. It would work well here.

1 If they tell us that we don't have enough
2 medical care case managers in this case --
3 that's your 40 to 1 ratio -- then we'll have
4 that discussion and we'll find money for it
5 either through an unfunded mandate process or
6 we'll palm for it in the outyears and we'll
7 get there from there. And we'll accept risks
8 going forward. Just like we do with anything,
9 where you can't afford the next aircraft
10 carrier or whatever.
11 MSGT MacKENZIE: Yet in many of
12 the site visits we went to, no one was meeting
13 the DoDI standard for ratio.
14 MR. BURDETTE: I accept that.
15 So from where we sit, then we
16 write the policy and then we hold accountable
17 and we shine a bright spotlight on it. So the
18 SOC was a vehicle that we used very
19 effectively to say you're meeting this or
20 you're not meeting this. And when the SOC has
21 the Deputy Secretaries of both Departments
22 sitting there taking the brief, that tends to

1 spur action. So the JEC now needs to take up
2 that flag and make sure that when like issues
3 of noncompliance are brought up that we then
4 have a mechanism to get there.
5 The services, to their credit,
6 when it was shown that they weren't investing
7 properly in IDES said well, buy me PEBLOs,
8 PEBLO assistants, doctors and some lawyers.
9 And that's what we went and did. So I think
10 that that's a good construct. And I think
11 it'll work going forward.
12 LT GEN GREEN: Is there another
13 one that we want to focus this gentleman's
14 efforts on?
15 MS. MALEBRANCHE: You mentioned
16 earlier about the Centers of Excellence in
17 relation to the question that was asked
18 earlier about how we're resourcing. And I
19 just was wondering if you could follow on that
20 one. I think it sequentially happens to be --
21 MR. BURDETTE: So can we bring up
22 the DCoE one, please or the Centers of

1 Excellence?

2 MS. MALEBRANCHE: It's the next

3 one.

4 MR. BURDETTE: So I'm so in love

5 with this concept that we had them brief the

6 SOC over the summer at my invitation to try to

7 raise awareness across our community for what

8 the Centers of Excellence can do for us. And

9 I think there's still a lot of work to be done

10 as far as that goes. So when I say I'm a

11 demanding customer of them, I want them to

12 help us with predicting outcomes and telling

13 us how long it's going to take for that

14 compression injury, TBI, PTS person to get

15 through the system.

16 The investment is significant.

17 The results are incredible. If you visit

18 them, and you have, they're impressive places.

19 We need more at the macro level now from them.

20 And I'm anxious to have that in '12.

21 MS. MALEBRANCHE: And I guess one

22 of the things that just brought to mind

1 earlier we were talking about this what the
2 expectations are. So for a patient and their
3 family, if they know that they have a double
4 above-the-knee amputation, what their
5 possibilities of staying on active duty or
6 doing something else, they should know that.
7 But I guess the thing when you're doing the
8 DCoE and you've got professionals and
9 physicians on both sides too, we have the DoD
10 and the VA folks. But that has to be the
11 expectation provided by Defense, has to be
12 known by the VA providers as well, so that
13 they do have that and they've talked together
14 and it's not just telling the patient this is:
15 well, gee.
16 So those sorts of things --
17 requirements from the -- it seems like the
18 natural place for a lot of these to occur.
19 But I don't think it has. So I was just
20 wondering how you're going to resource the
21 Centers of Excellence and guidance in that
22 area.

1 MR. BURDETTE: Well, that's why I
2 invite them to the Joint SOC, so that half the
3 table is VA and half the table is DoD, so we
4 could all learn at the same time; that's what
5 they were doing.
6 So I think that was the first
7 step. I think the second step is to continue
8 having them come back and then have the SOC
9 send them tasks. So we had the nice info
10 brief about here's what we offer.
11 Now it's time for the SOC -- in
12 its new form, JEC -- to say, here's what I
13 need from you. And I think it comes right off
14 the recommendation.
15 MS. MALEBRANCHE: And I know you
16 probably don't know this -- or I don't know
17 this, but in the new forum, the JEC -- which
18 is now the new SOC -- you have the Deputy
19 Secretary from VA. Do we know that we have
20 the Deputy Secretary from DoD?
21 MR. BURDETTE: We will not. As
22 your recommendation 21 said, it requires

1 legislative change to change the chairperson.
2 So the PNR chairperson from DoD will remain
3 the chairperson on DoD, but from DoD's
4 perspective.
5 MS. MALEBRANCHE: Okay. I thought
6 it was: they can go up, but they couldn't go
7 down to a certain level.
8 MR. BURDETTE: No. Your
9 recommendation 21 says: in order to change
10 the chairpersons, it requires legislative
11 action. And we agree. We, DoD, agree.
12 LT GEN GREEN: On the CoEs, so
13 when we follow up with them, is it reasonable
14 then to use our recommendation 3, based on
15 what you said, that we would expect them to be
16 working on milestones and outcomes, et cetera,
17 since that's what you've said? Is that
18 correct?
19 MR. BURDETTE: That's my polite
20 request. Yes, General.
21 But also this term of art -- the
22 Defense Centers of Excellence and Centers of

1 Excellence -- when I speak of it, I'm speaking
2 of all five -- your limbs, your traumatic
3 brain injury, your prosthesis, vision and
4 hearing, I think is the last one. I mean, I'm
5 an aggressive customer of all five. We've got
6 wounded warriors that need help in all five
7 portfolios. I'm a little paternalistic on
8 that, so --
9 LT GEN GREEN: I'm not certain
10 that that's currently in their purview. And
11 so, getting that into their purview would be
12 helpful.
13 MR. BURDETTE: I agree, General.
14 MS. CROCKETT-JONES: I'm also
15 going to jump ahead to recommendation 13. I
16 want to say, this statement is made currently:
17 Every recovering service member assigned a
18 recovery care coordinator receives benefit
19 information on a regular and recurring basis,
20 including information about the National
21 Resource Directory and Military OneSource.
22 That's a wonderful, wishful thinking. But

1 that is not the experience we are getting at
2 our installation visits.
3 I can honestly say -- I've
4 probably spoken myself to 20 to 30 say, family
5 members. And not once has anyone heard of the
6 National Resource Directory. Some of them
7 have never heard of a recovery care
8 coordinator. Some of the service members I
9 talked to have spoken to their recovery care
10 coordinator once in a year. And that person
11 did not give them any information regarding
12 National Resource Directory, Military
13 OneSource, or any benefits they might get.
14 They gave them a photocopy of a static CRP or
15 a CTP.
16 I understand you might be aiming
17 toward that, but it is not current.
18 Currently, that is not happening. Not at all.
19 You're really far from that standard. And I
20 would hope that we can hear some concrete
21 ideas on how you're going to get to that, so
22 that you can say that it's happening

1 currently.

2 LT GEN GREEN: And I could add,

3 before you step into this one, there's also

4 now a Presidential Directive, as well as

5 Congressional interest in us combining a lot

6 of the websites, getting to a single entry

7 point for this. And so, we're looking for

8 your efforts to try and get it so it's easier

9 for people to get information.

10 MR. BURDETTE: So I can report

11 that progress on that is great? It's sort of

12 like if major league baseball was to contract.

13 All 32 teams have come into the room and it's

14 like whose team is going to lose. It's a very

15 fun fist fight to watch between all of us,

16 because we're all very proud of our websites.

17 But that work is continuing,

18 General, and will result in fewer websites,

19 better streamlined experience for service

20 members and veterans. I think the two front

21 runners are probably eBenefits.gov -- because

22 it's fantastic and connects our veterans

1 across their continuity of service -- and I
2 think the National Resource Directory or
3 Military OneSource inside the Pentagon are
4 front-runner websites to try to be a
5 consolidation point.
6 Let me make a couple points on
7 that. And I think I've got some real concrete
8 that's working.
9 I share the anecdotes. What?
10 What's that website? But at WWCTP, we have
11 three primary missions. One of them is
12 connecting people to resources. So I could
13 show you my Facebook likes, and I could show
14 you how many times we tweet, and how many
15 people are following me and doing those
16 things. And that might be a little
17 impressive, at a trickle.
18 But here's what's really
19 impressive. And you mentioned it earlier,
20 sir. We brought in a guy from Google name
21 Guha -- who's not a European soccer star with
22 one name, but he's like their guy. And he's

like 23 years old and wears sneakers and flew in on the company plane and landed with us. And we said, we've got to get better at the National Resource Directory. Help us. And he did.

And he sat there and helped us write code and wrote a scheme that let us crawl through the web and find all veteran-friendly job sites and then put them on the National Resource Directory and something called the National Jobs Bank.

So if you go to the National Resource Directory today, two sides -- there's a resources side with 13,000 resources. And then there's a get-a-job site at the National Jobs Bank.

So as much as I hear -- just as you do -- what's the National Resource Directory, I know 228,000 people since October have gone to that job bank. And they can only get to it through the National Resource Directory.

1 MSGT MacKENZIE: But how many of
2 those are actual recovering service members?
3 MR. BURDETTE: Don't know. And
4 unless I start trolling the Internet, I won't
5 know.
6 MSGT MacKENZIE: But that was a
7 question that was brought up last year --
8 MR. BURDETTE: Yes. Good point.
9 MSGT MacKENZIE: -- and it was the
10 same answer. It was: until we're willing to
11 make the tough decision and find a way to
12 identify folks.
13 MR. BURDETTE: Well, you're not
14 going to identify who's on the Internet and
15 clicking on the button. It's not going to
16 happen.
17 MSGT MacKENZIE: Right.
18 MR. BURDETTE: Not in the society
19 we live in.
20 MSGT MacKENZIE: So then how do
21 you judge that as being successful?
22 MR. BURDETTE: Well, because those

220,000 people: a) found out about it through channels that I advertised and invested in. It's the same way if you own an advertising firm that came and said, how am I going to grade that I'm spending $100K on this advertising campaign? They may tell you the demographics, but they may say I don't know, but we have increased traffic to your site by X percent.

So I know what I invested in. I had the President do -- I didn't -- we had the President do a Rose Garden ceremony where he announced the website. Significant uptick in traffic off of that. And then we monitored other investments, both in print, online and in other media that we put out. And the traffic went up.

So we did it scientifically, the way any ad firm would do it. And I'm not saying that those were all wounded warriors. But 228,000 people did go to that website and look for a job since October, which seems

1 significant, especially if you compare it
2 against the strata of who goes to these
3 websites.
4 I don't think we're home. We're
5 not declaring victory, but we are doing a
6 couple things. We're using outside people
7 that are smart in doing it. We brought them
8 in. They helped us. It was great. And we're
9 trying to develop resources that get to the
10 community.
11 I don't think we're home yet. The
12 NRD's still not widely known, nor is it the
13 greatest. It may be eclipsed by OneSource or
14 eBenefits. But whatever it is, we've got to
15 make sure that our strategic goal of
16 connecting wounded warriors to opportunities
17 and resources is there. Right now, this is
18 doing it and trending in the right direction.
19 But we can do better.
20 LT GEN GREEN: Mr. Burdette, I
21 think in fairness to you, because of your
22 timing, we need to let you go.

A special thanks from us, based on some of the things that were implemented -- rather rapidly with regards to the elimination of the SOC and the combination into the JEC -- and as well as the work that was done on special compensations.

So we thank you for the things you are doing. We're happy that you're listening to us, and forgive us as we grill you a little bit. But we don't get too many opportunities to talk with you. So thank you.

MR. BURDETTE: Thank you, General. Thank you, all, very much.

MS. DAILEY: Lunch is served, ladies and gentlemen. And my staff will assist you in getting to the location where lunches are. Don't ask me. They're going to assist me also.

(Whereupon, at 12:05 p.m., the above-entitled matter went off the record and resumed at 12:47 p.m.)

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

12:47 p.m.

LT GEN GREEN: Okay, ladies and gentlemen. Welcome back.

I'd like to introduce Brigadier General Darryl Williams -- who's been kind enough to walk around and shake everyone's hand -- Commander of the Warrior Transition Command. And Colonel Priscilla Berry, I believe, is the other person who's here. I'm going to let him introduce the rest of his team, basically from the -- I'm sorry, Colonel Berry is from the Army MR&A -- to lead the Army's update to the Task Force and address their input to the 3 December submission to Congress.

All the other briefers, I'll let General Williams introduce. And they are also in your agenda. Please look at your agenda for the specific questions that they are addressing at Tab E, is I believe where you'll find the Army Tab.

1 And over to you, General Williams.
2 BG WILLIAMS: Thank you, sir.
3 Good afternoon.
4 I hope everybody had a good lunch.
5 Did you have enough time for lunch?
6 Sir, thanks for this opportunity
7 again, Ms. Crocker-Jones, member of the Task
8 Force.
9 I am Brigadier General Darryl
10 Williams, Commander of the Army's Warrior
11 Transition Command, and also Assistant Surgeon
12 General for Warrior Care and Transition.
13 It is indeed a pleasure to have
14 the opportunity to appear before the Task
15 Force again to provide an update concerning
16 the work the Army is doing in support of the
17 Warrior Care and Transition Program.
18 I would like to begin by
19 commending the Task Force on the excellent
20 work accomplished, as documented in your 2011
21 Annual Report to Congress. While I was glad
22 to see many positive observations concerning

1 the Army program in that report, I also
2 welcomed the comments on areas in which we as
3 an Army can improve our care and support of
4 the wounded, ill and injured soldiers and
5 their families.
6 As you're aware, that's why we're
7 here today, to review a number of findings
8 from that report and tell you what the Army
9 has done to address some of those findings.
10 To ensure you hear from those who are the Army
11 and the Warrior Transition Command's experts
12 in the various areas that will be discussed,
13 our presentation today will be conducted by
14 several individuals.
15 Colonel Priscilla Berry,
16 representing the Office of the Assistant
17 Secretary of the Army for Manpower and Reserve
18 Affairs, will discuss with you the Task Force
19 recommendations.
20 Colonel Henry Spring of the Office
21 of the Surgeon General -- and an expert in
22 medical readiness and standards -- will

1 address the support provided soldiers as part
2 of the Soldier Medical Readiness Campaign
3 Plan, which ensures that soldiers who remain
4 in their units while they undergo an
5 integrated disability evaluation system
6 termination receive the care and support they
7 require.
8 Ms. Nancy Adams, who works for me
9 in the Warrior Transition Command, Branch
10 Chief for Career and Education Readiness, will
11 do a presentation for you on meaningful work.
12 And then Colonel Greg Swanson, who
13 presently is the Chief of the Army's
14 Integrated Disability Evaluation System Task
15 Force, will bring you up to date on the
16 efforts of the Task Force to establish a
17 standardized approach to conducting Medical
18 Evaluation Board and Physical Evaluation Board
19 activities.
20 Before I turn the presentation
21 over to Colonel Berry, I would like to take a
22 moment to talk about the Army's position

concerning the Warrior Care and Transition Program.

The Army views the program as being enduring. The Army leadership understands the value of the program, even in the era of fiscal constraints, along with the fact that even after the conflict in Afghanistan draws to an end, there will be a number of soldiers requiring care for devastating wounds and injuries, as well as those requiring care and treatment for behavioral health conditions such as PTS, traumatic brain injury and the like. As an enduring mission, the Warrior Care and Transition Program will be there to provide these soldiers the care and support they require.

We've accomplished a lot over the past year. And I would like to get started telling you all about that by asking Colonel Berry to come up.

COLONEL BERRY: Good afternoon.

1 As General Williams stated, I am Colonel
2 Priscilla Berry, and I'm here today on behalf
3 of the Assistant Secretary, Mr. Thomas Lamont.
4 And I want to thank you for the opportunity to
5 brief you today.
6 You asked us to lay out our
7 implementation plan for many of the
8 recommendations that were made in the 2011
9 report. So I'm going to walk through those
10 and discuss our responses to that.
11 Next slide, please.
12 So the first one is recommendation
13 #3. And in this one, you asked us to ensure
14 that we had protocols in place that drove the
15 care that we provide to our wounded soldiers,
16 and that those should include decision points,
17 specific milestones and outcomes, and that a
18 part of that lays out the options for our
19 soldiers' opportunity to either return to duty
20 or transition out of the military.
21 For those protocols, we believe
22 that clinical practice guidelines really serve

1 as the basis for guiding that care. Now while
2 we recognize that those guidelines or CPGs are
3 not available for every single possible
4 diagnosis that our soldiers might have, they
5 are in place for the most common ones. And
6 we've worked collaboratively with the VA in
7 developing approximately 24 of those CPGs.
8 They do cover some of the most
9 common conditions that we see in our wounded,
10 ill and injured population, to include post
11 traumatic stress, pain control -- and there
12 are actually the three CPGs that are in
13 existence for that -- amputee care, and also
14 care for those with traumatic brain injuries.
15 These guidelines are taught to our
16 clinical staff, specifically through the nurse
17 case manager courses, and then also the
18 orientation programs that our clinical and our
19 senior leaders go through. So they are made
20 aware of these, and what they contain. And
21 then these individuals can use these as a
22 roadmap for ensuring that our soldiers are

1 hitting the targets and receiving the care
2 that they should as they go through the
3 process.
4 In addition to the CPGs, we also
5 have contracts in place that allow us to use
6 the Milliman Care Guidelines and the MD
7 Guidelines. Again, these are additional
8 sources of protocols that exist, and these are
9 provided to our nurse case managers. And
10 again, they are able to use these to develop
11 the plans for our soldiers and to make sure
12 that they are receiving all of the care that
13 they should be.
14 We are using these tools -- in
15 addition to the data that we receive from the
16 care that we provided -- to do further
17 research to further predict and refine
18 expected outcomes as best we can, with the
19 understanding that of course it's hard to
20 pinpoint that specifically or precisely for
21 every single soldier. But obviously it does
22 give us some guidelines that we can provide.

1 Key to conveying this information
2 to our soldier is the Comprehensive Transition
3 Plan. And this is a key document that I'll
4 refer back to several times. But it does
5 contain information in there for the soldier
6 in collaboration with the team in developing
7 what that treatment plan is going to be, and
8 it helps to establish what recovery goals are.
9 Included in that is working with the soldier
10 to determine if one of their goals is to stay
11 on active duty if at all possible, and if not,
12 then developing plans to help him transition
13 out of the service.
14 DR. TURNER: Colonel Berry?
15 COL BERRY: Yes?
16 DR. TURNER: Before you proceed,
17 just a quick one.
18 First of all, well done on what
19 your work with the VA and with the CTPs and
20 everything. Very good.
21 Based on your experience and your
22 research that you're ongoing now looking at --

1 what's the right clinical path for our wounded
2 warriors -- do you think there would be any
3 value added in promulgating these clinical
4 pathways and milestones throughout DoD, based
5 on what you've seen so far? And if so, how
6 would you do it?
7 COL BERRY: I think there's always
8 value added in sharing best practices, and in
9 sharing what we've found with our population,
10 and sharing those with other services.
11 I think the key to getting that
12 information out is through OSD, through WWCTP,
13 and then sharing the results of what we find
14 and making that information available to the
15 other services.
16 DR. TURNER: Any more specific
17 ideas on that? I understand the generalities,
18 but do you have any specific ideas?
19 COL BERRY: I kind of look around
20 to my WTC colleagues to see if they have
21 anything.
22 COL SCOTT: I'm Colonel Susie

1 Scott, and I'm the Chief Nurse for Warrior
2 Transition coming in, and the consultant nurse
3 case management consultant to the Surgeon
4 General.
5 The clinical practice guidelines
6 are DoD/VA collaborative clinical practice
7 guidelines and were developed collaboratively
8 among all the services and VA.
9 And there have been members from
10 each of the wounded, ill and injured programs
11 who have a vested interest and knowledge and
12 expertise in caring for the wounded, ill and
13 injured that have served as proponents for the
14 development of those clinical practice
15 guidelines. As an example, for the PTSD
16 clinical practice guidelines, from Army we had
17 two or three case managers and a PCM and a
18 behavior health that were specifically
19 involved in the care of our warrior transition
20 population. They actually worked in our
21 warrior transition units that helped develop
22 that CPG.

1 Does that answer your question,
2 sir?
3 DR. TURNER: That's good. Thank
4 you.
5 COL SCOTT: Okay. Thanks.
6 MSGT MacKENZIE: As kind of a
7 follow-up to that before you yield the
8 microphone, Colonel Scott, you may want to
9 answer this, or you may, Colonel Berry.
10 The question here with this
11 probable outcomes, the work that you're doing,
12 is it going to give you the ability to not
13 only give the recovering service member
14 targets, goals, but also as managers of our
15 recovering service members, is it going to be
16 able to help you in -- for lack of better
17 terms -- encouraging these guys to meet a
18 standard, versus slowing the process down
19 because, for whatever reason the service
20 member decides, or whatever's happening -- I'm
21 don't know if I'm getting to my point directly
22 -- but do you see what I mean? Is this going

1 to give you that ability to go: this is the
2 target? Because I know with my guys at the
3 bedside, they're like: tell me how long this
4 is going to take, so I can beat it by 20
5 percent. Tell me how long, so I can keep
6 going. I can keep moving forward. But with
7 that ability, also is the ability for you guys
8 to manage people that may need some more
9 encouragement. Does this give you that
10 ability?
11 COL SCOTT: If my doc were
12 standing here, he would say every patient is
13 different and has a different path that they
14 take to get through the healing and transition
15 process. From a nurse case manager's
16 perspective, I think the clinical practice
17 guidelines, Milliman Care Guidelines, MD
18 Guidelines give you a tool and a framework for
19 expectation management. And when we teach
20 this at the cadre course for the nurse case
21 managers, we introduce these as tools to help
22 facilitate conversations with the primary care

1 manager, based on evidence that's in the
2 literature for expectation management, and
3 then be able to facilitate the conversation at
4 the bedside as well with our individual
5 soldiers for expectation management, to say:
6 look, this is where the evidence and the
7 literature says this path would take for this
8 particular illness or injury.
9 Does that answer your questions?
10 MSGT MacKENZIE: It does. It
11 does. And because there's a significant level
12 of value there, which is one of the things
13 that we identified. And for a target for an
14 individual so they don't feel like they're
15 just squandered away, they're actually going
16 somewhere. And I know from my four-plus years
17 at the bedside, this is what everyone of my
18 guys want to know. How long is this going to
19 take, and when can I get to X?
20 COL SCOTT: And Milliman and MD
21 Guidelines provide you that tool, as do our
22 DoD/VA Clinical Practice Guidelines. They

1 provide you a little bit of tools so you can
2 help with expectation management.
3 LT GEN GREEN: I think that the
4 only way I would ask to expand on that, just
5 a little bit, is that clinical practice
6 guidelines and Milliman are really guidelines
7 for the professional staff. And what we're
8 looking for are ways that that's actually more
9 formally presented to the patients to manage
10 their expectations.
11 And so, one of the things you
12 said, Colonel Berry, was that you're going to
13 use a CTP for that. And if you're going to
14 use a CTP for that, does that mean that you're
15 actually developing a standard CTP for a
16 single above-the-knee amputation?
17 And again, I realize that this is
18 all individualized when it comes to any given
19 patient and comorbid conditions, et cetera.
20 But for someone who comes in and has a
21 question as to what can I expect, being able
22 to refer to something and actually take pride

1 in beating the times -- or knowing when
2 they're behind the timetables in terms of when
3 people start talking to them about maybe the
4 next step is whether you're going to stay on
5 active duty or not -- are very helpful. And
6 so, what we're looking for is beyond what
7 would be given just to the provider, and
8 something that would help with expectation
9 management at the patient level.
10 BG WILLIAMS: Yes, sir. And I see
11 my CTP expert standing up. Dan, I'll give you
12 a shot here in a second.
13 So I think that's exactly right.
14 I think Priscilla kind of laid out
15 strategically, sort of generically as you
16 said, but at the tactical level down where a
17 squad leader and a nurse case manager and a
18 doc -- what's a reasonable expectation that
19 you could create some thrust, incentivize this
20 program. I'm going to be here in X amount of
21 days, and if I do these things. And the CTP
22 provides that roadmap now.

1 And the units that do this very
2 well do it very well. And they meet their
3 expectations, and soldiers and their families
4 move through very quickly. The units that
5 struggle a little bit haven't quite automized,
6 made it to where they can see all their
7 soldiers, and it's a little bit cumbersome,
8 they struggle a little bit.
9 I think the basics -- a squad
10 leader, a nurse and a doc -- in concert with
11 the triad of leadership -- the senior mission
12 commander, the MTF commander, and the
13 battalion commander and in two cases brigade
14 commander -- the synergy between those two
15 triads, if you will -- with the CTP as the
16 center of that -- can create that traction.
17 That's my word. That's not to take your word,
18 Sergeant Major. But that's kind of what I
19 see.
20 LT GEN GREEN: Yes. And I'd
21 rather not go down the venue of the CTP,
22 because we've done that several times.

1 So I hear you. I understand how
2 you want to use that to bring the team
3 together. But I'm still asking one step
4 further, which is what does the patient have
5 that kind of gives them some expectation, so
6 that they know whether they're being fully
7 successful, a little delayed -- and basically
8 everybody's worked with them to help them
9 understand where they're going to go next?
10 And please don't misunderstand. This is not
11 rote. I'm not trying to take away from
12 individualized therapy. But I think every
13 patient -- especially with the amount of the
14 volume we've seen -- should have some idea.
15 So I've lost my leg above the knee. What can
16 I expect? When will I walk again?
17 LTC DUDECK: My name is Lieutenant
18 Colonel Danny Dudeck, and I'm one of the
19 people in the operations that actually crafted
20 -- and I'm the policy writer for the CTP.
21 The CTP -- just to get the
22 specifics and no, I'm not going to get too

deep into it -- but there is a document called the scrimmage worksheet, where quarterly we get together with the soldier. And it's more than the triad of care. So it's more than the nurse case manager or the squad leader. We have the whole interdisciplinary team. So all the different components that really apply to that soldier -- OT, members from the SFAC, other members of the interdisciplinary team that may provide some benefit -- are in that room, and we map out using the comprehensive soldier fitness domains -- so physical, emotional, career, family, social, personal. We had career in there as one of our domains, because that's what they all ask: What do I do when I get done here? We roadmap out for three months the benchmarks we're going to get.

And we also have long-term goals that we apply. We have goal-setting training in the meeting and self-assessments.

LT GEN GREEN: If I can interrupt

1 you for just a second.
2 I appreciate what you're doing
3 with the CTP. My real question is, how do you
4 bring the standards into that, and then you
5 can individualize it with your CTP. So how do
6 you bring the standards of: this is kind of
7 what we would expect, and so based on our
8 experience -- and I know you have doctors over
9 at Walter Reed that can do this just in their
10 sleep -- so based on what my experience is,
11 you'll be in a prosthetic in X number of
12 months, you'll be walking within X number of
13 months, if things are going well for you and
14 you decide at that point you'll be in an MEB
15 process or not -- I'm kind of looking at where
16 are you pulling together the data that says,
17 these are the rough estimates of where you're
18 going to be -- not how you put it into the
19 CTP, but how are you building the data sets
20 that say this is our experience?
21 COL SCOTT: We are just now
22 beginning to pull length-of-stay-by-condition

1 data together. I think last year when we
2 briefed you, we had just completed our first
3 initial proof-of-concept with length-of-stay
4 by one clinical condition. So we're getting
5 now deeper into that so we can pull the data
6 in by condition, to be able to look at length-
7 of-stay and be able to compare that to
8 evidence-based guidelines and clinical
9 practice guidelines, as to what we're seeing
10 in the civilian sector and then what we're
11 seeing in our own care. But we're not at the
12 point yet, sir, that we can be able to take
13 that to the tactical level at the bedside to
14 say: in general, this is how long it would
15 take for you with this particular condition to
16 go through the system, yet.
17 MG STONE: So going back to last
18 year, Darryl, when you were here, you promised
19 us that you'd put an aggressive attempt to
20 really bring everybody on line with CTPs, and
21 you've done that.
22 But in addition, the Committee

1 believes -- and I think rightfully so -- that
2 the Army is the key element in all the
3 services that has a large enough patient
4 population to really drive data-driven
5 outcomes, and that we have enough experience
6 over these years to be able to look at that
7 above-knee amputee and say that at six weeks
8 you ought to be here, at six months you ought
9 to be here. And when you come off track from
10 those, we ought to be really engaging to say
11 why are we two months off or three months off
12 track.
13 Do you have all the tools
14 necessary to accumulate that data and then to
15 drive it into a data-driven evidence-based
16 process for outcome management?
17 BG WILLIAMS: Sir, thanks for
18 that.
19 I think we do. And I agree, sir.
20 I'm tracking where you are and General Stone.
21 The next step -- so I think we've
22 got -- we're just south of 10,000 wounded, ill

1 and injured, 29 WTUs, nine CBWTUs. And
2 General Stone is spot-on. We have a lot of
3 data that we're accumulating right now.
4 Now it's a matter -- to answer
5 General Stone's question -- I believe we have
6 the tools, either internally in the Warrior
7 Transition Command and/or with the Surgeon
8 General's help at MEDCOM -- the analytics, the
9 metrics to get at sorting all this data.
10 And so, the Surgeon General just
11 concluded a very successful offsite about
12 three weeks ago, where we basically ensured
13 that subordinate units were aligned with her
14 strategic themes and message. And this was
15 one of them. How do you know -- how do I know
16 -- that okay, Williams, you've got a wounded
17 soldier in your command for ten months. Is he
18 above the line or below the line? Should he
19 have been gone two months ago? Or does he
20 have three more months to go?
21 So long answer to -- I believe we
22 have the right tools, sir. And if I don't,

the boss can get them for me. And the next time we sit in front of you, we'll be able to show you some of those metrics.

DR. TURNER: Brigadier, do you also think -- and I absolutely agree the Army's the key to this. Do you feel that you are resourced well enough to do this for the long term? Because this is certainly not just a short-term thing, but more of a strategic look. Do you see any difficulty in securing strategic resources to keep this as an ongoing project?

BG WILLIAMS: The command in general, or the specific project here? Oh, yes. Yes.

The project -- yes, sir, I do. I have a very robust G3 shop -- my operations shop -- you heard some back in the back -- along with the lean Six Sigma folks that go through and pull things apart. I believe so, sir. And I'm comfortable that the Surgeon General will set conditions if I don't.

1 And then the Warrior Transition
2 Command in general, I agree with you. This
3 must endure. I think this is. The story I
4 like to tell is, I've got a kid at Virginia
5 Tech who wants to be an airborne ranger --
6 wants to be like Sergeant Major there. He's
7 a sophomore -- ROTC. I said -- God forbid --
8 if something were to happen to him on a
9 battlefield somewhere, that we have the
10 conditions in place, a warrior transition
11 command structure, the ability to measure how
12 exact -- it's going to take you about six
13 months to recover from that amputated arm you
14 had there. So yes, I believe we do, sir.
15 DR. TURNER: And you're a POM
16 line, and you go through all the POM --
17 BG WILLIAMS: I am, sir. Yes. We
18 are POM'd. Yes, sir.
19 MG STONE: Okay. I think we've
20 beat this one up. Go ahead.
21 COL BERRY: All right, sir.
22 Next slide, please.

1 Recommendation #4. We were asked
2 -- related to that Comprehensive Recovery Plan
3 -- to ensure that we have the standards and
4 the appropriate oversight to make sure that
5 that became a meaningful tool and that it was
6 used consistently, and that we were clear on
7 which member of our team, or members of our
8 team, had responsibility for ensuring that
9 that CTP was in place.
10 We do, as we've alluded to
11 already, believe that -- that a recovery plan
12 is a very key document to use actively and use
13 across the board.
14 As noted on the slide, the
15 guidance -- the written guidance -- that
16 guides and directs how that plan is to be used
17 and what it contains was just updated as of 1
18 December of 2011. And so that contains the
19 latest information that we have and provides
20 that guidance to the field. And it really
21 lays it out very plainly, as to what should
22 happen at what points, what counseling should

occur, and definitely involves all the members of the team, to include the soldier.

In terms of training, all of our AW2 advocates receive the training to include the DoD-level training that is required.

Of course, key to our program is that triad of care. And we ensure that all of those members have all of the required training, and that both when they assume the job and then on an ongoing basis.

We are looking at the possibility of expanding members of the team that receive that advocate-level type of training. And so we are going to be looking at that over the next year, to determine if additional members of our team should be participating in that DoD-level training.

And that's true with all of the training opportunities that we have, both the resources themselves and who should be participating them -- an ongoing assessment to ensure that the right people are getting the

1 training that they need.
2 CAPT EVANS: Earlier I believe we
3 heard -- I'm not sure -- the recovery plan --
4 the oversight is the squad leader. Am I
5 correct?
6 MS. CROCKETT-JONES: The response
7 said that it was designated the recovery care
8 coordinator -- the RCC.
9 CAPT EVANS: Right. But I'm
10 hearing that AW2 has the training. They
11 receive the training. So that would tell me
12 that the squad leader never receives any
13 training, but they deliver the plan to the
14 member.
15 BG WILLIAMS: So two different
16 training forms.
17 Colonel Greg Gadsen, who was here
18 last year, runs the Army Wounded Warrior
19 Program. Oversees around 9,000 veterans with
20 200 advocates who receive formally -- when you
21 said earlier, you're talking about another
22 brief?

1 CAPT EVANS: From OSD.
2 BG WILLIAMS: Oh, from OSD. Okay.
3 CAPT EVANS: Right.
4 BG WILLIAMS: So recovery care
5 coordinators -- the training -- that's what
6 you're talking about? One week which is
7 identical to the advocate training which our
8 AW2 personnel receive, that's where the
9 analogy is. We have -- all 200 of those
10 advocates are RCC trained by the WWCTP
11 standard.
12 What Priscilla was talking about
13 -- I'm looking at -- when you talk to warriors
14 at their bedside and you talk to soldiers --
15 in fact, I was on the Hill a couple of weeks
16 ago and I was asked, why are all these folks
17 coming in touch with our warriors? So the
18 Army's position is: you have an Army
19 sergeant, you have a nurse and a doc -- the
20 triad of care. And other folks --
21 recovery care coordinators -- that sergeant
22 can get that training. That's what Priscilla

1 was talking about. I'm looking at expanding
2 that training. We have totally rehauled our
3 training -- overhauled our training at the
4 company level and below at San Antonio, if you
5 get a chance to go out there. I think you all
6 saw some of that.
7 Focus on that 19-delta -- that
8 infantrymen, the artillerymen, that 68-
9 whiskey, to ensure that he or she can work
10 24/7 with a solider and his family. I mean,
11 this is hard work, as you all know. You've
12 seen it.
13 So right now, we meet the DoD
14 standard by having our advocates -- no. The
15 AW2 advocates are embedded inside these
16 warrior transition units. These aren't
17 mutually exclusive things. If you go to Fort
18 Bragg and talk to Clyde Foster, who's embedded
19 inside the WTU and provides that linkage from
20 soldier to veteran, that's how we provide
21 that.
22 I'm looking at that squad leader

1 training -- this RCC training being done by
2 our squad leaders as well.
3 CAPT EVANS: And that may explain,
4 when they did a site visit at Fort Stewart,
5 some of the issues with understanding the CTP
6 and the comprehensive plan delivery to the
7 member. I'm not sure if we have the right
8 person at Fort Stewart or some of the other
9 commands delivering that to the member,
10 because of the lack of training.
11 I mean, it was just a concern when
12 we heard OSD say, this is who we should be
13 delivering. But then we hear here AW2.
14 BG WILLIAMS: Yes. The honorable
15 Mr. Campbell and the Surgeon General, they met
16 a few weeks ago. I'm committed -- I told the
17 boss I'm committed to looking at expanding
18 this. But I think we're in a pretty good
19 place right now in terms of Sergeant Joe
20 Tavera. When Sergeant Williams shows up, he's
21 empowered by recovery care coordinators, by
22 FRC -- by all the list of things. There's

lots of acronyms that we could throw at these soldiers and their families. But our position has been an Army sergeant -- his battle buddy, his wingman is the person where information is.

Now I will tell you also -- and we don't have our slide here -- but in the continuum of care, I could see downrange after -- what happens, month one or month two is: all these folks show up and want to help. And we want to limit all those helps.

And so downrange -- downstream -- perhaps month two, month three, month four, we can bring in more of these acronyms and other people who want to help.

But critically, that Army sergeant who knows that soldier and his family is our position right now. And that sergeant -- I have three goals -- three objectives as the Warrior Transition Commander -- training, education, and career and jobs. So we inform, we empower, we educate that Army sergeant with

1 the tools. We potentially in the future will
2 send him or her to get this one-week training.
3 And we've crosswalked the one-week
4 training. The training actually came from the
5 advocate training that we currently have. So
6 we crosswalk the training. And there's a lot
7 of overlap in the training.
8 That's a long answer to -- we're
9 using them, but we're using them primarily
10 with our veteran population right now. The
11 one-stop shop still, with the 10,000 -- just
12 south of 10,000 warriors is the Army sergeant.
13 MR. REHBEIN: Colonel, if I may --
14 and please excuse my back. I can't talk into
15 the microphone and look at you too.
16 I want to focus in for just a
17 minute on that reliance on the
18 interdisciplinary process and shared
19 responsibility. I've spent a lot of years
20 working on interdisciplinary scientific
21 projects. And my experience says, that only
22 works when you have frequent regular contact

1 between all of the members on a team. And I'm
2 wondering if you publish or put out any
3 standards to the WTUs -- because the family's
4 a member of that team -- if you publish any
5 standards as to how often that team should get
6 together to make sure everybody stays focused
7 on the recovering warrior's recovery.
8 BG WILLIAMS: Let me take that
9 too.
10 Sir, spot on. And it's published.
11 When I came into the job, if you
12 go into my office, you'll see about 60 white
13 notebooks on the wall. And I said, wrong
14 answer. We're getting this all into one
15 notebook -- in one book. And I don't know if
16 we provided copies, but we can provide copies
17 of our CTP.
18 In the CTP, it talks about
19 expectations with time. Within one day --
20 within 24 hours, you will do this with the
21 team. And it in great detail talks about the
22 responsibilities, role clarity for the team

1 coming together -- the interdisciplinary team
2 -- one day, seven days, 30 days, two months,
3 three months. It lays it all out there by
4 time, by time horizon, and by person who
5 should be at the meeting. And it even has an
6 example of who should be at the meeting, sir.
7 MR. REHBEIN: That's really what
8 I'm asking, is: do you expect this team to get
9 together --
10 BG WILLIAMS: Yes, sir.
11 MR. REHBEIN: -- every two weeks -
12 -
13 BG WILLIAMS: Yes, sir, we do.
14 It's all in there.
15 MR. REHBEIN: -- every 30 days?
16 What is the frequency there because it's very
17 important?
18 BG WILLIAMS: Yes, sir. Some of
19 it is conditional. But it lays it out. And
20 sir, we'll make that available for you. It
21 tells you who you are on the team, where you
22 sit at the table, how often you come together,

1 and then on up to the triad of leadership as
2 well. Senior mission commander, this is when
3 you get involved. You know you have the
4 ability to allow soldiers to stay in after one
5 year. It lays out in very detail all those
6 time horizons and who's there.
7 MR. REHBEIN: And I think you
8 understand why I consider it so important,
9 because when everybody on the team is of equal
10 importance, sometimes things fall apart
11 because nobody's really in charge.
12 BG WILLIAMS: Yes, sir. Your job
13 is to pull, your job is to hand off the
14 football, your job is to throw the football,
15 your job is to receive the football.
16 Everyone's got to know -- role clarity.
17 And I think we've done a pretty
18 good job of laying it out. It's not perfect,
19 but it's -- even the artillerymen such as
20 myself can find his way. I could show up at
21 one of those meetings, know what my
22 responsibilities are, know how I interact, how

often I'm supposed to interact, and what the outputs are of those sessions, along with family members as well.

COL BERRY: Okay. Moving on to the next slide.

Recommendation 5. You asked us to ensure that we had appropriately defined command climate and make sure that those standards were appropriately disseminated to our field.

Certainly within any Army -- really any military organization -- having the right command climate is of course key. And we have the support of our leadership all the way to the highest levels from the Secretary of the Army, Chief of Staff and the Vice Chief of Staff down through the Surgeon General and through General Williams to ensure that everyone understands -- and everyone agrees -- that taking appropriate care of our wounded warriors is one of our highest priorities.

That expectation is set with

1 commanders as they assume their command
2 through the pre-command course. We also
3 participate in other cadre and nurse case
4 manager courses to again set those standards
5 for what an appropriate command climate is for
6 these organizations. Site visits are
7 conducted on a regular basis to actually go to
8 the field and see boots on ground, to provide
9 assistance, answer questions and do an onsite
10 assessment of how things are going within each
11 of our organizations.
12 Communication is key to that as
13 well. There is a quarterly newsletter that
14 General Williams' organization puts out. It
15 provides the latest updates, best practices --
16 all of those kinds of things. And of course
17 you can't do anything these days without
18 social media -- without a Facebook page and
19 Twitter and those kinds of things. So those
20 things are in place to provide an even greater
21 level of communication.
22 BG WILLIAMS: Just to amplify that

1 a little bit, I talk to every single company
2 commander course at San Antonio -- either
3 physically there or by VTC. I talk to every
4 single commander, senior mission commander who
5 owns the dirt -- he or she owns the dirt and
6 comes in the command. The senior leader
7 orientation program, clinical leader
8 orientation program -- I speak at all of those
9 that we have. I talk to the -- well, PCC, we
10 only have two a year. In fact, the PCC is
11 this week -- pre-command course -- for all our
12 leaders going into command. And Priscilla
13 talked about the other opportunities.
14 It's really important -- my former
15 Sergeant Major -- the real takeaway here --
16 what's the bottom line upfront? Compassion
17 with standards. You have some soldiers out
18 there -- cadre, full transparency -- who get
19 tired, and who think perhaps warriors don't
20 warrant some of this. And so, I make sure
21 it's clear to them that they do warrant it,
22 and that they have my support. If they get

tired, we'll take you out and bump you out and let you sit out for a half quarter or a quarter. And I have a rest policy in place.

But the senior, the two star who owns the dirt -- or three star who owns the dirt -- owns this program, implements that.

So the journal that Priscilla talked about, I routinely talk to senior mission commanders. There's a course coming up, I believe next week -- all brand new. I'll give you an example. Come off the high and come down to reality.

We had about 15 senior mission commanders about six months ago. And they came to me, hey, Darryl, I need you to come out. I need you to OIP me now. I have my own organizational inspection program. They're out right now looking at California. And they said, I need you to send my teams -- I'll leave the fort unnamed -- I need you to come see me next week. Can you do that? I said, yes, sir, we can.

1 So we put together a short and an
2 abbreviated OIP inspection. Went out to them
3 and helped him as a new guy coming in see
4 himself and his program and what he needed to
5 work on. The same thing in the National
6 Capital region with the General here.
7 So we have multiple ways to
8 communicate. The key to changing the command
9 climate is to talk to commanders. So I talk
10 to all commanders from two- and three-star
11 level all the way down to captain level, all
12 the time, either through my newsletter,
13 through the PCC, through the nine or ten times
14 a year they do the company commander course,
15 our senior leaders.
16 We're now bringing in our docs and
17 nurses, sir. We didn't before. A doc and a
18 nurse and the commander never got together
19 before they showed up on the battlefield. I
20 said, we're going to fix that.
21 So we have a third one, I think,
22 next month coming up -- our senior leader

1 orientation program. One-week program. My
2 doc designed it. My other chief nurse
3 designed the nurse part.
4 So WTB battalion commander, the
5 doc and the nurse come together as a triad
6 there, and they talk about what their plan is
7 -- how are we going to handle it, how are we
8 going to get at command climate, what should
9 our position be, how should we talk to our
10 soldiers?
11 And I talk to them about dignity,
12 respect, Army values, compassion with
13 standards. Because you'll see units out there
14 that are either into that continuum -- a
15 little bit more on the compassion side, or a
16 little bit more on the standards side.
17 Sir?
18 LT GEN GREEN: Yes. So the line
19 up there that says the WTC does not provide
20 command and control for any of the WTUs or
21 CBWTUs. So what does your command control?
22 BG WILLIAMS: Policy and

1 oversight, sir.
2 LT GEN GREEN: Policy and
3 oversight.
4 BG WILLIAMS: Yes, sir.
5 LT GEN GREEN: And so really just
6 within the directorate or wherever you are on
7 the Army Surgeon's staff?
8 BG WILLIAMS: Yes, sir. So I work
9 for -- the Surgeon General is my boss. But
10 the tactics, techniques and procedures that
11 we've used, where I'm able to swoop down. I
12 can go to the Surgeon General, and the Army
13 leadership gives me the ability to cross
14 tactical and operational strategic levels.
15 We have a couple issues brewing
16 right now that I'm going to go down there. In
17 fact, I've got my doc on a mission right now
18 at a particular post looking at the tactical
19 level. I'm going to migrate those lessons
20 learned, his observations back. So I'm able
21 to move up and down.
22 But sir, on paper, I am the policy

1 oversight guy. And the senior mission
2 commander implements the program with the
3 medical treatment facility commander and the
4 WTB battalion commander. So a lieutenant
5 colonel reports to a doc, reports to an
6 infantryman or an artilleryman or an armor
7 guy. And I give them the play book.
8 LT GEN GREEN: So actually owns
9 all the line assets that are actually the
10 squad leaders?
11 BG WILLIAMS: The senior mission
12 commander, sir.
13 So General Campbell at Fort Hood,
14 Texas, if he needs more squad leaders -- if
15 his battalion commander says I need more.
16 Ratios are 1 to 10. My ratios are not 1 to
17 10, sir. Okay. He backfills the squad
18 leader.
19 Besides five places, I do Fort
20 Meade, the National Capital Region, HR --
21 Human Resources Command provides that cadre --
22 West Point, and somebody help me with the

1 fifth one. I don't know what the fifth one
2 off the top of my head. Oh, San Antonio
3 because they don't have any troops there. So
4 San Antonio, Fort Meade and the National
5 Capital Region.
6 LT GEN GREEN: And the actual
7 wounded warriors who work within that squad
8 belong to the line commander as well?
9 BG WILLIAMS: They do, sir. They
10 do.
11 The warrior transition battalion
12 commander, and then who belongs to the MTF
13 commander who belongs to the line commander.
14 So across something or -- a
15 battalion commander owns those warriors, sir.
16 And it could be active Guard Reserve,
17 infantry, armor, artillery, who reports to the
18 senior doc on that camp, post or station who
19 reports to the senior mission commander.
20 That's the line, if you will -- the line of
21 command.
22 LT GEN GREEN: Okay. Thanks.

1 BG WILLIAMS: Yes, sir.

2 COL BERRY: Okay. Next slide,

3 please.

4 Recommendation 6 is where you

5 asked us to ensure that our entrance criteria

6 was firmly established and that there was a

7 clear appeal process for when those decisions

8 were questioned.

9 As indicated on here, the

10 reference for where those standards are set,

11 as with all of our documents, those undergo

12 regular review and we feel that they are

13 appropriate. And these are in fact of course

14 briefed to the commanders when they assume

15 command.

16 This program is implemented at the

17 installation level. And so of course there

18 may be some influences there at the

19 installation based upon the unique needs of

20 that particular population. But the standards

21 are basically set.

22 Within the regional medical

1 command, there is a warrior transition office
2 and they do have oversight of the
3 installations within their particular
4 geographic region. So there is some oversight
5 there as well as a place for the installations
6 to go if there are particular questions.
7 There are, or there is an
8 established appeal process in place. And as
9 always, we continue to assess our criteria to
10 ensure that it's meeting the needs of our
11 population.
12 Next slide, please.
13 Recommendation #7 is to ensure
14 that we have sufficient numbers of our case
15 managers to take care of the population that
16 we have and that we ensure that transition
17 between the various organizations is
18 established well.
19 The metrics that we use to monitor
20 the numbers of our wounded population is
21 established in the DTM. It includes the
22 number of case managers, the number of service

1 members receiving case management services,
2 and then the acuity levels of those.
3 But we do agree that it's the
4 acuity of that population that really should
5 drive the numbers of staff that we have
6 working. Of course, because each case is very
7 unique, one soldier may require an extensive
8 amount of assistance and involvement of the
9 team whereas another person within that
10 organization may require much less. So we
11 believe acuity is very key.
12 And lined with that then, a case
13 management acuity workload calculator has been
14 developed, has been tested at some of our
15 installations and found to be a very good tool
16 in determining or keeping track of the acuity
17 level to make sure that each case manager has
18 the right mix or the right numbers based upon
19 the acuity of the troops that that person is
20 individually managing. And this calculator is
21 expected to be in the next update of the
22 workload management system. So we believe

that that will help ensure that we've got the right mix of the triad as compared to the soldiers in that particular population.

As far as transition is concerned, we do have those standards in our policies. And it does require a warm handoff. So at each transition point, there is a warm handoff to ensure that the receiving person knows the history and the background and the goals of that particular soldier.

And in addition to that, we're working with the VA to ensure that we have an information sharing agreement in place. And that will help to ensure that as our members leave the military and go to veterans status that the information that the information that the VA needs to pick up the ball where it is and carry it forward is available.

MSGT MacKENZIE: Let me throw out a couple questions here.

What's the plan to meet the current ratio requirements within the WTUs and

1 the CBWTUs? And is that being impacted by
2 this delay in acuity base management that
3 you're working on?
4 BG WILLIAMS: No, I think at the
5 end of the day we know for instance in the
6 National Capital Region, they need more folks.
7 So the standard is 1 to 10. But
8 if you go over to Bethesda, I think I have 55
9 or 56 amputees right now in the Army. And so,
10 this takes its toll over time on the cadre.
11 So this manpower analysis that's
12 going on, we've been to Fort Bragg and Fort
13 Lewis and they're going to Campbell next
14 month. We're going back and I've just kind of
15 hunch known that -- so let me segue for a
16 second. So Fort Campbell because they have
17 the capacity -- the division commander has the
18 ability to put more squad leaders at their
19 very acute ill soldiers. They operate at
20 around 1 to 6, 1 to 7.
21 I think in my mind -- and
22 hopefully this manpower analysis will show it

1 out -- at the divisions, at the 82nds, at the
2 101st, 10th Mountain where we have -- half of
3 Bethesda right now is 10th Mountain soldiers,
4 3rd Brigade -- we probably need ratios at
5 squad leader at like 1 to 6, 1 to 7, I think.
6 I think this audit will weight that out. At
7 the TDA places -- TDA locations -- 1 to 10 is
8 probably okay.
9 I think this assessment by my team
10 will bear that out. So to answer your
11 question, is there a delay in it, how are we
12 doing at meeting it now? We're pretty close.
13 And what we do is soldiers that fall below, we
14 move them around the battlefield. My G-1
15 actively tracks. And they come on up the
16 ACER. We don't have the cadre this month or
17 next month to meet the requirement of the
18 number of wounded, ill and injured soldiers.
19 I need to borrow some soldiers.
20 So the first way to do that is
21 that they do it with cadre members. The way
22 they do that is within the RMC - within the

1 Regional Medical Command. So that two-star
2 manages that one in the RMC. If he can't do
3 it -- if Joe Caravello can't do it in the RMC,
4 then he appeals to me and we reach outside the
5 RMC and we find him a cadre member. So we're
6 pretty good -- pretty close to that right now.
7 I think there's going to be
8 adjustment though based on -- and it's not
9 just the active divisions. I don't mean to
10 disparage the Guard or Reserve at all. If
11 there are places where units had a hard go at
12 it, we may need to up their cadre for some
13 time.
14 So the good news is FMG357 -- the
15 bean counters that are working with us on this
16 -- are willing to work with us and adjust
17 that. Because this is not something well, we
18 got it about right, Williams. Now we're going
19 to leave it that way. No, you're not. We're
20 going to adjust it based on the demand --
21 based on what's coming out.
22 I think there will be a shift in

1 our forestructure here probably this fall in
2 terms of getting it right. I don't know what
3 right is. But it'll change a little bit, I
4 think.
5 Does that help?
6 MSGT MacKENZIE: It does in a way,
7 sir. One of the CBWTUs we went into had
8 incoming warriors from the battlefield, and
9 they weren't at ratio before these guys even
10 were in their way back in.
11 Now there's more coming in. You
12 see there's a standard already in place by the
13 DoDI that we're supposed to be at. So the
14 question is what's the goal for meeting that
15 standard and then are you managing continuum
16 based on the acuity-based. There's two
17 different goals we're shooting for here. But
18 one of them is just the basic standard. And
19 that was where my question was going towards
20 was how are doing with meeting that basic
21 standard and then this part, or is this
22 preventing you from reaching that initial

standard.

BG WILLIAMS: Yes. It ebbs and flows. And it's not perfect. But I will tell you -- and I probably know that bumper number of that CBWTU.

My G-1 actively goes after this. So yes, they must be done standard. And then as it changes -- I will tell you though, we have not -- I think this is the first real manpower analysis that we've had since I've been here. So I think that we're going to bear some fruit on this.

Sir, you've got something?

MR. REHBEIN: If I may, Colonel, for just a minute. Part of that recommendation about transitioning between case managers, as we've talked to recovering warriors around the country, we've met some that have had more than one. And at times we hear stories about how much more frequently they meet with the second one. But then we also hear how much less frequently sometimes

1 they meet with the second one.
2 I'm going to take that back to
3 that shared responsibility thing for a little
4 bit. I think about this Task Force without
5 the able leadership of our Co-Chairs and
6 wonder just how much we would get done. That
7 shared responsibility in those kinds of
8 situations can really become critical because
9 of that continuity of care. Obviously if the
10 recovering warrior sees his case manager much
11 less frequently, he wonders who cares.
12 BG WILLIAMS: Yes, like I said
13 before, it's not perfect but I think it's
14 pretty good.
15 You're talking about pitching and
16 catching is what you're talking about. And I
17 talk about that all the time in the
18 organization. And Colonel Niemetz back there
19 who's my Guard rep will tell you, it's not
20 perfect. We screw this up sometimes where a
21 soldier comes to a new location and new
22 command is having to recreate everything

1 because we didn't do a good job of sending
2 that person off.
3 Your point about the multiple -- I
4 hear that a lot too. Make sure I'm on my
5 third case manager and my sixth squad leader,
6 and I'm having to re-tell this story. We need
7 to get better at that, sir, is what I will
8 tell you.
9 We track it at the WTC. I have a
10 Guard rep and a Reserve rep who if there are
11 any issues, General Stoltz and General Ingram,
12 I mean I talk to them. I spoke at NGAUS last
13 year.
14 What I see most of the time which
15 is why I'm talking about Guard and Reserve is
16 soldiers that were on Title 10 and are going
17 back to Guard and Reserve status. That's
18 where I see us pitching and catching not real
19 well.
20 Within the active, it's pretty
21 good. It's not perfect, but it's pretty good.
22 But it's that hand off when they go from Title

1 10 back to their Guard or Reserve status.
2 That's where I need to spend more time.
3 And so I'm engaged at the
4 strategic level with General Ingram and
5 General Stoltz and Susan makes sure she keeps
6 me straight on that.
7 I speak and I talk these very
8 issues. Said sir, look, you had a soldier who
9 was doing the right thing on his sixth
10 deployment and came into my WTU for a few
11 months and now is going back to some place in
12 Illinois. And I want to make sure we have the
13 audit trail on this guy or gal.
14 So we work these issues every
15 single day. I'll tell you, she probably works
16 five or six a day on this very issue that
17 you're bringing up. So we're committed to it,
18 sir.
19 DR. TURNER: Just real quickly,
20 while I certainly do appreciate your
21 subjective monitoring of acuity and staffing
22 and there's no substitute for that time, I

1 guess I'm a little more interested in
2 programmatics because the program has to
3 supersede the individuals.
4 So Colonel, if you could maybe
5 tell me a little bit more about this acuity
6 model that you guys are developing, and do you
7 think there's any future for it.
8 MS. CROCKETT-JONES: I can bring
9 him in at another time for a full briefing,
10 ladies and gentlemen.
11 MR. BURDETTE: Go ahead, Susan.
12 COL SCOTT: We have absolutely
13 recognized that the intensity of the work in
14 patient care varies from patient to patient.
15 And the workload of the nurse case manager
16 varies based on that intensity.
17 So we had a team actually at Fort
18 Bragg develop a workload management tool that
19 calculates the level of the intensity of work
20 for a nurse case manager based on Society of
21 America Standards of Practice for Case
22 Management. They did time-in-motion studies

1 based on those activities and developed a
2 model so that they can look at that workload
3 intensity and the acuity that provides then a
4 tool for the supervisors to help balance
5 workload.
6 We then piloted that at five other
7 locations to see if this was a tool that we
8 could use outside or just the Fort Bragg
9 community. Discovered that it is a good model
10 and a good tool. So we're now training our
11 nurses. And it's as simple as an Excel
12 spreadsheet that helps the nurse case manager
13 quantify the work and intensity of the work
14 that they're doing and that they anticipate
15 doing.
16 We are now teaching that at our
17 case management course down in San Antonio.
18 And we are going to work that -- the model
19 into the workload management system for
20 nursing Internet. The next version of that
21 that comes it will then be Army-wide.
22 And we have showed it to the other

1 services for consideration. And I believe
2 there's one Navy facility in California that
3 is looking at that as a potential feasible
4 model for them as well. But we have demoed
5 this to the other services.
6 DR. PHILLIPS: Question. Do you
7 have plans in place to respond to the needs
8 demonstrated by that tool? In other words, if
9 you suddenly see a major acuity need at one
10 installation and you don't have the staffing
11 there, can you be mobile enough to fix that
12 quickly?
13 COL SCOTT: Well, this goes right
14 back to where General Williams had referred to
15 earlier. That supervisor now has a tool to be
16 able to articulate what those needs are. She
17 can then communicate that to her battalion
18 commander, to the MTF commander to provide
19 those clinical resources. And there's a
20 partnership between the nurse case manager and
21 the squad leader so that we can also
22 anticipate the rest of the triad resources

that are needed that can be communicated to the senior mission commander to be able to get those resources either from locally within that MTF from the region or from coming back up to WTC to be able to work through the G-1 to be able to --

BG WILLIAMS: But sir, let us come back to you in a formal way like was mentioned earlier.

I think my folks finish this in May. And we think we'll have it wrapped up about July -- this whole process.

We're pretty excited about it. We found some good first practices. But that's where it is. And my boss is late on the standardization metrics. So before we put anything out to the field and start blooming everywhere, we want to make sure it's gone through rigor and it has some outcomes associated with it.

DR. TURNER: I really applaud what they've done. And as everyone well knows,

it's much easier to use an objective tool when you're apportioning resources and subjective tools.

BG WILLIAMS: Yes, sir. I appreciate your question.

COL BERRY: All right. And the discussion about the Reserve components is a great segue into the next slide on recommendation #8 where we asked to ensure that the unique needs of our Reserve components members were in fact being met and that the care that they were receiving was equivalent to active component standards.

And I think anyone that's ever been in the Reserve components understands that it's no matter what topic you're talking about making active component equal to Reserve component is a challenge. And I don't think that this population is any different.

However, as General Williams indicated, we are doing our very best to ensure that those Reserve component members

1 are getting the care that they need and
2 getting the resources that they need to
3 support their recovery.
4 Part of that is ensuring that they
5 are getting placed close to where their
6 support network is. And if that means going
7 somewhere other than an active component
8 installation so that they can be closer to
9 family, then that's what we do. And that's
10 what we support.
11 We are looking at the remote care
12 program and work that ensuring that that is
13 meeting the needs and doing some restructuring
14 as necessary.
15 In addition, the FRANKS-2 study is
16 due to be published in the relatively near
17 future. And we will of course be looking at
18 those recommendations and looking to implement
19 what we can out of those findings.
20 MR. REHBEIN: Colonel, one of the
21 things we also hear from focus groups, the
22 families in particular, is how important the

SFACs are to them. And I understand we can't put SFACs out there where every Reserve component soldier is located. But is anybody kicking around any ideas on how could we deliver SFAC-type services out there to Reserve component families -- webinars, electronic media, social media?

BG WILLIAMS: Yes, sir. Well, the reality is we already do that. I mean, the Guard and Reserve -- Susan can talk more. I'll give you 20 seconds to walk up to the mic.

But, sir, we are -- the virtual piece is currently being done now. And Susan will talk more about that.

But while they're in the Title 10 status -- the Guard Reserve soldier -- they have full access to the Soldier Family Assistance Centers.

And they are best practice.

MR. REHBEIN: I'm thinking along the lines of all the folks in the CBWTUs.

1 COL NIEMETZ: Good afternoon. I'm
2 Colonel Susan Niemetz. I'm the Army Guard
3 advisor to General Williams.
4 And for the SFAC-like services,
5 the Army Guard has put out -- National Guard
6 Bureau -- in total has put out the joint
7 service support. And it's a website that you
8 can literally go in and you can type in your
9 zip code into this website portal. And it
10 will bring up a list of resources within a 50-
11 mile radius of that zip code to include things
12 -- family, medical, financial, housing. And
13 it goes through every available resource that
14 the Guard knows about to provide remote care,
15 if you will. And there are phone calls that
16 are made. There's a transition assistance
17 advisor in every state.
18 So this portal is run basically
19 through that office through the family
20 services -- the family programs joint service
21 support at Guard Bureau through the joint
22 office. So it's available. Actually intended

for Guard, but we support every service, every component.

And those statistics are maintained by the National Guard Bureau of how many they're supporting. So whether you're active component, you're active component family in a remote area who needs assistance -- a mom or a dad who need assistance or you're a soldier or a sailor, marine -- it doesn't matter. You can go in and just type in your zip code -- I do that all the time -- and go okay, what's available in Maryland within 50 miles of 21114. It's a very useful tool.

LT GEN GREEN: What is the website?

COL NIEMETZ: It is called JointServiceSupport.org. I'm almost positive it's org, but I can get back to you.

LT GEN GREEN: Thanks.

COL NIEMETZ: Yes, sir.

COL BERRY: All right. Next

slide, please.

MR. CONSTANTINE: Real quick. When we out to the California CBWTU, they expressed a lot of frustration with the way the Reservists and were treated compared to active duty folks, even with access to care and getting appointments. Is that something you've seen at other places? And if so, how do you fix something like that?

BG WILLIAMS: Great question.

So my OIP team, I mentioned earlier, that's where they are right this week looking at that. I saw that you were out there and I saw some of the stuff that was bubbling. So we directed the OIP out there.

Communication is really the key. As I look at the slide, shapes strategic solutions. Well, strategic solutions are going to be shaped by strategic leadership and from there.

And a lot of listening. I mean, Priscilla mentioned earlier, when I go, I've

1 been to half of the CBWTUs. And I make it
2 very clear that I'm the active Guard and
3 Reserve wounded, ill and injured warrior
4 transition commander. About nine or ten
5 months ago, there were folks that were wanting
6 to come off of that. I said I'm not coming
7 off of that. Guard and Reserve are just as
8 important to me as active. So I think the
9 short answer to your question is
10 communication.
11 Now with the local issue there
12 with the commander, with the Guard leadership,
13 I have done this in the past but I've already
14 adjusted my TTP. When I travel, I'm meeting
15 with the TAGs now when I go out. When I went
16 to Arkansas about four months ago, I met with
17 the Guard leadership at the state level and
18 work our way down.
19 So they have a venue now through
20 either my OIPs to give me feedback, through
21 Colonel Niemetz. I also have a Reserve on my
22 staff as well. They write me everyday. I'm

1 an n of one. But my whole staff is geared --
2 they know this -- my team back there knows
3 that this isn't the active duty hour here.
4 This is for Guard and Reserve and for all
5 soldiers and their families.
6 So I think the short is just to
7 listen to them and make sure their voices are
8 heard. We give them a lot of mediums to talk
9 back to us either on my website, my training
10 conference -- we had over 1100 people there
11 last summer -- the interdisciplinary team and
12 also families. Colonel Greg Atson holds
13 forums. He has the community support network
14 where soldiers' voices can be heard.
15 What I've found after doing this
16 for about 18, 19 months is that soldiers and
17 families, they want to make sure someone is
18 listening to them.
19 Over the weekend, I had six
20 families call me, send me pictures and say,
21 sir, I need help. I said Roger. I'll help
22 you Tuesday. I'll help you today, but I need

1 resources to get to some of this stuff.
2 So I really think that's really
3 the answer. I could give you a bunch of BS.
4 But I think it's really about communication
5 and listening.
6 MR. CONSTANTINE: So sir, what
7 happens though? They say in California where
8 they weren't getting appointments for a month
9 or two at a time and their active duty
10 counterparts were getting a week later. What
11 can you do about that?
12 BG WILLIAMS: Yes. So what I've
13 done in the past and what I would do is send
14 some of those folks in the back of the room
15 down there on a mission. I've done this a lot
16 in the past. I've got one at a fort right now
17 doing this, to look under and do my own sort
18 of command. It's the WTC command. And I said
19 before on policy and oversight and the
20 commanders run it. But I take that very
21 liberally.
22 I will do inquiry. I've done a

1 few of those over the last 18 months where I
2 will go down and say there's enough here that
3 smells that we need to do a little more of a
4 deep dive on. So that's what I would do.
5 And then have a conversation with
6 the TAG or the state leadership, or if it's an
7 active duty with the senior mission commander,
8 and get after it and say is this a problem, is
9 this a trend, or is an n of 1 or is it an n of
10 40, and listen to them. We do town halls.
11 So I started getting after their
12 problems. One person, one soldier, one family
13 at a time. I mean, just get after it and roll
14 your sleeves and get after it.
15 MR. CONSTANTINE: Okay. Thank
16 you, sir.
17 MSGT MacKENZIE: One of the things
18 I was curious about in this Reserve component,
19 in several of our locations, you've got
20 Reserve component soldiers who were wounded on
21 a Title 10 orders, deployed overseas, going
22 through medical care, Med Board processes, not

on orders. I mean, this is one of the biggest travesties I saw was why is it that an active component guy is on orders, he's collecting a pay check, recovering, and a Reserve component soldier is not. Yet they were both Title 10 in combat, wounded, but there's a disparity. What are we doing to fix that? And is your staff providing you the numbers of how many of those that are in the IDES process who are not on Title 10 orders or Title 10 injuries?

COL BERRY: It's my understanding the programs are in place so if they choose to be on active duty that they can. There is a certain amount of soldier option in there. And you all can correct me if I'm wrong. But if they are injured, then they have the opportunity to come or remain on active duty or come back on active duty for that care.

BG WILLIAMS: Yes. If you're Guard or Reserve and are injured in your active duty status, you're in the club. I mean, you get in to the Warrior Transition

1 Command. You don't have the same level of
2 rigor now. If you've got some numbers, give
3 them to me.
4 So to answer your question, about
5 51 percent of the warriors in the Warrior
6 Transition Command are going through the
7 integrated disability evaluation system right
8 now, up about five or six percentage points
9 since I've been here.
10 So you asked about IDES. Go
11 ahead, Susan. You want to elaborate on it?
12 COL NIEMETZ: Just one of the
13 things is when Reserve component soldiers are
14 coming home to demob, if they decide they say
15 no, thank you, I'm going to decline care of
16 going into this program -- into the Warrior
17 Care and Transition Program -- and they go
18 home and they revert back to Title 32 status
19 and still have a medical condition that is
20 unresolved, they can apply to come back
21 through or come into this program. But if
22 they decide not to do that and they want to

1 stay in their Reserve component status in the
2 Title 32 status and it is then determined they
3 need to go through an MEB or PEB, no, they do
4 not come back into the program because they've
5 declined to come in one time.
6 It's a volunteer program. So if
7 you find soldiers who are going through an MEB
8 in a Title 32 status, it is because they have
9 declined to come into the program during
10 demobilization. Any soldier that I know of --
11 and I have had soldier cases come up that say
12 this guy can refrad because he can go home and
13 go through the MEB -- those that I know I'm
14 like, no, absolutely not. They are entitled
15 to remain on active duty through the DoDI,
16 entitled to remain on active duty until that
17 determination is made.
18 BG WILLIAMS: Yes. Colonel
19 Niemetz keeps me straight. Notwithstanding
20 what you saw -- and I'm willing to take
21 whatever you saw -- but we're very aggressive
22 about allowing -- in fact, about once a week

she walks in my office with a bunch of soldiers who are in that case who are trying to get back into the WT. And we look at it, and I'll make an assessment yes or no, based on her recommendation.

COL BERRY: And I believe our current IDES population is about 20 to 30 percent Reserve component. So the vast majority of individuals going through IDES are on active duty.

MSGT MacKENZIE: So the responsibility is on the soldier then to apply to get brought back on active duty. It's not on the WTC to bring them back on active duty.

COL BERRY: I believe it would be the commander's responsibility to lay that out as an option to that soldier.

CSM DeJONG: It's also education on the point of how it's explained, how well it's explained. It's a growing pain. And we've noticed through the demob process, sir, that a lot of soldiers are pushed, heavily

1 influenced into the VA side of things and then
2 they find out that well, I can't go to work
3 now. I can't provide for my family and now
4 they've already made this choice and we can't
5 get them back.
6 BG WILLIAMS: That is fair,
7 Sergeant Major. In fact, I was just doing one
8 of the San Antonio courses. And the gal, a
9 young Captain who had run the demob site at
10 Fort Knox -- wasn't it at Knox -- who said
11 hey, sir, I'm seeing a disparity between
12 soldiers -- just what you got through saying.
13 There's a disparity. And I have not been
14 there to look at that.
15 If you've got data that suggests
16 that there's a little bit of a bump there, let
17 me know and we'll go after it. We work this.
18 We drill this pretty hard though.
19 CSM DeJONG: It was also with some
20 of the contracts that we had because on the
21 Guard and Reserve side, you get a lot of
22 contract doctors and a lot of contract

1 dentists that come in. And some of it was the
2 training in the contracts. Some of what we've
3 seen across the board as far as what brought
4 on to this -- even level of care -- came down
5 to the nuts and bolts of if a soldier stands
6 up and says I need some help, I want to talk
7 to a counselor, those docs are automatically
8 making him a 3. And there was a lot of
9 training on that side and a lot of standards
10 that were not explained.
11 COL NIEMETZ: Can I just add one
12 more thing to go along with that?
13 I just had a conversation matter
14 of fact Friday, the Deputy Army Guard Surgeon
15 and I were on the phone for about an hour
16 together. And one of the things we talked
17 about on declination on those soldiers who
18 decide no, thanks, I'm just going to go home
19 and I'll get it taken care of home, is
20 specifically right now it's just the solder
21 has to sign it and if they are on Title X,
22 it'll just go right up to HRC and the soldiers

1 will be refrad and sent home. We want to
2 include -- and this is very preliminary -- we
3 want to include insurance that someone from
4 the state or the Army Reserve has talked to
5 the soldier and said do you realize that if
6 you decline care now and you decline being in
7 this program, you will give up this benefit,
8 this benefit, this benefit and this benefit.
9 Because I don't think that that is clear to a
10 lot of soldiers who say just let me go home
11 and I'll heal at home, and then end up at a
12 later having to go through PEB determinations.
13 I'm sure it happens. And if I can
14 just add, there's one other initiative that is
15 on my list of things to do and that's an I/O
16 campaign to the soldiers. How do we get that
17 word out? And I was talking to one of General
18 Williams' peers who were talking about demob
19 and getting that information out to soldiers
20 -- to Reserve component components -- because
21 I honestly don't think they understand what
22 benefits they are declining.

1 LT GEN GREEN: Just in the
2 interest of time, we're kind of running behind
3 here. I'm looking at several of the next few
4 items. So PTSD, your answer is we understand.
5 And then the next few slides are actually on
6 training which I think we got a lot of input
7 on when we were down in San Antonio.
8 And so what I'd like to do is have
9 you shift towards about #18, unless any of the
10 panel or Task Force have any objections. So
11 can you go to #18 for us?
12 COL BERRY: Yes, sir.
13 So #18 --
14 MSGT MacKENZIE: I'm sorry. Real
15 quick. One thing, sir. My apologies.
16 In recommendation #14, we get
17 right back to the same point again that we
18 keep wondering which is when -- it says,
19 You've recognized the need to continue to
20 better educate and inform the recovering
21 warrior population and their family. But if
22 it's not a requirement to talk to the family

1 unless the service member gives you
2 permission, how do you plan to implement that
3 with your current stance on not talking to the
4 family unless the service member says so?
5 BG WILLIAMS: If that's what you
6 communicated, no. Families are an active part
7 of the comprehensive transition plan. So --
8 MSGT MacKENZIE: But we see it
9 everywhere, sir. They're not because the
10 service member says well, I don't want you
11 talking to my wife. So then nobody talks to
12 her.
13 And in one of your -- not the FRG.
14 I'm trying to remember the name -- but she was
15 in charge of the family program. But her only
16 metric to report was that she'd reached out to
17 100 percent of her population. But when you
18 asked her how much percent of the population
19 had she actually talked to -- spouses and
20 families -- it was less than 20 percent. So
21 yet she was toting she was successful based on
22 the Army numbers. But the reality to it was

less than 20 percent of the family was being reached out to. So it's contradictory to this statement at that realm.

BG WILLIAMS: Well, I think it's something we got to get better at. I mean, I know it's not 100 percent. I've got a battalion commander back there who had these sessions.

Danny, have you got any insight on that?

DR. PHILLIPS: And sir, we hear that frequently.

BG WILLIAMS: Yes, sir. Oh, no, I don't --

CAPT EVANS: While he's walking to the mic, I'm surprised to hear that because as part of the orientation to all families, we have to brief them as soon as they arrive. And then that's an ongoing process that we do at Walter Reed Bethesda. So I'm not sure where the gap --

BG WILLIAMS: I'll let Danny take

1 a shot at it.
2 LTC DUDEK: And I understand what
3 the Sergeant Major is talking about.
4 For the majority of the family, we
5 do everything we can. We bait them in with
6 food in the SFAC where there's pizza parties,
7 there's Facebook, there's multiple avenues to
8 try to get information out. We mail packets
9 the first week they're in there in processing
10 to the household and hopefully that gets to
11 the spouse. We have a did-you-know campaign,
12 letting people know about different aspects of
13 it. But there are families where the service
14 member, the RW says I don't want you
15 contacting my family. That's a huge challenge
16 when there is an active nonparticipation.
17 But we try to reach out and bait
18 them in and use the Internet to best serve and
19 use mail. And we inundated them to the -- we
20 mail out as much as we can. But if they
21 actively nonparticipate, it does get
22 challenging.

1 MSGT MacKENZIE: Well, it's not a
2 matter of the family's actively
3 nonparticipating. It's the fact that they
4 don't know. We get there everywhere we go,
5 sir, and I understand that. But when you talk
6 to the family members themselves, they don't
7 see anything. And then when you ask who's
8 responsible for reaching out to the family
9 member, they're supposed to be part of this
10 continuum of care. But yet they're not.
11 LT GEN GREEN: And even if you
12 can't speak with them specifically about their
13 service member -- so the service member says
14 no to sharing any information from the medical
15 -- I understand the HIPAA - you should still
16 be able to tell the families about the
17 multiple programs that are available that the
18 service member may or may not be pursuing.
19 MS. CROCKETT-JONES: Well, we
20 experienced units that when people came into
21 the unit, they basically gave them an
22 opportunity with a line item to say are you

1 giving or rejecting permission for us to
2 contact families. So they were creating a
3 point at which that door could be closed. And
4 I normally ask why they create that -- why
5 they have that specifically -- even worded are
6 you going to allow us. And the answer has
7 been varied because we must be -- it's a legal
8 issue. Because we don't want to make soldiers
9 mad which I find really interesting.
10 There's been a lot of reasons why
11 they want to give that opportunity to shut
12 that door. We have had one place that we went
13 to, worded it in only a positive way -- who
14 was the contact person that you give us
15 permission to give program and benefits
16 information to? Otherwise, it was frequently
17 worded leaving -- like asking for someone to
18 shut this door.
19 So it is sort of a cultural issue,
20 I realize. But we should be looking at ways
21 to take this out of the negative opportunity
22 and be more positive about the importance of

1 that contact.

2 BG WILLIAMS: Yes. Let me take

3 that for action.

4 So programmatic policy oversight

5 guy, the rules don't prohibit that. We

6 suggest families must be a part.

7 Now, at the implementation piece

8 on the ground -- the real politick -- when

9 that door closes and the interdisciplinary

10 team is in there and the soldier's in there

11 and he or she mama or husband's not in there,

12 yes, that's problematic. And if you're

13 telling me it's -- I think you used the

14 percentage 20 percent of the time -- whatever

15 end you looked at -- remember the continuum is

16 everything from folks with growing behavior

17 health PTS, as you know, and some forget they

18 even had an appointment. That in the

19 continuum to what you're describing, ma'am,

20 where maybe the command team set conditions

21 where it's an on or off switch. That's

22 problematic. I can go after that.

1 We should not be doing that, but
2 let me take that on, Sergeant Major. I'll go
3 after that.
4 LT GEN GREEN: And I would
5 actually add to this that I think that there's
6 a confusion regarding HIPAA rights -- okay?
7 Because obviously they can decide they don't
8 want anything specific shared with regard to
9 their condition. But that still should not
10 preclude families from getting program and
11 benefits information.
12 BG WILLIAMS: Sir, let me come
13 back to you formally on that.
14 MSGT MacKENZIE: And especially
15 those that are on official military orders.
16 BG WILLIAMS: NMA-kind of folks,
17 are you saying? Yes.
18 MSGT MacKENZIE: ITOs, MAs.
19 Official military orders to be at the bedside
20 of the service member.
21 BG WILLIAMS: I appreciate that
22 though. But when I show up, the carpet gets

rolled out and a lot of squawking goes on. I don't have a problem talking to family members. A lot family members talk to me. So maybe I have somewhat of a skew. But I'll attack that. I appreciate that. I mean, I talk to a lot of family members.

MR. CONSTANTINE: And it's not just the case where service members say don't talk to my wife. We sit down and have these family meetings, and the husband and wife are right there and the women are pulling their hair out because they're saying he won't ever tell me anything, and he doesn't remember anything.

BG WILLIAMS: Yes, that's exactly right. That's my point.

I was in Bethesda last week. I'm sorry. You're finished? Go ahead. I'm sorry.

LT GEN GREEN: I'll say my wife complains about that a lot too.

BG WILLIAMS: Yes, sir.

1 (Laughter.)

2 BG WILLIAMS: Yes, sir. I walked

3 through and had lunch at the Warrior Caf, and

4 walked through Building 62, and I probably had

5 30 to 40 family members give me an earful.

6 And I was only there for about an hour. A

7 good earful. Some of it not so good.

8 But hey, I got it. We'll take

9 that for action. I appreciate that

10 observation. Yes, sir.

11 COL BERRY: Okay. So slide 18

12 addresses the vocational rehabilitation and

13 employment initiative. As of 1 February, a

14 memorandum of understanding was signed between

15 DoD and the VA. And that is going to place

16 VR&E counselors on military installations that

17 have approximately 200 or more individuals

18 going through the IDES process.

19 And one of the other points of

20 agreement is that we will make it a

21 requirement for anyone going through the IDES

22 process or anyone that may be referred to the

1 IDES process -- it'll be given an option to
2 them -- but if you're going through IDES,
3 it'll be a mandatory referral to VR&E and also
4 those involved in ETI will go through this.
5 So our tasking them for this year
6 is to find places for those counselors to sit
7 on our installations to make them readily
8 available to our soldiers and working out
9 those arrangements and getting those things in
10 place. So the VA is ready to implement or to
11 station about 90 individuals. And we expect
12 probably two thirds or so of those will come
13 to Army installations to support our staff.
14 CAPT EVANS: So Colonel, what's
15 the difference between this individual and the
16 VA liaison? I would think that your VA
17 liaisons at each of the installations should
18 have on board should be able to tell you about
19 this program. So are we adding another layer
20 -- another entity that again the warrior has
21 to see to explain the benefits and the
22 process?

1 COL BERRY: I believe so. I think
2 it's -- go on, sir. Go ahead.
3 MS. MALEBRANCHE: No, I was just
4 going to say being the VA person, I was going
5 to help the Captain hire the two newest
6 members here.
7 It is another person. And the VA
8 has similar to like -- they're talking Army,
9 Air Force, Navy -- we have VHA, NCA and VBA.
10 The Army works out of VBA.
11 Now a lot of the VA liaisons have
12 the information but not to the extent that
13 these VR&E folks do who are specially trained
14 in this. That is their livelihood. So it is
15 another layer, if you will.
16 And hopefully, it's an addition.
17 But they're more specialized. The VA liaisons
18 for the most part if you're thinking the same
19 as I are social workers.
20 COL BERRY: And it's my
21 understanding that they'll be assessed to
22 determine whether they need a full plan to

1 assist them in that. And --
2 MS. ADAMS: If I could speak to
3 that? Nancy Adams from the WTC G-1. I work
4 with Ruth Fanning's staff at the VR&E.
5 They're one of the lines of business inside of
6 VBA that is specifically focused on providing
7 counseling, vocational assessment and testing
8 and employment preparation for folks with more
9 severe disabilities.
10 So the intent of this particular
11 effort is to put trained vocational
12 rehabilitation counselors on military
13 installations with the soldiers that are going
14 through the IDES process and making it a
15 mandatory piece of their transition. The Army
16 has identified that we don't have that
17 particular skill set in our warrior transition
18 units. So this is really a joint effort with
19 VA vocational rehabilitation to provide those
20 services to soldiers with moderate to severe
21 disabilities to help prepare them for
22 employment and a path for transition after

they separate from the military.

LT GEN GREEN: And so I'm going to have you skip #19 and go into the part about support to recovering warriors, medically not ready soldiers and then see if we can't take your briefing from there.

COL BERRY: Okay. I'm going to pass it off to Colonel Spring.

COL SPRING: Good afternoon. It's a pleasure to be here. I appreciate you giving me the opportunity to talk.

The question as I understand it is what type of training and are we giving senior leaders and helping them manage the recovery of our warriors.

And before I talk about the four tools and/or modalities that we have available to us, some of which I understand you've already been exposed to during your visits to the field. I just want to put forth a premise -- that's one premise when we talk about training and information. And that

1 information in of itself is probably the word
2 itself, but it really is about knowledge
3 because knowledge comes out of information.
4 And so we recognize that it's
5 knowledge that we're trying to be able to
6 impart to our senior leaders and those that
7 have the command and oversight responsibility
8 of soldiers because it's only through that
9 that you have a basis to really influence and
10 change and hopefully make a difference in the
11 lives of warriors as they're trying to recover
12 and go down this path.
13 And to that end, the Army medical
14 department works in collaboration with our
15 Army leaders to define what are the best ways
16 to give them the information that would impart
17 the knowledge they need to ensure the soldiers
18 are physically and emotionally supported and
19 prepared for the work that they have in
20 traveling down this road to recovery.
21 Some of our partners that we have
22 within the Army medical department we work

1 with TRADOC, or training and doctrine command,
2 the MCOM Installation Management, Forces
3 Command and the Headquarters G-1. We work
4 extensively with the G-1 and the G-357.
5 And I think what's important about
6 that is that medical is probably late in the
7 game of putting things in words that the
8 average person can use. Though people often
9 beat up lawyers, lawyers learned a long time
10 ago that you can have legalese and then you
11 have something that says the same thing in a
12 way someone can understand it. And I think
13 that what we have -- especially when you're
14 talking to nonmedical people, the ones who are
15 responsible for solders -- we are at fault for
16 not getting out of our medicalese and talking
17 to people even though the information is
18 valuable and usable.
19 And so that we are now ensuring
20 that, through collaboration and coordination,
21 we're taking that medicalese and putting it in
22 formats that is usable to line commanders from

1 the company level all the way up to the Army
2 leadership.
3 And the basis for that really
4 starts with our MEDPROS database, MEDPROS
5 being the pronunciation of the acronym for
6 medical protection system. It contains all
7 the medical and dental information on
8 individuals that go to their medical readiness
9 or designed by those things that make the
10 person operationally capable in order to do
11 their job. It's accessible to commanders all
12 the way down to the company level. It
13 recognizes that the commander has the primary
14 responsibility to monitor the medical recovery
15 and readiness of soldiers, to ensure that they
16 have timely compliance and work with them to
17 ensure their compliance toward recovery.
18 What it does basically, this one
19 particular database ensures a real-time,
20 accurate, reliable information on both the
21 soldier's medical readiness issues or those
22 things that affect their medical readiness as

1 well as their medical nonreadiness.
2 That being the fundamental
3 database. Within that, you will find -- that's
4 MEDPROS. On the next slide, I'll talk about
5 eProfile.
6 But right now, two of the tools
7 we've developed, going back to my opening
8 statements about putting things in a format by
9 which leaders can use, we have developed two
10 particular tools which I want to talk about.
11 That one is the Medical Readiness Leaders'
12 Guide, which is really a paper -- also
13 available electronically online -- guide that
14 is designed to help commanders understand the
15 mission capability of their units as well as
16 the medical status and deployability of their
17 soldiers.
18 The guide includes issues that
19 address things, like their roles and
20 responsibilities as a commander, what those
21 individual readiness elements are that they
22 can use to help define their unit readiness

1 and also understand what's going on with the
2 soldier, the reporting tools that are
3 available to them about their soldiers as well
4 as their unit, and it offers training
5 opportunities that are available in MEDPROS so
6 they can individually, they themselves,
7 increase their working knowledge of how to use
8 that information, and/or it enables them to
9 assign members of their staff, such as their
10 administrative clerks and/or subordinate staff
11 and guides them to additional resources.
12 So that is one tool we've
13 developed. And again, I want to underscore
14 the term that it is written in a sensible,
15 straightforward, easy-to-read and recognizing
16 a commander's need for that type of
17 information as a concise and informative
18 manner without having to go through pages upon
19 pages.
20 Next slide, please.
21 Another one is that eProfile. Now
22 eProfile is a rather broad-based database

1 program that accomplishes several needs. But
2 one of the most fundamental things it does, it
3 makes available to commanders and those who
4 are managing soldiers what is the medical, the
5 termination or status of that soldier that may
6 make them medically not ready or what their
7 medical condition is. And it's an electronic-
8 based report.
9 As compared to the process we had
10 before the implementation of this electronic
11 database, everything was hard copy. Paper.
12 And that even though we all are familiar with
13 the medical electronic record, line commanders
14 and nonmedical people don't have access to the
15 electronic medical record. And even if they
16 did, trying to understand what's in it would
17 not help them in managing soldiers and
18 understanding in an aggregate form what the
19 status of their soldiers were or what their
20 unit was.
21 A second problem or a third
22 problem with profiles prior to the electronic

1 availability of profiles was that they were
2 paper. And so that soldiers and others could
3 manipulate their medical status and/or
4 condition and/or not communicate that to their
5 commanders. And if you're trying to do
6 everything you can to help the individual
7 warrior or soldier or to help your unit be as
8 healthy as it possibly can, get them to their
9 appointments and work with other members, you
10 don't know what you don't know.
11 What eProfile allows providers to
12 do, as well as line commanders, is to know
13 what is the status of the individual at that
14 time. So when you talk about an
15 interdisciplinary team, everyone can have the
16 same base, come from the same basic
17 information and work with it.
18 The other thing about eProfile,
19 it's designed to minimize medicalese so that
20 the average line person doesn't have to take
21 a night course in understanding what all the
22 medical terms are. It's intended to give them

1 the information they need to be able to
2 understand --
3 LT GEN GREEN: If I could
4 interrupt for just a second?
5 COL SPRING: Yes.
6 LT GEN GREEN: So you've got some
7 wonderful training courses and some new tools
8 that you're letting people use. MEDPROS has
9 been around for a while. The eProfile is
10 obviously serving you well. And we've
11 identified on our visits really, as someone
12 else put, a laser-like ability now to know
13 kind of what your readiness is which is
14 fantastic. So really the reason why
15 we asked this question, do you know at this
16 point in time, are the majority of the people
17 going through disability evaluation processing
18 -- so IDES, are they in the WTU or are they in
19 the units? If you were to break it out, can
20 you tell --
21 BG WILLIAMS: The latter, sir.
22 LT GEN GREEN: The latter being

1 the units.
2 BG WILLIAMS: In the units. Not
3 in WTU.
4 LT GEN GREEN: Okay. And so, was
5 there ever a situation where you have somebody
6 in a unit who would have a case manager?
7 BG WILLIAMS: Yes, sir. In fact,
8 quite often we have medical MM -- I'm trying
9 to think of the acronym -- medical management
10 center cells.
11 COL SPRING: Centers. Centers.
12 BG WILLIAMS: We have MMC, sir, at
13 all the divisions right now to manage that
14 population.
15 LT GEN GREEN: Okay. And so what
16 we were really looking for in this is that we
17 have run into -- not necessarily with Army
18 units -- we've run into some sites where
19 people in the units were not being released
20 for necessary medical appointments or those
21 type of activities. And so the reason we're
22 asking all the services is to find out how

1 people get priority for medical care if
2 they're in a unit and basically a line
3 commander says, no, you won't go to this
4 appointment -- that kind of thing.
5 COL SWANSON: Yes, sir. I can
6 speak to that. I'm the IDES person here.
7 And so what we've embarked on, we
8 have an aggressive program that's actually
9 being managed through the Army leadership, not
10 through the medical channels, through the line
11 commanders and particularly forces command in
12 the Army. They have an aggressive program
13 where all of their installation commanders,
14 starting at the company level and cascading up
15 through the chain of command all the way up to
16 the senior commander on the installation, will
17 review soldiers' profiles at particular time
18 gates -- 60, 120 days, 180 days, 270 days.
19 That recently was published in the last week
20 or so as an EXORD to the Army. But that
21 guidance has been in place in forces command
22 for some period of time, and several

1 installations have been following that for a
2 while.
3 What that does is it puts the
4 light on the soldiers in the unit and it
5 forces the commanders to be accountable for
6 how they're managing their soldiers in the
7 IDES process or prior to the IDES process in
8 the heal/treat phase.
9 What we look for in that is we
10 have dedicated resources at the MTF. The
11 Surgeon General has recently signed an access
12 -- an enhanced access to care policy for those
13 soldiers undergoing the IDES so that we can
14 get them expedited care and get them in with
15 the wounded warriors and others so that they
16 can receive that care that they need to be
17 able to resolve their case.
18 COL SPRING: Can I underscore what
19 he just said?
20 Part of that EXORD has to do with
21 the management before they actually get to the
22 IDES portion -- before they're in the

1 disability system. And that's a very
2 significant part of it that's driven by the
3 profile and the management of the profile
4 whereas before there was -- and still is --
5 but we're working at getting more uniformity -
6 - disconnect between medical, the line
7 commander's awareness of what medical is, and
8 that most significant entity, which is the
9 soldier. And so that collaborative case
10 management -- in this particular case the
11 interdisciplinary team -- is the commander,
12 medical and the soldier to ensure that
13 everyone is aware of what the needs are during
14 that temporary profile management phase.
15 LT GEN GREEN: Okay. And so I
16 think you're answering our question so clearly
17 -- some focus on this so that you wouldn't
18 have people who could not get the medical care
19 they need.
20 BG WILLIAMS: Yes, sir.
21 LT GEN GREEN: And then, the
22 follow-on piece of this was your next couple

1 of slides on meaningful use where those people
2 who now you've put them in a WTU and how do
3 you basically keep them feeling valuable and
4 involved. So back over to you.
5 MS. ADAMS: I am Nancy Adams, WTC
6 G-1. And I manage the Career and Education
7 Readiness Branch for the Warrior Transition
8 Command.
9 I was asked to address the
10 questions you had reference meaningful work
11 both inside the WTUs and out in the
12 operational units.
13 So you'll see our definition for
14 meaningful work there -- something that is
15 personally meaningful to an individual
16 soldier. Typically, it's something that he
17 will have crafted when he's in a warrior
18 transition unit as part of his CTP, would be
19 his personal career goal for him- or herself.
20 It's designed to be personally rewarding,
21 enabling the soldier to be financially
22 independent, should they transition out of the

1 military, and have some personal meaning for
2 them.
3 When they're in a unit, those
4 areas that I had talked to you about last May
5 that they're able to work include Operation
6 War Fighter internships in federal agencies.
7 They're also eligible to do onpost work
8 assignments. That would be in a position that
9 typically a green suiter would work in as
10 opposed to a civilian. They're free to
11 participate in education and training programs
12 within the unit and within the Army education
13 system. We also expect them to be going
14 through employment preparation with ACAP,
15 participate in resume classes and work with
16 staff in the SFAC such as DOL and VA VR&E to
17 pursue their career goals.
18 Out in the operational units,
19 there are elements of what we provide in a WTU
20 available to soldiers. But it is likely not
21 inherently intuitive to a commander in an
22 operational unit that they would be looking at

1 these meaningful work opportunities in the
2 same way that we do inside the WTUs.
3 So obviously onpost work is
4 something that would be a commander's
5 initiative if they chose to do that.
6 Operation War Fighter is an opportunity
7 available to soldiers, but they probably are
8 not even aware of that program because it's
9 typically provided inside the warrior
10 transition unit.
11 CSM DeJONG: Ma'am?
12 MS. ADAMS: Yes?
13 CSM DeJONG: Right here. I'm
14 going to kind of encompass quite a few things
15 from the beginning of the slides to the back.
16 One -- and that's what we're talking about
17 about access to the WTUs. Why would an
18 operational commander keep a soldier who needs
19 to be defined as having work defined as
20 meaningful work within their formation and not
21 allow them into the WTU, first and foremost?
22 And then when you're in the WTU, what we hear

1 from a lot of soldiers is once I meet that
2 medical decision point that I'm no longer
3 going to be in the Army -- and we get varying
4 answers across the board -- how come I can't
5 learn to be a civilian, a husband and a wife?
6 How come I still have to do certain trainings
7 we understand? How come I still have to take
8 map reading classes when I know that I'm on my
9 way out of the Army in 200-some days if the
10 IDES process is working the way it's supposed
11 to?
12 Families respond the same way. We
13 have a lot of spouses that ask us how come he
14 can't, why does he have to do? And it kind of
15 goes back to that compassion with standards,
16 sir. At some point in time, why can't we make
17 a standard that says that once we reach this
18 point -- a soldier reaches this point, we know
19 we're no longer going to keep them in our
20 formation. Or a soldier reaches a point where
21 they need work, why are we not allowing them
22 into the WTU and from that point forward, are

we not allowing them to transition into being a husband, father and a civilian?

BG WILLIAMS: You do the second one. I'll do the first one.

The first one is: the Realpolitik is you've got commanders of Brave Rifles or whatever who think they are gatekeepers of this. That's the godhonest truth. I mean, that's transparent. I'm being transparent with you.

So you've got junior commanders who are going oh, Williams ain't going in. You need to cowboy that up. Or we'll work another way through the medical management center and we'll manage you outside the WTU.

Unfortunately, sometimes there's a perception out there in the lines, sir, ma'am, that some of the perks that warriors get while they're in the program -- so you've got lower level commanders who -- don't let me find them; trust me -- who think they can interpret the policy that the Secretary of the Army and

1 the Chief of Staff of the Army have put out.
2 So they're going to do their own
3 interpretation.
4 That's what's going on. You'll
5 find that. I've found it. They'll write me
6 and say hey, sir, look, I've got this injury
7 and I should be in there. And so we'll look
8 at it and we'll have a conversation with the
9 senior mission commander and we'll help them.
10 So that's really the straight, no
11 BS answer to your question is what's going on
12 sometimes. When I find it, if the cases
13 warrant them being in it, if they're
14 authorized six months of complex care and
15 they're active Guard and Reserve and they're
16 wounded, ill or injured, they're going to get
17 in the club -- period.
18 So that's the first answer to your
19 question. That's really what's going on.
20 The second one, go ahead and take
21 a shot at that, and I'll help you with that.
22 MS. ADAMS: Okay.

1 In order for a soldier to
2 participate in the activities that we provide
3 in the unit, they have to be medically
4 eligible and eligible from a command
5 perspective to participate. So for instance,
6 in a recent OIP inspection that I went on, not
7 all the soldiers were medically and command
8 eligible to participate in career activities.
9 Right now, the soldiers in our
10 units -- there's about 56 percent of them that
11 are eligible to participate. Of the ones that
12 are eligible, some of them opt not to
13 participate. They don't want to participate.
14 So at that point, it's the commander's
15 discretion about how they help that soldier
16 spend their duty day. So we have some of
17 those issues to weigh and balance. Between
18 one and two participate in career activities
19 and personal growth and those that either
20 can't or don't want to.
21 CSM DeJONG: Okay. Thank you.
22 And we get varying answers. And

1 again, I think that that brings light to the
2 fact that we need to really enforce and try to
3 really advocate bringing families in because
4 when you get wives asking: why is my husband
5 just sitting here doing nothing, well, there
6 may be a logical reason or an answer as to
7 why. They're just not being informed.
8 So thank you, sir, ma'am.
9 BG WILLIAMS: One point, are we
10 going to talk about the conference next week
11 or is that coming?
12 MS. ADAMS: Not yet, sir. Now go
13 ahead.
14 BG WILLIAMS: No, you go ahead.
15 MSGT MacKENZIE: Let me throw one
16 thing in too though. We've got to be willing
17 to document the tough information. Okay? In
18 some locations, there were individuals that
19 were not working because they weren't being
20 offered anything that was meaningful to them.
21 If a soldier's all busted up and he's going
22 through complex medical care and he's going

1 through Med Board and he's going to get out
2 and join his brother as a tattoo artist, well,
3 because he doesn't fall into this parameter,
4 he can't go do that as meaningful work. So
5 any of those things you offer this guy aren't
6 meaningful to him. So the percentage is
7 skewed because the documentation is not clear.
8 We have to be willing to say that
9 we won't allow them to do what's meaningful to
10 them because it doesn't meet X, Y and Z, or
11 that there's no meaningful work available that
12 meets this person's specialty, as well as this
13 percentage because they choose not to
14 participate.
15 MS. ADAMS: Right. And you're
16 absolutely right.
17 MSGT MacKENZIE: And that needs to
18 be clarified.
19 MS. ADAMS: We are constrained by
20 the limits of what we're allowed to do right
21 now for what kinds of work opportunities are
22 available. And some of them, you're right,

1 are absolutely not meaningful to the soldier
2 that may want to be a tattoo artist or
3 whatever it is when they get home.
4 MSGT MacKENZIE: They're being
5 labeled as nonparticipants. But the reality
6 to it is: by the nature of this initiative,
7 we're just not providing them anything to
8 participate in that's going to be anything
9 meaningful to them.
10 MS. ADAMS: Our staff in the units
11 -- the transition coordinators -- are working
12 themselves and they're working with the DoD
13 Wounded Warrior Care and Transition Program
14 Office -- the Operation War Fighter Folks --
15 both on and off post and in a variety of
16 different settings. It could be medical. It
17 could be MWR. It may not be the soldier's
18 ultimate personal goal of what they're doing.
19 But they're trying to find something that will
20 interest them.
21 It's not possible in all cases. I
22 understand that. But the staff is trying to

1 help that soldier either find an education
2 program that they're interested in, college
3 classes or some kind of a work opportunity
4 that may not be their ultimate personal goal,
5 but something that they are interested in
6 working while they're still on active duty.
7 But the choices are not limitless. You're
8 absolutely right.
9 Next week, the Army is hosting a
10 joint service conference down at Fort Belvoir
11 -- the Wounded Warrior Employment Conference
12 -- for two days. Army senior leadership is
13 going to be meeting with General Williams to
14 work out what it is that we want to do in a
15 more intensive way in the Army to provide
16 employment opportunities to wounded, ill and
17 injured service members and veterans. We also
18 have families coming in.
19 We have over 90 employers from
20 both federal government and private
21 corporations and 501(c)(3)s, state and local
22 government that are going to be participating

1 in this. And we're giving the wounded, ill
2 and injured soldiers, veterans and family
3 members in the National Capital Region the
4 opportunity to meet with those recruiters on
5 the second day of that conference and
6 interview for employment.
7 We've done a lot of preparation
8 work in advance of that particular conference.
9 Our command has hosted two multi-day resume
10 writing workshops at Fort Belvoir. And we've
11 also solicited resumes from our wounded, ill
12 and injured service members in our warrior
13 transition units, our AW2 veteran program all
14 over the country. And we are providing those
15 resumes to the employers at this conference to
16 look at prior to the conference to see if they
17 may be interested in our soldiers that are
18 interested in them for employment.
19 DR. PHILLIPS: Ma'am, please
20 correct me if I'm wrong. I've been told that
21 the only website a soldier can look at for a
22 job other than a WTU is the federal website.

1 They cannot look at state or local websites
2 because of some liability --
3 MS. DAILEY: For internships. Not
4 for employment. For internships.
5 DR. PHILLIPS: For internships?
6 MS. DAILEY: Internships.
7 MS. ADAMS: It would be for
8 volunteer work or an internship they wanted to
9 do while they're still on active duty. We
10 absolutely encourage them to look at every
11 possible opportunity, from running their own
12 small business to working for the federal
13 government or a state and local government as
14 far as employment goes. And we help them in
15 those avenues when they identify what they
16 want to do. So the post-separation employment
17 is different than the internships.
18 DR. PHILLIPS: Okay. I stand
19 corrected.
20 But even then, doesn't that limit
21 their future potential if it's only for
22 internships?

1 MS. ADAMS: I am sorry. I don't
2 understand.
3 DR. PHILLIPS: If they can't look
4 at a regional or a state or a county, city
5 website -- say at Fort Stewart -- for an
6 internship but can only look at the federal
7 website -- and maybe they overlap; I don't
8 know -- but that's what I --
9 MS. ADAMS: Well, it does. The
10 language was inserted into NDAA this year to
11 change that option and to allow state and
12 local internships and internships with private
13 companies. When that bill went to conference
14 between the House and the Senate, some of the
15 language got rearranged. The authorization
16 obviously got passed. But right now, we're
17 waiting on a legal opinion from the general
18 counsel that works with wounded warrior care
19 and transition to get some guidance on what
20 soldiers will be allowed to do within the
21 purview of the new authorization.
22 BG WILLIAMS: Sir, but I don't

1 have any language or any policy that limits
2 scope from WTC.
3 MS. ADAMS: Next slide, please.
4 This particular slide was put in
5 here just to share with you. When I was here
6 last May, our transition coordinators down in
7 our warrior transition units had been boots on
8 the ground about five months.
9 We went through the summer and
10 picked up several others. So in our units
11 that are warrior transition battalions and
12 brigades, we have these staff members that are
13 focused on assisting soldiers with these OWF
14 internships on-post work and also looking for
15 appropriate education and career goals.
16 So we provide training for them in
17 a variety of different venues. We did a
18 couple of days of direct training with them in
19 our WTC annual conference last summer. We've
20 started including them in the senior leader
21 orientation program that General Williams
22 mentioned and the clinical leader orientation

1 programs this spring. And we're conducting
2 monthly training with them on a variety of
3 technical topics that they need to know about
4 related to executing their job down in the
5 unit.
6 We look at those transition
7 coordinators as a conduit between the
8 occupational therapists, the staff in the
9 SFAC, the Army education counselors and
10 working hand in hand with that squad leader to
11 make sure that whatever it is that they've
12 identified to do related to career or
13 employment preparation is being properly
14 tracked and that the soldiers have access to
15 the programs and services they need to work on
16 their personal career plans.
17 Are there any questions?
18 LT GEN GREEN: No. Thank you. I
19 think that just because we're running now
20 almost 15 minutes over, we're going to
21 probably cut this off, unless the Task Force
22 members have specific questions of you.

1 You've given us what we were
2 looking for -- thank you very much -- in terms
3 of the meaningful use. And it's nice to know
4 that there's not specific restrictions as you
5 seek legal counsel regarding the ability to do
6 private internships and things.
7 Regarding the IDES, which were
8 your last two slides, we're not going to have
9 you actually talk to that today. But you
10 listed a couple of things on here -- the best
11 practices and also your additional resource
12 and space in terms of personnel contract
13 without any specifics. And can I ask you to
14 give us in writing -- give it to Denise -- the
15 actual what you identified as best practices
16 and also the additional resources that have
17 been put into your program to improve your
18 IDES? But not necessarily talk about it today
19 if that's okay.
20 BG WILLIAMS: Sir, wilco. Yes,
21 sir.
22 LT GEN GREEN: Okay. Denise,

anything else?

MS. DAILEY: Yes. Thank you very much. There are certain back-up slides that we are still looking for from the Warrior Transition Command. So if you can get those to us as soon as possible, I would appreciate it. That is part of our data collection, and the longer it's delayed in us receiving it, the less data I can collate.

Thank you.

BG WILLIAMS: Ma'am, so do we know what those slides are, ma'am?

MS. DAILEY: Yes, sir.

BG WILLIAMS: Okay.

MS. DAILEY: They're listed in the agenda. You have the requirement.

BG WILLIAMS: I'm getting the thumbs up in the back. So are we ready to hand those off today before we leave here? ETA? When are they going to arrive on target?

STAFF: We're expecting them in about a week.

1 BG WILLIAMS: Is that okay, ma'am?
2 Or you need them today? Because I can go talk
3 to the lawyers and I'll beat them up.
4 MS. DAILEY: I would talk to the
5 lawyers, sir. I'm not sure what I'd asked for
6 that I didn't ask for last year.
7 BG WILLIAMS: Okay. So will one
8 week be okay, ma'am? Okay. Good, ma'am. If
9 you're interested, sir or ma'am, I've got
10 copies of the CTP as well, if the team here
11 would like them.
12 MS. DAILEY: We have it. We got
13 it in the December meeting.
14 BG WILLIAMS: You all have them?
15 MS. DAILEY: Yes.
16 BG WILLIAMS: Okay, ma'am. Sir?
17 LT GEN GREEN: Let me just say
18 thank you. Clearly your dedication and
19 commitment to the recovering warriors is
20 obvious. And so we appreciate you bringing so
21 many of your team over here and talking to us.
22 And we apologize. We've been

1 going late all day. So we've kept you about
2 25 minutes. And so our thanks to you folks
3 for coming over and spending time with us.
4 BG WILLIAMS: Thanks, sir.
5 I'll just say thanks, everybody.
6 I'm serious. If you have some
7 things you need me to follow up on, I will.
8 And if you've got some of those piece, I don't
9 know if they can come out of this process or
10 if it's premature if you can allow. But I
11 will run those down, and I'll get you an
12 answer today if I need to or by the end of the
13 week on these other things.
14 Just one comment if I could about
15 the IDES, sir. The Surgeon General's been --
16 it's one of her big foci as a new Surgeon
17 General. And my team two weeks ago -- and
18 Greg is the master of all things -- IDES,
19 MEDCOM -- but I've been the General sort of
20 given oversight. Fifty percent of my
21 population is going through the process.
22 So we did an orders drill three

1 weeks ago. The Department of the Army, as
2 Greg mentioned, will publish an order here --
3 it went out last week. We did in a parallel
4 fashion an orders process within MEDCOM. I
5 brought in Colonel Spring, Colonel Swanson and
6 a bunch of colonels. We had about 60 folks on
7 the seventh floor of the Hoffman Building, and
8 we went through it. I said if this thing gets
9 published next week, I want to put the Surgeon
10 General in a good place where we are in terms
11 of all things -- medically nonready soldiers.
12 So many of the things you'll see
13 in this order coming out, we will publish in
14 about three weeks. I'm going to send it out
15 to the field to make sure the MTF commanders
16 understand what we're asking them to do.
17 The key word is standardization.
18 I went to the Surgeon General and I said,
19 ma'am, standardization or standards-based? I
20 said my recommendation to you is that we do
21 not go standards-based right now. We've got
22 too much standards-based going on right now.

1 Let's get standardization -- Fort Campbell,
2 Fort Hood. Here's how you take care of a
3 soldier in a WTU, outside of a WTU as you
4 mentioned, sir.
5 So when we come back to you in the
6 future, this order will be done and it'll be
7 done this week. But the next time we come and
8 talk to you, I can go in more detail about all
9 things -- integrated disability evaluation
10 system. I'm sort of the general here that's
11 overseeing it for the boss as we try to get
12 our stuff together.
13 But clearly, we have a lot of
14 variants inside MEDCOM. We've got one doc
15 doing one thing and one doc doing another.
16 And I'm an artilleryman. I told them, I said
17 I want the gunner of gun 1 to be able to go in
18 the eighth gun and find his tool at the right
19 place. That's what we need in MEDCOM, ma'am.
20 And so, we're trying to bring
21 standardization. And I know I'm talking to a
22 group who knows this. The Surgeon General

1 certainly knows this better than I do. But
2 this is going to take some time. But she's
3 tapping the chalk line right now. And this is
4 where we're going. We're going for it. We
5 briefed the Vice two days from now and say
6 this is our plan. This is MEDCOM's plan to
7 get at the integrated disability evaluation
8 system.
9 So some of that stuff you've asked
10 for, sir, we'll give you in an information
11 paper. But next time we come in, we're
12 prepared to come back and talk to you some
13 more on that, sir.
14 LT GEN GREEN: Yes. And one just
15 suggestion for you, if you have not had your
16 experts go down and visit with LTJG Cook down
17 at Camp Lejeune, she has the best process
18 integrated with the VA --
19 BG WILLIAMS: Okay, sir.
20 LT GEN GREEN: -- that we have
21 seen anywhere. And the way that they manage
22 the paperwork is absolutely remarkable.

BG WILLIAMS: Lejeune, sir? Camp Lejeune?

LT GEN GREEN: Lejeune.

BG WILLIAMS: Wilco, sir. Thank you, sir.

LT GEN GREEN: Okay. Thank you, folks.

And for our team, I know we've got the Air Force a little late. We'll take ten minutes and start about five of the hour. Thanks.

(Whereupon, the above-entitled matter went off the record at 2:44 p.m. and resumed at 2:59 p.m.)

MS. DAILEY: We will now have Lieutenant Colonel Michael Wyatt. Is that where we're going?

LT COL WYATT: Yes, ma'am.

MS. DAILEY: Chief of Air Force Warrior Survivor Care to lead the Air Force's update to the Task Force and address their input to the 3 December submission to

1 Congress. Other briefers are listed in your
2 agenda and will introduce themselves as they
3 appear. This is all under Tab F.
4 And there you go.
5 LT COL WYATT: Thank you.
6 Good afternoon, ladies and
7 gentlemen, sir, ma'am.
8 Thank you for having us here today
9 to discuss Air Force Warrior Survivor Care
10 programs.
11 I'm Lieutenant Colonel Mike Wyatt
12 from the Air Force Warrior Survivor Care
13 Office. And I'm here to brief the Air Force
14 responses to your questions and also to
15 provide answers. Your subject matter experts
16 are here to provide answers to your questions
17 as well.
18 Let me explain to you just
19 basically real quick for those of you that
20 might not know. The Air Force is aligned
21 under the SG and the A-1. The SG takes care
22 of the clinical aspects of warrior survivor

1 care. And under A-1S, we take care of the
2 nonclinical aspect of warrior survivor care.
3 So as I go through these briefing
4 slides today, as I answer the questions,
5 understand that some of these answers I'm
6 provided from the subject matter experts and
7 they're going to be here and ready to answer
8 any questions or provide any details that
9 you're going to need in regards to those
10 questions that you might have.
11 Next slide, please.
12 The first recommendation 3A was to
13 develop standardized data-driven protocols for
14 a condition-specific recovery care. The Air
15 Force agrees with this recommendation and
16 understands that patients and their families
17 deserve the information about the care and
18 expected outcome for the service member.
19 The DoD and VA produce many
20 evidence-based protocols that are followed.
21 The individual nature of each patient, their
22 condition and potential complications do

1 result in a variety of recovery protocols.
2 It's important to tailor information to each
3 patient's unique needs.
4 And Colonel Poindexter, if you
5 have additional information.
6 COL POINDEXTER: Yes. My name is
7 Colonel Todd Poindexter, and I'm the Chief of
8 Clinical Operations Policy for the Air Force
9 Medical Support Agency.
10 I actually did have the
11 opportunity to sit in and I heard some of the
12 questions and concerns that were raised when
13 the Army briefed. And I would actually just
14 go ahead and address straight on that we do
15 still have work to do when it comes to
16 providing information to families.
17 If you look at, for instance, the
18 Clinical Practice Guideline for Amputee Care,
19 it does actually require a plan -- a treatment
20 plan -- that would be discussed with the
21 patient and the entire team so that the
22 patient will receive that information.

1 However, as we know and we've heard, part of
2 the challenge is that the family can be part
3 of that plan as well, plus there are issues of
4 not just the medical care but there's also the
5 nonmedical aspects of it. And I think that's
6 where we do need to work with our sister
7 services.
8 Given the fact that we do have a
9 smaller number of wounded warriors, our data
10 alone would not be enough to adequately come
11 up with data points, but certainly in
12 conjunction with the other services, we do
13 feel that we would have the data needed to be
14 able to provide the information that you have
15 asked for.
16 DR. TURNER: And sir, from a
17 nonmedical management aspect, this kind of
18 stuff would be valuable to your folks, I would
19 assume --
20 LT COL WYATT: Absolutely.
21 DR. TURNER: -- in managing the
22 portion that's assigned to you, as this is

1 decentralized. It's not so much about medical
2 care. But it's about those decision points
3 and those goals and guidelines. And so I
4 would find that that's probably pretty
5 critical to your guys even though --
6 LT COL WYATT: Absolutely, it is
7 for the RCCs and also the WFW2 advocates.
8 Next slide.
9 All right. Recommendation 3B. To
10 ensure RWs have the accurate, consistent and
11 timely information about options for returning
12 to duty and transitioning out of uniform
13 across all services.
14 In support of OSD initiatives to
15 return wounded warriors to a productive
16 military or civilian life, the AF A-1 revised
17 several personnel policies in February of '09
18 and we continue to work through Air Force
19 warrior survivor care to develop and grow the
20 policies that were put in place to afford our
21 seriously wounded airmen additional
22 opportunities despite having suffered

1 significant wounds of war. These policies
2 were implemented in areas of classification,
3 promotion, evaluations, retention and
4 retraining and allow combat wounded airmen to
5 continue their careers and compete for
6 promotion while undergoing treatment or
7 rehabilitation.
8 Those airmen who are no longer
9 able to continue in their AFSC -- or Air Force
10 Specialty Code -- due to disqualifying
11 conditions will be afforded the priority to
12 retrain in another Air Force specialty codes
13 and to continue to contribute to the Air
14 Force.
15 It's our goal to continue finding
16 ways in order to work. We have a young
17 airman; his name is Senior Airmen Mike
18 Malarsie. He works at Air Force Services
19 Agency under the RCC program as a mentor for
20 our seriously ill and injured and he briefs
21 with us as we go around the Air Force
22 explaining or educating people on our

1 programs. So that's just one example, and
2 we'll talk about that a little bit later.
3 The AFW2 program nonmedical care
4 managers are strong advocates for the wounded,
5 ill and injured. They maintain regular
6 contact and ensure that they're educated on
7 the benefits and the entitlements and options
8 available prior to, during or after the
9 Medical Evaluation Board. When the Air Force
10 decision is to medically separate or retire an
11 airman, the resources and services are made
12 available to address all transition needs to
13 the family member and their family. Followup
14 with the wounded warriors continues after
15 separation and retirement as long as needed to
16 ensure that the airman and family reach the
17 highest possible level of resilience,
18 independence and stability.
19 LT GEN GREEN: Sir, can I just
20 ask? You say that there's policy. But how is
21 the Air Force wounded warrior program
22 codified?

1 LT COL WYATT: Okay. Right now,
2 I'll just come out and explain something
3 that's been a challenge for us, especially
4 over the past year. We have developed and
5 actually have an external coordination the
6 policy that has been needed so much over the
7 past several years. We've had memorandums --
8 guidance memorandums. We've had policies.
9 We've had many other avenues of reference or
10 support to go back and reference for a myriad
11 of different issues. We do have an AFI that's
12 gone through external coordination at this
13 point -- is going through external
14 coordination. And we'll have that on the
15 street very soon.
16 At the same time, we're
17 reorganizing the way that we're managed from
18 the FOA level. We have gone through a series
19 of AFSO-21 events -- the smart ops exercises.
20 And the Air Force A-1 has approved the
21 reorganization of the new super FOA, we call
22 it, at AFPC. We're going to have the warrior

survivor care team, the RCCs, the Air Force wounded warrior, all of our nonclinical aspects of care under one O6 at the personnel center. So hopefully that'll clear up some of the confusion that sometimes comes along with trying to figure exactly where that policy is coming from or where to find the reference to support our airmen and their families. So that's an ongoing effort right now, and we're making great strides from the nonclinical standpoint for that.

DR. TURNER: Lieutenant Colonel Wyatt?

LT COL WYATT: Yes, sir?

DR. TURNER: Thank you very much.

Maybe you'll address this later, and if so, I'm sorry.

LT COL WYATT: Yes, sir.

DR. TURNER: You've made several comments about the policies and the development of your policies. And so by your answer now -- and make sure I'm not

1 misunderstanding -- is you're still not as far
2 along in developing programs and the
3 resourcing of those programs? I understand
4 the policies are well along. But where are we
5 on programs and resourcing those programs?
6 LT COL WYATT: Okay. Sir, as far
7 as programs, I believe we're very solid. I
8 mean, we have our RCC program supporting a
9 combat-injured airman from the time they're
10 injured in the AOR through Landstuhl, back to
11 either San Antonio or Andrews. And we have
12 them every step of the way until they get back
13 to their unit of assignment.
14 Air Force Wounded Warrior Office
15 is very involved just from the point of injury
16 of knowing exactly what's going on, what's
17 being done to make sure that that airman and
18 their family. When they get to the point in
19 their recovery process where they need to
20 start looking at employment and different
21 retention opportunities or other opportunities
22 for transition, it's there.

DR. TURNER: How are those funded?

LT COL WYATT: Okay. The funding for those programs, we have the RCC contract is ONED funds. That's funded with ONED funds. And we're currently in the process --

DR. TURNER: POMS?

LT COL WYATT: Yes, sir. Yes, sir. POMS.

Same goes with -- correct me if I'm wrong, Colonel Black -- but the same goes for AFW2. And they're actually at the Air Force Personnel Center. And that's POM4, under the same process.

LT GEN GREEN: Can you tell us what the draft AFI is? What is the number? Does it have a number yet?

LT COL WYATT: Where's Mr. Tim Towns? He can tell me.

STAFF: It's 34-1101.

LT COL WYATT: I knew that.

LT GEN GREEN: And expectation for publication?

1 LT COL WYATT: Sir, right now,
2 we're running into some site delays based on
3 the reorganization efforts. But I would say
4 within the next six months we should have our
5 initial draft. If not that, then we're going
6 to have a guidance memorandum out very soon to
7 go ahead and get the information that we're
8 trying to get out to leadership there in the
9 guidance memorandum.
10 MSGT MacKENZIE: One of the
11 things, sir, when talking with the service
12 members and finding out, we have the unique
13 ability to talk to folks and find out what it
14 is they really do know versus what you guys
15 tell us. Within this policies and this AFI,
16 everything else is there. Are there any steps
17 for oversight or accountability for the
18 effectiveness of your policies actually
19 reaching the service member?
20 LT COL WYATT: Well, right now --
21 and we'll talk about the RAND survey that we
22 have ongoing. That's one way we go out to say

1 a company like RAND to ask for surveys.
2 Another thing that we'll try to do
3 is through one of our databases. We're
4 currently in the process of developing or
5 trying to field a database that will track
6 that more effectively, kind of like the Army
7 MCWIC system -- I'm sorry, Marine Corps. I
8 knew that.
9 But just like the Marine Corps
10 MCWIC system, it's called AFWIC. And as soon
11 as we can get that system up and running,
12 we'll have a more -- I'm going to say
13 effective tool as far as to gather information
14 like that in order to get that back out and
15 understand exactly what's going on with the
16 service members and their families.
17 MR. REHBEIN: Colonel, if I may,
18 and some of the other folks that were down in
19 San Antonio on that visit, correct me if I'm
20 wrong, but I'm remembering from that visit
21 that by the time someone -- one of your
22 recovering warriors -- was in the AFW2

program, the MEB had begun. And by that time returned to duty options were pretty much by the wayside. And so I'm wondering how they receive any information about return to duty options?

LT COL WYATT: Sir, that is a very good point.

Right now, there's a trigger -- a trigger point when a recovering service member will officially be part of the Air Force Wounded Warrior program. And Colonel Black, you can chime in here for me if you will.

LT COL BLACK: Yes, sir. Actually when you're looking at return to duty, that decision is made after the MEB. So after your MEB, your PEB, and you're found that you're pretty much not going to be returned to duty, that's when you can apply for the limited assignment status in the programs that we have there. So it would actually have to be after your MEB and after your PEB.

MSGT MacKENZIE: Yes, ma'am.

1 That's understood, but providing that
2 information so that the recovering service
3 member is prepared is I believe the question
4 was getting at. If the person providing the
5 information, they don't get to talk to until
6 they're already at that point. A lot of these
7 decisions are made during the recovery
8 process. And so, if they don't know what
9 their options are, then it's not an effective
10 decision for the service members and their
11 families.
12 So the question once again is: if
13 the person providing the information doesn't
14 come on board until so late in the game, how
15 are we effectively a service member options or
16 preparations?
17 LT COL BLACK: Right. And you're
18 correct. And that is something that with our
19 PEBLO training that we have to make sure that
20 they're getting that information out.
21 I can tell you that the folks that
22 are in the AFW2 program, they will have that

1 information. So that is an area.

2 COL POINDEXTER: I think I'd like

3 to add, the other thing is, there are a couple

4 of other pieces. Obviously, as you go through

5 the continuum of care, you have medical case

6 managers that are also working with recovery

7 care coordinators. And the RCCs are integral

8 in talking about some of those nonmedical

9 aspects, such as the potential for return to

10 duty or other options like that.

11 Some of our more seriously injured

12 individuals are going to have an RCC. That

13 RCC will have developed a comprehensive

14 recovery care plan. And part of that will be

15 talking to them early on about their various

16 options.

17 So many people have an RCC long

18 before they have an AFW2 advocate. And so

19 they will have already heard about that. Not

20 everyone will. But many will.

21 MSGT MacKENZIE: But that's my

22 point is that there are people who qualify for

1 AFW2 who do not qualify for RCCs. So those
2 folks don't get the data until they're already
3 long into the process.
4 From point of injury, regardless
5 of the overall continuum of medical care, a
6 person that's wounded is a person that's
7 wounded.
8 COL POINDEXTER: Correct.
9 MSGT MacKENZIE: But you see what
10 I mean? Okay? It doesn't change. That
11 should be automatic. And that's how we -- and
12 if you're going to label somebody -- forgive
13 me, my point just escaped me. But the point
14 is a person who qualifies for AFW2 --
15 LT COL WYATT: Is combat wounded.
16 MSGT MacKENZIE: -- qualifies, is
17 combat wounded.
18 LT COL WYATT: Yes.
19 MSGT MacKENZIE: They're combat
20 wounded from the moment they get combat
21 wounded. They shouldn't have to wait to get
22 information.

1 LT COL WYATT: Very true. And
2 they don't wait.
3 I stated earlier that as soon as
4 the RCC is fully engaged -- and it's like, we
5 call it a trigger point or -- it's not really
6 a hand-off entirely because from the very
7 beginning, AFW2 tracks every member.
8 And what we're doing as far as the
9 reorganization is concerned, we've had Colonel
10 Black and Stephen Page. Stephen Page leads the
11 Air Force Recovery Care Coordinator Program
12 for us. They have had meetings in San Antonio
13 just recently based on some of the earlier
14 reorganization meetings we had. And what
15 they're doing is they're meeting with each
16 other to find out okay, how can we change the
17 roles of an Air Force wounded warrior advocate
18 to make sure -- and we say recovery care
19 coordinator -- while they're coordinating with
20 even AFW2 at the point where that airman needs
21 that assistance. So we're trying to find ways
22 where initially that RCC if there's a VA

question or if there's an education employment question -- whatever that might be -- that there's a teaming between the RCCs and the AFW2 that it's been there but not solidified as much as it should be. And we're working on that right now.

And there's still that division as far as seriously ill and injured, say if there's a car wreck or something like that, versus combat wounded. But when it comes to combat wounded, there's definitely a need for more partnering. And we're in the process of making sure that happens.

Any other questions on this slide? Okay. Next slide.

Okay.

LT GEN GREEN: Can I just -- I'm still just a little foggy on what you're saying.

So the process as I understand it is that basically folks who are identified that are not going to be able to perform in

1 whatever their AFSC is, go through local
2 evaluation with a determination made that
3 they're need to be -- well, I'll call it in
4 lieu of Medical Board, but essentially the
5 package is sent down to AFPC, where expert
6 physicians look at it and decide whether or
7 not they can stay in their career field or
8 not. If they cannot stay in their career
9 field, then there's a question as to
10 retraining. The same group of people working
11 with the personnelist make that decision. And
12 then if they can't do that, then they're
13 forwarded to the DES system. Is that correct?
14 LT COL WYATT: Yes, sir.
15 LT GEN GREEN: Okay. So I think
16 that when we're talking about the RCCs and
17 obviously now you're talking the wounded
18 warriors or, you know, those folks, I guess
19 the question is are they handled differently
20 other than the fact that they may have an RCC,
21 an R followed by somebody in the personnel
22 world. But is the process the same?

1 LT COL WYATT: Between us, just
2 seriously injured and a combat wounded airman
3 --
4 LT GEN GREEN: Right.
5 LT COL WYATT: -- the process is
6 different.
7 LT GEN GREEN: Is it still up to
8 the local dog to make the decision whether or
9 not they're going to go down to be evaluated
10 whether they can stay in their AFSC or not?
11 Is that same process the same?
12 LT COL WYATT: There are some
13 exceptions. And Colonel Black, if you can
14 help me out on that. There are exceptions.
15 LT GEN GREEN: The exceptions come
16 later. If I just heard what she said, the
17 exceptions come after they've gone through the
18 DES Board, is that correct?
19 LT COL BLACK: Yes, sir. Actually
20 after they have actually accepted the Board
21 results, they can apply for retraining. So
22 they would have to accept the decision of the

1 Board, and then they can apply for retraining.
2 And once they apply, the only way that they
3 cannot be trained -- the only person who can
4 deny that is Steve. Air Force A-1 can deny
5 them that.
6 LT GEN GREEN: And who is that
7 offered to? That's offered only to people who
8 are in Air Force WW2? Who is that offered
9 that to?
10 LT COL WYATT: Only those that are
11 combat wounded. So, yes, sir.
12 LT GEN GREEN: So only combat
13 injured?
14 LT COL WYATT: Yes, sir.
15 LT GEN GREEN: Okay. All right.
16 And so your question, Mack, is
17 that the RRC, if they don't have an RRC, that
18 they may not be advised regarding their
19 retraining until that point? Okay.
20 MSGT MacKENZIE: Yes, sir. That
21 is correct.
22 LT COL WYATT: And really, the

1 only combat injured -- there's a difficulty
2 say if there's a diagnosis of PTSD after a
3 service member returns back to the states.
4 Then that's one of those areas where we need
5 to have visibility. We need to have
6 referrals.
7 But if there's someone that's
8 physically injured or is BSI or very seriously
9 injured or seriously injured in the AOR, we
10 have them -- definitely have them from point
11 one. And they will have an RCC. They will
12 have a FLO or a family liaison officer at
13 Landstuhl and then back here in the states.
14 So they're covered. But there are
15 certain instances, and I think it's what the
16 diagnosis. Say if there's a traumatic brain
17 injury and a diagnosis of PTSD after the fact
18 is where we sometimes miss them with the RCC
19 coverage. So that's something we need to do
20 better as far as communication if we don't
21 have that casualty report that states what the
22 seriousness of the injury is. So definitely

1 I know that that's an area of improvement.
2 MSGT MacKENZIE: And see, that's
3 one of the complications. And I don't mean to
4 beat a dead horse here. But the SI and VSI
5 reporting is done by the medical folks, if I'm
6 correct. So that service member gets to
7 Landstuhl. He's then downgraded, but still
8 has to go back to his unit for continued
9 medical care.
10 LT COL WYATT: I see what you're
11 saying.
12 So you're saying if there's not a
13 --
14 MSGT MacKENZIE: You see, it's not
15 all combat wounds qualify for an RCC.
16 LT COL WYATT: I understand. So
17 --
18 MSGT MacKENZIE: But yet they will
19 always qualify regardless of the complexity or
20 severity. A combat wounded airman will always
21 qualify for AFW2.
22 LT COL WYATT: And they will not

1 always have an RCC. You're correct. Because
2 they're --
3 MSGT MacKENZIE: So the fact of
4 the matter is, if AFW2 is not reaching out to
5 them until that Med Board process, that's a
6 problem because they are missing a gigantic
7 chunk of information that is not being
8 provided because of those constraints.
9 LT COL WYATT: Okay. And that's a
10 very good point. And definitely as we re-
11 evaluate the partnering here, maybe it's not
12 the RCC that's partnering, but it's just a
13 little bit different way of doing business.
14 LT COL BLACK: And I think that's
15 when we had our offsite, in that offsite we
16 did have the RCCs, AFW2 as well as the medical
17 case managers there. So it's the referral
18 process is what you're alluding to -- making
19 sure that we get that referral.
20 When we get an individual from the
21 DES system, you're right, that's too late in
22 that process. So we did address that. And I

1 think one of the gaps that we identified was
2 identification process of those individuals
3 who should be qualified for the recovery
4 coordination program.
5 MSGT MacKENZIE: And that's the
6 whole thing. And I guess to provide perhaps
7 a perspective, this individual gets combat
8 wounded. They don't qualify for an RCC. I
9 mean, there should be a team meeting of
10 different agencies that goes okay, this
11 service member's coming back to the states.
12 He doesn't qualify for an RCC. AFW2 you've
13 got him. Come back to the states. AFW2 still
14 has him, but hey, he qualifies for an RCC.
15 Okay. AFW2 steps into the background because
16 that RCC is handling that SI or VSI. But
17 they're still partnered together but there's
18 that decision point going. Who needs to be
19 directly involved?
20 I mean, I love my AFW2 advocate.
21 I get phone calls on a regular basis. I mean,
22 it's great. If I was not involved with the

1 things I'm involved with, I'd use him a lot
2 more than I do.
3 LT COL WYATT: Right.
4 MSGT MacKENZIE: But the point of
5 the matter is that there's that gap for those
6 newly wounded airmen that if they don't
7 qualify, nobody talks -- it's too harsh of a
8 term. It's like nobody communicates with
9 them. So they kind of flounder out there
10 hoping their command or their unit or their
11 base level has that information. And they're
12 just not as educated as the experts are in
13 providing that information. So just a point
14 for review.
15 LT COL WYATT: Okay. All right.
16 Okay. Next recommendation 4. The
17 DoD should clarify which member of the
18 recovery team is responsible for engaging the
19 RW and the family and ensuring they actively
20 participate throughout the entire CRP/CTP
21 progress.
22 The way the DoDI is stated, the

1 DoDI states that the RCC will be designated as
2 that individual. Air Force RCCs maintain the
3 comprehensive recovery care plan for every
4 member that they have in their case files.
5 The RCC will go over this comprehensive
6 recovery care plan with the active duty member
7 and use RCPSS which is the mandated program
8 through DoD to track and make sure that that
9 recovering service member is progressing
10 through their care. And that's the way that
11 we do that. The RCC is specifically the one
12 that takes care of that recovery care plan.
13 Next slide.
14 Okay. Recommendation 8A says
15 shape strategic solutions that address the
16 unique needs of Reserve component RWs. Care
17 for these RWs must meet active duty standards.
18 Specifically evaluate the adequacy of civilian
19 health care delivery systems to ensure RWs
20 receive appropriate care before transfer to
21 remote locations.
22 We agree with this recommendation.

1 Air Force Medical Services provide the same
2 standard of quality care for Guard and Reserve
3 members as their active duty counterparts. We
4 will work with the TRICARE management agency,
5 PEBLOs and case managers to ensure that
6 members transition to adequate civilian health
7 care systems for continued care through their
8 recovery care coordinators and TRICARE
9 regional office and make sure that they are
10 aware of the benefits that they're entitled
11 to.
12 DR. TURNER: Have you developed
13 any kind of metrics on that -- how to ensure
14 accountability that that occurs yet?
15 LT COL WYATT: Colonel Silver, do
16 you have any?
17 COL SILVER: Good afternoon.
18 Colonel Silver, Reserve Advisor.
19 The metrics is one of the things
20 that we don't currently have as far as how
21 we're managing these folks. We did have a
22 NAFSO 21 event that kicked off last February.

1 And we have three teams that are working to
2 come up with metrics. So that's something
3 we're planning to do in the near future.
4 LT COL WYATT: And that's another
5 area where AFWICMs or another type of data
6 collection tool will come in handy as well.
7 LT GEN GREEN: So in terms of the
8 reservists, what I do know is that there's
9 been a long-term first work that MADCOM is now
10 consolidated into a medical continuity cell.
11 And so are you telling me that there's no
12 metric or nothing that's followed regarding
13 the reservists based on that continuity cell?
14 LT COL WYATT: Well, sir, there
15 were two AFSO initiatives. One was from the
16 Reserves and one was active duty. And we also
17 actually have progressed to the point where
18 under the new warrior survivor care
19 directorate under the new whatever they're
20 going to call the new super FOA. There will
21 be a Guard and Reserve cell that's actively
22 involved in the process so we have that link

1 with the active duty.

2 And sir, do you have anything else

3 to add?

4 LT GEN GREEN: But the medical

5 continuity cell that's down at AFMOA today,

6 whether it gets rolled into this combined

7 effort or not, is doing something. What are

8 they doing today?

9 COL SILVER: Yes, sir. They do

10 have metrics as far as how long an individual

11 has been in the system. The problem with that

12 is that it only takes care of those Title 10

13 folks -- the individuals that have been

14 wounded, ill or injured on MPA Title 10 active

15 duty orders.

16 What the AFMOA cells metrics show

17 is mostly just how long they've been on orders

18 and what kind of injuries they have. And as

19 far as the case management of that, that is

20 one piece that we work with the active duty

21 on, and I'm not too sure if case managers have

22 any kind of metrics as far as the types of

1 injuries or how long they've been in the
2 system or the type of appointments, if that's
3 what you're asking.
4 LT GEN GREEN: So how many people
5 does the continuity cell track?
6 COL SILVER: The AFMOA cell right
7 now tracks about 500. What our goal is is to
8 have the Super FOA cell track all components,
9 including Title 32 for the Air National Guard
10 and the RPA for the Reserve -- traditional
11 Reserve units in addition to the Title 10 MPA.
12 LT GEN GREEN: And so the 500 are
13 all Title 10?
14 COL SILVER: Yes, sir. As of
15 currently, the ones that are tracked at AFMOA
16 is just Title 10 MPA.
17 LT GEN GREEN: And so the MPAs are
18 not tracked anywhere? The folks that are on
19 MPA orders, where are they tracked?
20 COL SILVER: As far as?
21 LT GEN GREEN: Are they on MPA
22 orders based on injuries?

1 COL SILVER: Yes, sir. As far as
2 how long -- when you say how are they tracked?
3 LT GEN GREEN: Tracked by who's
4 cutting their orders. Somebody has to be
5 cutting their orders.
6 COL SILVER: Yes. The AFMOA
7 cells, General Green.
8 The AFMOA cell is just about seven
9 individuals on MPA. And all they really do is
10 just take care of their orders. It's mostly
11 like care coordinators, but not case managers,
12 per se.
13 LT GEN GREEN: So do you know how
14 long they've been on MPA days?
15 COL SILVER: Yes, sir. Some of
16 them have been on there for quite a while. We
17 have about maybe 15 or 20 that are greater
18 than 500 days. Those are the ones that for
19 some reason they just keep getting extended.
20 As you know, we've had a problem with when
21 they get close to an MEB, they'll drop a new
22 line of duty, and that starts the whole

1 process again. We're looking at South MR to
2 give us policy to be able to not to have to
3 start from the get-go. And the majority of
4 the folks are less than a year -- 90 days,
5 120.
6 LT GEN GREEN: The majority of
7 them on MPA days. How many are there that are
8 on MPA orders right now?
9 COL SILVER: About 500, sir.
10 LT GEN GREEN: I thought that was
11 the Title 10.
12 COL SILVER: MPA and Title 10 is
13 the same thing. Title 10 -- that's the only
14 folks that we currently track is MPA which is
15 Title 10. And that's all that AFMOA handles
16 is MPA.
17 What we want to do when we set up
18 this solid AFPC is track all the Reserve
19 component members who are ill and injured.
20 And the Title 10 would just be the MPA, of
21 course. But we want to also pick up the
22 traditional reservists, the RPA, Title 32 for

the Guard.

LT GEN GREEN: And you're telling me that the RPA and the Title 32 are not tracked anywhere?

COL SILVER: Those are tracked at their units. The Guard would track the Title 32 by individual state. I'm not too sure if the Air National Guard Bureau tracks them as a conglomerate total. But each state would have a handle on their number.

And as far as the traditional reservists, each Reserve unit would have their own numbers.

MSGT MacKENZIE: This would explain how we found six airmen with Title 10 injuries down range not receiving any Title 10 benefits in Massachusetts.

And I may have heard you incorrectly, sir, so I apologize. But you said this is something that you would like to do. So is this not part of the super cell assembly is to do this? Or is this --

1 COL SILVER: It's a total force
2 effort. The AFSO 21 event includes active
3 duty Air Force as well as Guard and Reserve.
4 We briefed our leadership two
5 weeks ago, and they sent us back to the
6 drawing table. We've got our implementation
7 plans put together. So they still have to buy
8 off on it. And it will require resources.
9 DR. TURNER: So moving on to 8B,
10 the next slide -- a kind of segue -- a natural
11 segue, it says, care for these recovering
12 warriors must meet active duty standards. So
13 there's really no way to ensure that, nor is
14 that resource currently is what you've just
15 said, is that right?
16 COL SILVER: This particular one
17 here, sir, addresses the active duty. The
18 SAF/MR policy only addresses active duty folks
19 that are on Title 10. So we understand that
20 the SAF/MR policy is not all inclusive. And
21 so, they are using the same active duty
22 standard.

1 There's only one standard of care.
2 CSM DeJONG: Okay. But on the Air
3 Guard side, sir, can you tell me when they are
4 doing -- there's a huge population out there
5 that are receiving Title 10 injuries and not
6 being continued on Title 10 orders, and then
7 we get into the INCAP pay and the abuse of
8 INCAP pay. Can you tell me when these LODs
9 are being done and how a Reserve component
10 soldier gets back on Title 10 orders?
11 COL SILVER: Let me take a cut at
12 the first part of your question.
13 Speaking from the Reserve
14 perspective, line of duties are supposed to be
15 done at the time of injury. Obviously
16 sometimes that doesn't happen. An individual
17 may not identify an injury until later. PTSD
18 is a good example that shows up later.
19 We will initiate the line of duty
20 at the member's unit at that point. If the
21 decision is made at that point that it is
22 within the line of duty and it occurred during

1 an active duty order, that member is brought
2 back on status. Whether it's MPA or RPA, they
3 come back on active duty to receive care.
4 And the second part of your
5 question?
6 CSM DeJONG: Well, the first
7 bullet here says SAF/MR, which I'm not exactly
8 sure. I'm not even going to pretend to know.
9 It talks about dated 9 December 2011, directs
10 policy and assigns responsibility to prescribe
11 for authorizing medical continuing for Reserve
12 component recovering warriors. And you just
13 made a statement that SAF/MR is only for
14 active duty. So I'm just kind of lost.
15 COL SILVER: That particular
16 policy -- SAF/MR's policy only addresses those
17 folks that are on Title 10.
18 LT GEN GREEN: So basically
19 they're a Reserve component that are put on
20 MPA days. So what he didn't answer in your
21 question is when is INCAP pay used.
22 COL SILVER: INCAP pay is an

1 option that the individual can qualify for if
2 it's determined that they can go back to duty
3 -- military duty but not do their in civilian
4 pay.
5 CSM DeJONG: But INCAP pay is not
6 designed for Title 10. INCAP pay is designed
7 for Title 32.
8 COL SILVER: Okay. We have used
9 INCAP pay in this Title 10 arena before.
10 That's really outside my
11 expertise. It's mostly an entitlements issue.
12 And I can only answer what we know for a fact
13 that we have used INCAP pay in those cases.
14 LT GEN GREEN: I think it would
15 suffice to say that the absence of guidance is
16 dominating your program right now?
17 LT COL WYATT: Yes, sir.
18 LT GEN GREEN: Okay. I'll let you
19 guys go on. Thanks.
20 LT COL WYATT: Recommendation 10,
21 please.
22 Recommendation 10. DOD and VA

1 must ensure timely access to routine PTSD care
2 across the continuum of service to provide
3 exacerbation and crisis.
4 The Air Force concurs that timely
5 access to PTSD care is a necessity for our
6 quality health care. We recommend replacing
7 routine care with evidence-based care in
8 conjunction with the VA/DOD clinical practice
9 guidelines for PTSD.
10 And sir, do you have anything to
11 add, Colonel Poindexter?
12 COL POINDEXTER: Actually I would
13 just like to add the main points and I'm sure
14 Lieutenant Colonel Dickey who is our mental
15 health expert would agree. We just wanted to
16 remind you that we feel that evidence-based
17 care would be a better phrase than routine
18 care. Routine care could include nonevidence-
19 based and evidence-based. And so we're just
20 asking for a slight alteration in the verbiage
21 just to make the point that we believe that
22 there is a lot of evidence-based care and PTSD

1 deserves that level of care.
2 LT COL WYATT: Recommendation 13.
3 Tailor a plan that facilitates and ensures
4 effective communication between caregiver,
5 support personnel, family and recovering
6 warrior.
7 To highlight the Air Force's
8 enduring commitment to its wounded warriors
9 and to honor the sacrifices of our airmen and
10 their families by providing the best
11 nonmedical professional support throughout the
12 recovery and re-integration. Strategic intent
13 is to raise positive public awareness of the
14 Air Force's wounded warrior program,
15 supporting our wounded, ill and injured
16 service members, Air Force and public on the
17 vital role airmen play in today's national
18 security operations. To educate
19 internal/external audiences on the cultural
20 changes in the Air Force on how we support our
21 wounded warriors. To raise awareness among
22 total force airmen and local communities that

the Air Force wounded warrior program is one of many ways the Air Force is caring for the Air Force family. Increased awareness and support of the Air Force wounded warrior program to internal audiences, wounded warriors and families, Air Force leadership, total force airmen and family members, retired Air Force community and external, the veterans service organizations, nongovernmental organizations, base communities, national media and potential employers. Also through the means of social media like YouTube, Facebook, Twitter, all the other media that we have available to get the word out on our programs.

Colonel Black, if you have anything to add?

MR. REHBEIN: Colonel Wyatt?

LT COL WYATT: Yes, sir?

MR. REHBEIN: Who is writing it and where it is in coordination?

LT COL WYATT: Okay. I can answer

1 that.

2 We are writing it. I'll explain

3 where we are.

4 Initially, we had a lot of

5 operational work that needed to be done on the

6 air staff as far as starting the recovery care

7 coordinator program. A lot of things

8 operational were going on, and not enough

9 policy was being taken care of.

10 So our current initiative right

11 now is to divest -- and we have -- all of

12 those things to the new Super FOA because we

13 have those entities available and standing up.

14 Just like week -- last Friday, I

15 went to Dover and met with -- there are two

16 people that are going to be moving to San

17 Antonio as our survivor care directorate -- to

18 finally pull together our flow programs. We

19 have a flow program for seriously ill and

20 injured and one for mortuary. We're going to

21 have a group of people working just those

22 issues operationally so we can do that.

1 So we do have an AFI. We are
2 currently working with our partners in the SG
3 and also with the Reserve and Guard.
4 MR. REHBEIN: So who is writing
5 it, and where is it in coordination?
6 LT COL WYATT: My office is
7 writing it. And right now, we have part of it
8 in coordination at the Air Force Personnel
9 Center. And the other part is working through
10 external coordination through the Air Staff.
11 MR. REHBEIN: Thank you.
12 LT COL WYATT: You're welcome,
13 sir.
14 LT GEN GREEN: Are you referring
15 to a communication plan, or are you actually
16 talking about the AFI? What are we talking
17 about?
18 LT COL WYATT: I am talking about
19 the AFI, sir, and also in the interim, the
20 guidance memorandum that we are drafting in my
21 office right now to solidify what was
22 discussed at the AFSO events and actually

1 during the meetings with the recovery care
2 coordinators and the AFW2 staff a couple of
3 weeks ago.
4 And it's hard for our advocates to
5 work without it. So we understand how
6 important that is. And we're working to get
7 it as soon as possible.
8 MSGT MacKENZIE: The only thing on
9 that second bullet, I don't want to
10 incorrectly apply this. But we've addressed
11 this on multiple occasions. And it's not so
12 much how much communication out there. It's
13 managing at the communications being received.
14 I mean, we can flood the communication, but if
15 the right people are not receiving it, then
16 we're not really effectively doing our job.
17 So that accountability that
18 they're receiving that information I hope as
19 part of this -- I mean, it's stressed in the
20 training. But if they're not accountable to
21 make sure that this information is presented,
22 you can stress all you want.

1 So I urge you as you go through
2 this process just to make sure that we're
3 looking at that accountability. Because if I
4 walk up on an airman and he's not briefed, it
5 doesn't matter how many layers of
6 communication are out there. If he doesn't
7 have it, he doesn't have it.
8 LT COL WYATT: I'll give you an
9 example. And we'll talk a little bit more
10 about education on a later slide.
11 But when I go brief 420 or so
12 senior NCOs at the Senior NCO Academy, one of
13 the first things I ask is how many of you know
14 what the Air Force Wounded Warrior Program is.
15 And everybody raises their hand. And then
16 I'll ask how many of you know what the Air
17 Force Recovery Care Coordinator Program is.
18 And maybe I'll get a dozen.
19 And I tell you that the biggest
20 part of this education information process is
21 down to the superintendents in the squadron,
22 the squadron commanders, the group commanders,

1 the wing commanders. And it's our job to make
2 sure -- and we're focusing on them right now
3 to make sure that when an airman is injured,
4 a tech sergeant can go to the superintendent
5 and say what do we do. And it starts moving.
6 But if they don't know where to look, then
7 they're spinning their wheels. So I totally
8 understand that. And we'll try to get that
9 through the educational process as well to
10 make sure leadership out there knows how to
11 access the programs.
12 MSGT MacKENZIE: Thank you, sir.
13 LT COL WYATT: You're welcome.
14 All right. Recommendation 18.
15 Ensure that the VA Vocational Rehabilitation
16 and Employment Program is available and
17 accessed to recovering warriors before their
18 separation from the service.
19 The Air Force agrees service
20 members should be encouraged to participate.
21 And we have at Nellis Air Force Base, it's
22 standing up right now to have the VR&E rep at

1 Nellis as a resource for transitioning
2 members. Nellis is committed to working
3 together with the VA to ensure the program
4 gets a very healthy start. The point of
5 contact is the Flight Commander, TRICARE
6 Operations and Patient Administration at
7 Nellis.
8 LTC KEANE: Is that just for those
9 injured airmen at Nellis?
10 LT COL WYATT: No, it's -- ma'am?
11 LTC DIETRICK: I'm Lieutenant
12 Colonel Dietrick, Patient Administration.
13 This is the pilot program for VR&E
14 counseling. It will be involved with anybody
15 going through IDES. They will be encouraged
16 and coordinated with the VA for those
17 individuals to be able to accept those
18 services.
19 LT GEN GREEN: I don't think you
20 answered the question.
21 So if you're going to put a VR&E
22 counselor out at Nellis because we have a

1 combined VA-DoD facility out there, are you
2 saying that you're going to use them across
3 the whole IDES system or only for those being
4 processed at Nellis?
5 LTC DIETRICK: Sir, for the pilot
6 site, yes, it will only be at Nellis. But
7 eventually VA will staff an individual at
8 every location across DoD.
9 Does that answer your question?
10 LT GEN GREEN: Yes. So basically
11 today there is no VR&E for Air Force members
12 going through the IDES system other than what
13 may be available if they're at Walter Reed or
14 at SAMC. Is that pretty much where it stands?
15 LTC. DIETRICK: Correct. Yes,
16 sir.
17 LT GEN GREEN: Okay.
18 MS. DAILEY: And will
19 encouragement in the VR&E program at the
20 appropriate locations going to be included in
21 your AFI?
22 LT COL WYATT: Yes. And we'll

1 take note. Or in our guidance memorandum.
2 LT GEN GREEN: Yes. The answer is
3 -- the reality of that is probably not because
4 I mean, you're talking about the Air Force
5 has I think the most DES, IDES sites just
6 because of the number of bases. And yet we
7 also have those very small numbers of
8 casualties. So it's very unlikely that you're
9 going to see VA actually invest in all those
10 sites with very small numbers.
11 And so the question really becomes
12 how do you make this accessible through the
13 WW2 program where you see the sickest of the
14 sick and make certain that they're getting
15 this counseling at the sites where you've got
16 them and where you're sustaining them.
17 LT COL WYATT: So I think it's
18 more back to the partnering with the FRCs --
19 the federal recovery care coordinators in the
20 VA -- in making sure I guess what I mean by
21 solidifying that and provide the information
22 that those resources are available and how to

1 resource them. Because I'm sure it's a pilot
2 program. So we're not sure exactly how that's
3 going to come out.
4 LT GEN GREEN: Right. It's a
5 straightforward pilot because there's probably
6 already a VR&E counselor at Nellis or at
7 Elmendorf or at Keesler. But in terms of
8 actually the other sites where you're doing
9 IDES, no.
10 And so -- anyway. All right.
11 Thanks.
12 LT COL WYATT: Thank you, sir.
13 MSGT MacKENZIE: One of the things
14 -- sorry to jump in here -- but it's getting
15 that information out there. I mean,
16 unfortunately you mentioned working with the
17 FRCs. Well, quite frankly, VR&E qualification
18 starts with a memorandum rating at I believe
19 20 percent in hire. So once again, the people
20 you're thinking are going to help you don't
21 reach all the people that actually qualify.
22 So it's that joint connection of

1 resources available, even if it's just at the
2 PEBLO level. I mean, when we're dealing with
3 just wounded warriors, obviously that's AFW2.
4 But even at that PEBLO level where you're
5 going there's a VR&E coordinator now and maybe
6 I'm at Herbert Field and it's actually at
7 Pensacola. But knowing I have that resource
8 available to me, even if it is at a Navy
9 facility or at an Army facility, is what an
10 airman's looking for. Not necessarily that
11 they have somebody at that Air Force base, but
12 that they just need to go here to get that and
13 that they qualify and that there is that
14 potential and that benefit.
15 So probably some more input for
16 your AFIs. Do you guys round table this after
17 you get done with us?
18 LT COL WYATT: Thank you.
19 Next slide, please.
20 Recommendation 19. To develop a
21 uniform DoD manpower and staffing model for
22 the Physical Evaluation Board liaison officers

1 -- PEBLOs -- and legal support to ensure
2 adequate PEBLO and legal staffing levels to
3 provide appropriate IDES education and
4 advocacy to RWs and their family caregivers.
5 The Air Force agrees that there
6 needs to be uniform DoD guidelines. Right now
7 in the -- Major Clark, if you can fill in --
8 I'll just say that right now there's
9 augmentation in place, is that right?
10 MAJ CLARK: Hi. I'm Major Teresa
11 Clark. I work IDES Operations at AFMOA in San
12 Antonio.
13 And yes, the MTFs that are not
14 currently operating under the 1 to 20 ratio --
15 1 PEBLO to every 20 cases -- they are using
16 internal resources, i.e., 4As that are
17 available to them to offset those shortages.
18 When I said there are 15 MTFs in
19 that meeting, they may be one over. They may
20 be 1 to 22, or 1 to 23. So some are not
21 significantly over, but we stuck with the 1 to
22 20. And there are only 15 Air Force MTFs

1 right now meeting that criteria or not meeting
2 it.
3 LT COL WYATT: Okay. And one more
4 slide before you're up.
5 DR. TURNER: Major? Right here.
6 Fifteen out of how many? I'm not familiar
7 enough with the Air Force to have a total
8 count.
9 MAJ CLARK: I'm sorry. Seventy-
10 four.
11 DR. TURNER: Okay. Thank you.
12 MAJ CLARK: Yes, sir.
13 LT COL WYATT: Next slide, please.
14 Okay. And just a follow-on for
15 Recommendation 19, the DoD should continue to
16 include workload from TDRLs when determining
17 manpower ratios.
18 LT GEN GREEN: Was any action
19 taken to provide legal support for people
20 going through the process? That was an issue
21 last year that came up in terms of whether or
22 not Air Force members had legal advisement as

1 they went through the process.
2 MAJ CLARK: Sir, from my
3 experience, initially when IDES came on board,
4 we did get a lot of feedback from the MTFs
5 that service members were having a difficult
6 time getting in to seek legal advisement. But
7 that was early on in the process. We haven't
8 had as many complaints or as many responses
9 from the MTFs on this situation.
10 Don't know if that means the
11 members aren't voicing it as much or if that's
12 actually gotten better at the local level.
13 When approached with the issue, that was
14 initially brought up by the members. Legal
15 did say that it was a manning issue. They
16 weren't initially equipped to be available to
17 this volume of individuals.
18 LT GEN GREEN: And what they told
19 us last year was that they were utilizing the
20 central lawyers in support of the PEB and that
21 they were going to beef up that manpower. Did
22 that occur?

1 MAJ CLARK: Sir, I don't know that
2 for sure. But I could assume -- and I hate to
3 use that word -- that because we haven't
4 gotten a lot of the negative feedback from the
5 field that they may have.
6 LT GEN GREEN: So Colonel, can I
7 ask you to get the answer to that and get it
8 back to us whether or not there's increased
9 legal support to the MEB/PEB process at AFPC?
10 LT COL WYATT: Yes, sir.
11 MS. DAILEY: Sir, we do have that
12 answer. We've been working with the Air Force
13 legal and we've got an information paper on
14 it.
15 LT GEN GREEN: Okay. Thanks.
16 MS. DAILEY: So you don't need to
17 take that as a tasking, Lieutenant Colonel
18 Wyatt. We've got it.
19 MSGT MacKENZIE: Well, I was going
20 to chime in also that they --
21 MS. DAILEY: And they briefed us
22 also when the small team was down at San

1 Antonio.

2 MSGT MacKENZIE: Right. And

3 they're working on the accuracy of the legal

4 support -- that stuff that we discovered where

5 there is a separate certification. And in

6 many installations, the legal support that's

7 there is not that it's not robust enough.

8 It's just the level of qualification in

9 directly dealing with this in our

10 decentralized model was a problem. And they

11 are working on that as well.

12 LT COL WYATT: All right. Next

13 slide.

14 We're going to have a briefing on

15 IDES by Major Teresa Clark.

16 MS. DAILEY: And Colonel Wyatt,

17 before you leave, you have an AFI for the AFW2

18 program in staffing? Is that what I

19 understood you to say?

20 LT COL WYATT: That is correct.

21 And the Warrior and Survivor Care covers the

22 recovery care coordinators. It covers the

AFW2 as well and our Survivor Assistance Program.

MS. DAILEY: So the AFI is going to cover your survivor program which includes survivors of deceased airmen --

LT COL WYATT: Deceased and the family members of seriously ill or injured and seriously ill and injured.

MS. DAILEY: So the AFI is going to cover that whole area?

LT COL WYATT: It is. And that part of the survivor assistance for say the FLO program, it covers a family liaison program for both and then the other programs you mentioned, ma'am.

MS. DAILEY: Okay. So just want to make sure I understand.

LT COL WYATT: Yes, ma'am.

MS. DAILEY: All right. I'm good on that. And I think that the Task Force will probably be very interested over the next how many years are you going to be here?

LT COL WYATT: I'm not certain.

MS. DAILEY: Just got promoted, brand new assignment. Maybe three years.

LT COL WYATT: Yes, ma'am.

MS. DAILEY: We're going to be here about three years. We're going to be very interested over the next three years in that actually making some traction, getting it out and putting many of your good policies in place and getting them documented.

LT COL WYATT: Yes, ma'am. Thank you.

MAJ CLARK: Vertically challenged here.

Good afternoon. As mentioned earlier, I am Major Teresa Clark from AFMOA. And I'm going to talk to you today about what we're doing for the MTFs that are not performing as well as we'd like them.

I'd like to think of our approach to this as a proactive and reactive approach combined. Right now, we use the information

1 that is maintained in the Veterans Tracking
2 Application. This information is used by
3 senior leaders. Our metrics are drafted for
4 them monthly.
5 We use this on a weekly basis with
6 the MTFs. We use conditional formatting which
7 we make available to the MTFs, the PEBLOs, for
8 them to use this as a management tool. For
9 instance, if in the referral stage of the MEB
10 phase, the PEBLO still has a case and hasn't
11 transferred over to the MSC within six days,
12 on the conditional formatting spreadsheet that
13 we make available to them, that member would
14 turn yellow. And that would signify something
15 needs to be done with that.
16 So it's not 100 percent. It's not
17 anything extravagant. But we have seen an
18 increase in our timeliness since we began this
19 back in April of last year.
20 We use the information out of VTA.
21 And we have the MTFs focus on the stages that
22 they can actually control which is the

1 referral and the MEB stage. So on the next
2 slide you'll see that since we started this,
3 we've seen an incline positively in the
4 timeliness of the referral and the MEB stages.
5 And our big picture goal is for us
6 to work on the part that we can control. And
7 for the next PEB, VA to work on theirs. And
8 collectively, we'll meet and continue to meet
9 the 295 or better day goal for this program.
10 The MTFs are not meeting our
11 timeliness goals. Let me step back for a
12 second.
13 As I mentioned, we do provide this
14 information weekly to the MTFs. But on a
15 monthly basis, we combine everything and show
16 them a metric of how they're doing.
17 With the weekly data, they have
18 the opportunity to prevent things from going
19 overdue. And with the monthly data, we can
20 show them these things were not overdue. You
21 fixed them and look at where you are now.
22 So it's kind of a warm fuzzy, if

1 you will, to the PEBLOs to show them that
2 their hard work is making a difference and
3 that we need to continue to put the member --
4 which is what this whole IDES process is here
5 to help -- put the member first.
6 So those sites that have
7 challenges and don't meet the 80 percent
8 timeliness goals that we've put in place for
9 the referral and the MEB stage, we do require
10 a corrective action plan that has to be signed
11 by their med group commander.
12 In this action plan, we ask them
13 to identify how many cases were late during
14 this time period, what were the extenuating
15 circumstances that caused the cases to be
16 late, i.e., we had three out of five providers
17 deployed. That's something that we would need
18 to know.
19 And our response to them would be
20 is there anything we can do to aid in this.
21 We've discussed manning assistance with some
22 MTFs. So we've essentially put ourselves

1 available -- made ourselves available to the
2 MTFs to help them continue to meet the
3 timeliness goals.
4 DR. PHILLIPS: Ma'am, before you
5 go on. It's just very commendable that in
6 about eight months you went from 39 percent or
7 so to 69 percent of MEBs.
8 Could you identify the particular
9 practices that improved that?
10 MAJ CLARK: Honestly, it's
11 attention to detail. It's education of our
12 PEBLOs and our providers. We did have a
13 really big training conference last year. We
14 had over 270 attendees -- PEBLOs and providers
15 -- where we spent two and a half days really
16 digging into this process, showing each entity
17 -- PEBLO and provider -- where they fit in,
18 how they can help the process.
19 And a lot of it is not -- well,
20 all of it's time consuming -- but a lot of it
21 is things that they have in their control that
22 they can actually help. And as we progressed

in us bringing this to their attention, I think that's contributed to the improvement.

DR. PHILLIPS: Thank you. Were there any significant increases in staffing?

MAJ CLARK: Not significant. Our goal is to have at least one contractor at each MTF. That's the continuity. That's the steady number. And then whatever else we can provide whether it be active duty or not.

MR. REHBEIN: Is that contractor funded centrally or from the ONL of the MTF? Do you know?

MAJ CLARK: I'm not sure.

MR. REHBEIN: Okay.

MAJ CLARK: Not sure.

MS. MALEBRANCHE: One thing I'd like to just mention too, you use percentages here. I was wondering what the numbers were because I think one of the things you can do yourself a disservice and I guess potentially a service to is when you report percentages.

One of the things we noticed in

1 the DES process early on is the numbers are
2 fairly small in the Air Force. So when you
3 show a real low decline or something, that
4 doesn't mean that your performance was so bad.
5 Your numbers just aren't there. And one case
6 over time can do you in. And I suppose
7 likewise if you had only two cases, you could
8 reach 100 percent.
9 So I guess I would say that
10 whenever you do these sorts of things, it
11 would be important to know what the N is, just
12 a sidebar that I noticed at one of a general
13 meeting of all services.
14 MAJ CLARK: And ma'am, that is a
15 very good point. We do have that information
16 available when we make the percentages
17 available to the MTFs and their MAJCOMs.
18 There's a pivot table within the spreadsheet
19 that actually shows the raw numbers. So
20 they're able to see that small bases such as
21 Vance or one of the other small bases that may
22 have had only two cases that month and one of

1 those cases were late, that would be 50
2 percent. So yes, we absolutely acknowledge
3 that our numbers aren't as large as some of
4 our sister services.
5 LT GEN GREEN: Do you know when
6 they started the central decision making
7 regarding referral to DES? So it's currently
8 made at AFPC, correct? For actually a
9 referral to DES, the DOG forwards it up for
10 review and they make the decision at AFPC?
11 MAJ CLARK: Actually, sir, that
12 hasn't begun yet because all the providers
13 haven't been hired yet for AFPC. We followed
14 up on that AFSO 21 when we did discuss that
15 with Lieutenant Colonel Green and Colonel
16 Hodge. And they're anticipating May of this
17 year for them to start making that decision at
18 DPAM.
19 LT GEN GREEN: Okay.
20 MAJ CLARK: Are there any more
21 questions on this particular slide?
22 (No response.)

1 MAJ CLARK: Okay. Next slide,
2 please.
3 I mentioned earlier, our focus and
4 how we work on improvement. It could be a
5 little overwhelming looking at the bigger
6 picture of IDES. So we try to focus our
7 training and our guidance to our PEBLOs on
8 areas that they can actually control.
9 We look at the referral in the MEB
10 stages as I mentioned earlier. I don't want
11 to reinvent the wheel on that one. But I
12 really do think that this has proven to be a
13 success for our MTFs.
14 We're not 100 percent. We
15 definitely have room for improvement. But the
16 motivation is there. The desire is there.
17 And we're working collectively to make sure we
18 provide the best for our service members.
19 Next slide, please.
20 And I know this is a very busy
21 slide. But I just wanted to give you a
22 picture of what's the conditional formatting.

1 It's actually in this spreadsheet. Do you see
2 the reds? Obviously those cases are late --
3 the ones that are red. But the ones that are
4 yellow, that would highlight to the PEBLO, I
5 need to follow up on that. That may be
6 something that I could get with the providers
7 on and maybe prevent that from going red.
8 Okay. Next slide, please.
9 And this question, I did go to
10 AFW2 to get a response to this.
11 The AFW2 and ICCs, as you heard
12 earlier, they do provide advocacy and support
13 for service members. But there hasn't been
14 anything metric-wise to show that there's been
15 a difference in the IDES process with a person
16 having an AFW2 advocate and those that do not.
17 MR. REHBEIN: I guess I'm a little
18 bit confused by that bullet. How does the
19 AFW2 Office know anything about the people
20 that don't have an advocate?
21 That last bullet says the AFW2
22 Office has not seen a time difference in the

1 IDES process based on having an AFW2 advocate.
2 That tells me that the AFW2 Office must have
3 some information on people that don't have
4 AFW2s.
5 LT COL BLACK: What that bullet
6 addresses is that we have not seen a
7 difference in the time that it takes to get
8 someone through the IDES process waiting for
9 their claims.
10 What we're told by the disability
11 branch is that yes, if this is a member that
12 is identified as an AFW2 member or someone
13 that is seriously ill where the commander
14 needs to get involved, it is expedited at the
15 disability branch. So they will take that
16 case and put it at the top of the list.
17 However, when it comes to the processing time
18 that it takes to get that information, it's
19 taking between six to 12 months is what we're
20 seeing.
21 So we advocate and support those
22 members who are going through the IDES

1 process. However, we're not able to I guess
2 strong arm and get that process taken care of
3 any quicker. The six to 12 months is the
4 standard of what we're seeing.
5 MAJ CLARK: I think that's the
6 last of my slides.
7 COL POINDEXTER: You have three
8 minutes.
9 LT COL WYATT: All right. An
10 agenda question. How can Air Force programs
11 for wounded, ill and injured and operational
12 units offer meaningful work opportunities to
13 airmen?
14 The majority of airmen remain
15 assigned to their units and continue to
16 perform in the capacity of their primary job
17 initially. We do not have warrior transition
18 units or large groups like that. Our program
19 through the RCCs and AFW2, it is our goal to
20 get them back with the units with their
21 specialty, say an EOD member back with an EOD
22 unit initially because we believe that

1 enhances their care even if it's performing
2 some duty that's not exactly what they were
3 doing before. We find that the ability to
4 have them with their team, with their unit, is
5 beneficial to their care and recovery and a
6 commander's modified duties that will
7 facilitate the airmen attending their medical
8 and transition appointments at the same time.
9 MSGT MacKENZIE: So this has the
10 potential to create an issue?
11 LT COL WYATT: Pardon me?
12 MSGT MacKENZIE: This has the
13 potential to create an issue in the fact that
14 what tools does the Air Force provide unit
15 commanders for continuing to maintain their
16 deployable status if they have one, two, three
17 people in this program that can't deploy, yet
18 they're still tasked to deploy.
19 LT COL WYATT: For sorts ratings
20 and --
21 MSGT MacKENZIE: Exactly. Sort
22 ratings, C status, that kind of stuff.

1 LT COL WYATT: Right. And the
2 bottom line -- I mean, the commander has the
3 ability to adjust a sorts rating based on if
4 he feels that his unit is or is not deployable
5 or ready to deploy or mission ready. There is
6 a little bit of leeway from a squadron
7 commander group commander's perspective there.
8 And then from the Air Force, we're
9 not talking large numbers of individuals. So
10 if the commander sees that they have one EOD
11 member that's providing training, has the
12 ability to share experiences, is providing a
13 useful tool for that unit, then it's possible
14 that the C rating would not go down based on
15 that individual.
16 LT GEN GREEN: Rather than talking
17 sorts, the Air Force has an eProfile system
18 that's been in place now for four and a half
19 or five years that basically can tell by unit
20 or by specialty basically what the readiness
21 ratings are, what the profiles are, and then
22 what the permanent profiles are versus the

1 temporary profiles. So a lot of that same
2 visibility in terms of the unit readiness is
3 actually available through the profile system.
4 MSGT MacKENZIE: And thank you,
5 sir. I guess where I was going with this --
6 and I should be more clear -- was an
7 individual like me when I got wounded, I had
8 a number of years in, very well connected and
9 had a lot of knowledge to offer in many, many
10 different realms. But that's totally
11 different than an airman that's only been in
12 for a year.
13 LT COL WYATT: Right.
14 MSGT MacKENZIE: So you see what I
15 mean? I mean, this is great. I mean, if I
16 work in my unit, there's lots for me to do
17 that doesn't impact the mission while going
18 back and forth to medical appointments and so
19 forth.
20 But if you don't have a program in
21 place, I guess where I'm looking at is how
22 does that take care of the airman that's been

in for a year versus a guy who's been in for 12 years --

LT COL WYATT: With the same injury?

MSGT MacKENZIE: Yes. Was there a standardization across? Or --

LT COL WYATT: And we're talking right now, instead --

MSGT MacKENZIE: I mean, I could think about this again and -- I know I'm not coming across correctly.

LT COL WYATT: Okay.

Next question, or next slide.

Okay. Are you reducing Air Force wounded warrior staff?

The answer to that question is yes. The Air Force approved FY 12 reductions including the elimination of six of the 17 permanent civilian authorizations serving as nonmedical care managers.

Now with that said -- and I did discuss earlier about our looking at the

1 reorganization under our new Super Forward
2 Operating Agency -- there's a manpower study
3 ongoing right now looking at all of the
4 functions under that warrior survivor care
5 directorate under the Super FOA. And at the
6 same time, we're looking at efficiencies
7 gained by the synergies with the RCCs and the
8 AFW2 advocates. So based on the manpower
9 study that's ongoing and also the synergies
10 and the efficiencies that we're gaining or
11 hope to gain from our new organization, we do
12 believe that we can continue to -- go to the
13 next slide, please -- it asks the question, if
14 so, will you remain compliant with DoD
15 Instruction 1300.24 -- meaning the ratios in
16 place for the RCCs and the nonmedical case
17 managers.
18 In addition to the manpower study
19 going on and the reorganization, there's also
20 a lot of defining that needs to go on. And
21 we're right now defining the wounded warriors,
22 the need of care that will continue to receive

support based on level of care needed. So there are a lot of -- like AFW2, they're caring for service members that have transitioned out. They're currently trying to -- or I guess say the mission has been or the vision has been airmen for life to make sure they continue to contact an airmen continuously for life. There are other programs. So at the Marine Corps, they have a marine for life program. And a lot of that is based on contact when needed later on when it gets to a certain level. And that's what we're looking at instead of that -- and this is still in development and not fully approved yet.

So Colonel Black, if you want to chime in here.

LT COL BLACK: Sure. When the Recovering Warrior Task Force visited us at AFPC in December, I think in the comments that were made at the outbrief was that we're pretty much heading for an iceberg because we

1 didn't have an outflow in our program.
2 LT COL WYATT: Right.
3 LT COL BLACK: So we took that.
4 And in our offsiting, we looked at just the
5 continuum of care and the phases.
6 And the seventh phase which is our
7 final phase is the sustainment phase. And we
8 looked at our caseload and all of our cases.
9 And those folks that were actively in care
10 management and those folks that we can move
11 into a sustainment. And what sustainment
12 means is that we're going to continue our
13 commitment of care beyond duty. But what
14 we're going to do is instead of maybe that
15 monthly phone call, we'll do a semi-annual
16 phone call. But we'll still be in contact
17 with you through our newsletters monthly,
18 through events coordination and outreach. So
19 we'll still have contact with you. And also,
20 our wounded warriors have the ability to call
21 us if they need that.
22 So that's going to provide that

1 outflow that we were told that we needed and
2 that we didn't have, but also maintain our
3 connection with our wounded warriors.
4 So we looked at that as well.
5 MSGT MacKENZIE: It seems like a
6 lot of work to do while you're already
7 shorthanded. I mean, when you're losing
8 people is probably not the time to try to
9 develop this. But I appreciate it that you're
10 doing.
11 And the other thing too,
12 recovering service members do not know what
13 they don't know. So relying on service
14 members to contact you I caution because that
15 is a huge -- huge -- potential for failure.
16 Because if they don't know to ask the
17 question, they're not going to call you. So
18 they're not being cared for if they don't call
19 you.
20 Do you see where that's a huge
21 thing coming your way if that's is something
22 that you're relying on as a service delivery

1 option?

2 LT COL WYATT: She's referring to

3 the people that are transitioned out of

4 service or are gainfully employed out of the

5 service. Somehow down the line, there has to

6 be a trigger point. And there has to be

7 various trigger points along the way because

8 of the fact that we do have limited resources.

9 So when you transition out and you

10 have to make sure -- you're absolutely right

11 -- that individual has to know for a fact, and

12 it has to be a letter signed by a very high-

13 ranking person in the Air Force that states --

14 and this is what we're driving towards -- this

15 is where you are in your recovery. If there's

16 ever a time that you need assistance, you call

17 Colonel Black and her staff and they will not

18 hesitate to continue helping you as you need

19 help.

20 But that would have to be a key

21 portion of what they do to let them know.

22 LT COL BLACK: There is

1 eligibility criteria. So it's not that --
2 there's a strict eligibility criteria that we
3 staff the cases before we even look at that.
4 So there's certain things that you have to
5 meet.
6 And these are folks that are
7 stable -- the folks that we're looking at.
8 DR. TURNER: And I really
9 appreciate what you guys are trying to do.
10 But you still offer lifetime care?
11 LT COL BLACK: Yes, we do.
12 DR. TURNER: With a reduced staff?
13 LT COL WYATT: You have to, sir,
14 redefine lifetime care, I think.
15 DR. TURNER: Well, see now there
16 you go. All of a sudden I feel like I'm on an
17 Italian cruise ship.
18 (Laughter.)
19 DR. TURNER: Could you tell me
20 about this redefinition thing?
21 LT COL BLACK: Well, I think it's
22 just defining. I mean, we know that we didn't

1 have anything codified. And just working on
2 getting our program codified and just looking
3 at that. That's just something that we had to
4 do. It was necessary as you codify your
5 program in the AFI and just the continuum of
6 care. And that continuum of care includes not
7 only the AFW2 advocates but also our RCCs and
8 our medical piece as well.
9 LT GEN GREEN: I think we
10 need to stop. Because in the absence of
11 codification, what does it mean to redefine?
12 So okay. We got it. Okay? We're with you.
13 LT COL WYATT: Yes, sir.
14 LT GEN GREEN: All right. I think
15 we probably need to call a halt to this. Is
16 there anything else you'd like to bring to our
17 attention before we kind of let you off the
18 hot spot up there?
19 LT COL WYATT: No, I think we've
20 covered it all.
21 LT GEN GREEN: Okay. I appreciate
22 you folks coming down. Thank you for sharing

1 with us kind of where you are with the
2 program. This group will be very, very
3 interested in the codification of your
4 program. Okay?
5 LT COL WYATT: Yes, sir.
6 LT GEN GREEN: So thank you very
7 much.
8 LT COL WYATT: Thank you.
9 LT GEN GREEN: We're going to take
10 just a second to transition. So we're
11 bringing an update from the Federal Recovery
12 Coordination Program. And we'll give Ms.
13 Carol Weese some time to step up -- the Acting
14 Executive Director of the Federal Recovery
15 Coordination Program which is in Tab G.
16 MS. DAILEY: Okay. Members, don't
17 go too far. Just those most emergency bodily
18 functions that need to be taken care of and
19 then we need to bring you back for our partner
20 from the VA, Carol Weese, who'll be talking to
21 us about the Federal Recovery Coordination
22 Program.

1 (Whereupon, at 4:22 p.m., the
2 above-entitled matter went off the record and
3 resumed at 4:28 p.m.)
4 LT GEN GREEN: I apologize for the
5 delay as everybody kind of gets back in place.
6 But if we could have you go ahead, Ms. Weese.
7 We appreciate you coming and talking to us
8 about the Federal Recovery Coordination
9 Program.
10 Thank you.
11 MS. WEESE: Well, thank you, sir.
12 And thank you to all of you for the invitation
13 to come and speak and brief you again. I know
14 that Dr. Giess was the last one who came to
15 give the presentation on behalf of the Federal
16 Recovery Coordination Program.
17 Next slide, please.
18 Many of you that are on the
19 committee already know about the Federal
20 Recovery Coordination Program but in a very
21 brief capsule. We provide care coordination
22 services for severely wounded, injured and ill

1 service members, veterans and their families.
2 Federal Recovery coordinators
3 themselves are Masters-prepared, registered
4 nurses and clinical licensed social workers.
5 And we have a very extensive training program
6 in benefits programs, health care and services
7 across Department of Defense, Veterans
8 Affairs, other federal agencies and the
9 private sector.
10 Federal Recovery coordinators --
11 and the whole reason that the program came
12 into being out of Dole-Shalala -- was the
13 identified need for a recovery plan -- an
14 individualized plan that would be built for
15 injured service members and veterans to meet
16 their clinical and nonclinical coordination
17 needs and resources -- an individual then who
18 actually would provide those coordinated
19 services.
20 Federal Recovery coordinators are
21 assigned to a client whether they're a service
22 member or a veteran. And they stay with that

1 client then throughout all of the multiple
2 transitions that they go through in their
3 recovery, rehabilitation and reintegration
4 back into the community.
5 Next slide.
6 What I was asked to talk about
7 here was recommendation 11 which is
8 highlighted up there. And what I'd like to do
9 is provide a perspective from the Federal
10 Recovery Coordination Program in terms of what
11 we are doing to look at our piece of how we
12 are interacting with all of our colleagues as
13 we take care of our identified population.
14 And as I said a few minutes ago,
15 Federal Recovery coordinators are Masters-
16 prepared registered nurses and licensed
17 clinical social workers. And we spend a lot
18 of time in the program working on the
19 educational component. And I think this is
20 one of the things that people look to Federal
21 Recovery coordinators for in terms of the
22 knowledge base and what it is that we can

1 bring to the team.
2 In our orientation in our ongoing
3 education and training program for folks, we
4 actually bring in representatives from all of
5 the different programs. The subject matter
6 experts are the ones who come from Department
7 of Defense, from VA, from other federal
8 agencies, and also our community partners as
9 well. And these are the individuals who come
10 and meet with the Federal Recovery
11 coordinators and give ongoing education to
12 keep everybody up to date in all of the new
13 programs and everything that is going on.
14 Federal Recovery coordinators work
15 with service members and veterans. So we will
16 bring a case into an active status after they
17 go through a thorough evaluation process. And
18 we will come into the picture at whatever time
19 we receive a referral. So we can get that
20 from as early on as the first MTF where they
21 get treated or a facility in the private
22 sector or sometimes we will get them much

1 further down the road after they have
2 transitioned into veterans status. But
3 whenever we receive the referral is when we
4 will engage and start working with the client
5 and their health care teams and their families
6 to start developing the federal individual
7 recovery plan.
8 And again, we maintain our contact
9 with clients throughout all of their
10 transitions as long as they identify that they
11 need us.
12 The eligibility for the Federal
13 Recovery Coordination Program I'll go into in
14 a minute. And we have this documented in the
15 handbook and the directive which guide the
16 program through the VA.
17 Our program is designed to be
18 complementary to the other programs. And by
19 that what I mean is that in providing care
20 coordination services for our identified
21 population, we're the ones who are supposed to
22 track and maintain and make sure that service

1 members and veterans are getting the services
2 that they need. So we are not supposed to be
3 the hands-on, boots-on-the-ground individuals
4 who are actually doing all the work for
5 individuals. We are supposed to be making
6 sure that they are connected with the
7 individuals who are responsible for doing that
8 and getting the service and the care that they
9 actually require.
10 MSGT MacKENZIE: Ma'am, if you're
11 not hands-on or a boots-on-the-ground, how do
12 you know what they're getting and what they're
13 not getting?
14 MS. WEESE: Because we have a
15 requirement in the program that Federal
16 Recovery coordinators speak with their clients
17 at a minimum of once every 30 days and that
18 they're going through with their clients all
19 of the goals that have been identified and
20 developed in the FIRP -- that's what we call
21 the federal individual recovery plan -- and go
22 through those with the individual and their

1 family to make sure that those services are
2 being met.
3 MSGT MacKENZIE: Okay. So you're
4 actually asking them about all the services?
5 MS. WEESE: Yes.
6 MSGT MacKENZIE: Okay.
7 MS. WEESE: Yes.
8 DR. TURNER: So that sounds like
9 you actually have like a protocol checklist
10 that you go through on each call. Is that
11 what you use?
12 MS. WEESE: We use the FIRP. And
13 so, we work with the individual service member
14 or veteran, their family and their health care
15 team in developing this plan. And then that
16 is the roadmap that we use in order to provide
17 sort of a checklist.
18 DR. TURNER: If we don't already
19 have one, could we get an example of that?
20 MS. WEESE: Yes. We can give you
21 a sample.
22 DR. TURNER: Thank you very much.

1 MS. WEESE: Absolutely.
2 Everybody's always interested in
3 what the FIRP looks like. It's a common
4 question. Thank you.
5 Enrollment is offered to clients
6 that meet the eligibility criteria that was
7 set out for the program and a comprehensive
8 evaluation is performed by the Federal
9 Recovery coordinator. And the FRCs have 30
10 days to conduct that evaluation.
11 Additionally one thing that I
12 wanted to point out is that the VA Chief of
13 Staff has chartered what is called the
14 Wounded, Ill and Injured Task Force. And this
15 is a VA initiative that is looking at all of
16 the case management and care coordination
17 programs that are available in the VA taking
18 care of veterans and service members. And the
19 Federal Recovery Coordination Program has been
20 integral as a participant in that Task Force.
21 Next slide.
22 MR. REHBEIN: If I may for just a

1 moment before you go on?
2 MS. WEESE: Yes?
3 MR. REHBEIN: When you say
4 enrollment is offered, that tells me that the
5 client has the option of turning it down?
6 MS. WEESE: That is correct.
7 MR. REHBEIN: Does that happen
8 often -- much -- at all?
9 MS. WEESE: It doesn't happen
10 often. But if an individual is not interested
11 in the level of care coordination services
12 that we provide or they feel that they are
13 getting their needs met by one of the other
14 programs that is available, it is strictly a
15 voluntary program and that they are not
16 required to enroll with us.
17 MR. REHBEIN: Is that just a one
18 time offer then? Or do you go back in the
19 future and re-offer at some point?
20 MS. WEESE: We have re-offered.
21 And actually we have had some clients who have
22 initially said you know what, I really don't

1 think I need you, but then down the road as
2 they are going through transitions, at
3 different points they'll come back to us and
4 say, you know what, I think I really could use
5 a Federal Recovery coordinator. So we've had
6 it go both ways.
7 DR. PHILLIPS: Are there any
8 issues if they're in the program and want to
9 leave?
10 MS. WEESE: Yes, there are. And
11 we do have a category of individuals in the
12 program that we call inactive. And those are
13 individuals who will decide over a period of
14 time that they no longer require the services
15 of an FRC. And they may say you know what,
16 you got me to this point now and I think I'm
17 good to go, and I don't need to have you call
18 me every 30 days and work on a FIRP. And so
19 we will send them a letter and give them all
20 of our contact information and tell them that
21 if they would like our services in the future
22 to please contact us and we're happy to re-

1 establish that 30-day contact with them.
2 Okay. Next slide. Or this slide.
3 MS. DAILEY: Carol, are you at all
4 concerned that you and the other programs are
5 tripping over each other to help these
6 individuals? That's really kind of the
7 question we were trying to get at. Who would
8 you like to see moved out or moved down the
9 road or moved over because you and they are
10 doing the same thing for the client?
11 MS. WEESE: There's been a lot of
12 discussion about duplication of efforts and
13 work. And in all the forums that I have been
14 present in recently, it appears that that is
15 getting less and less and that there is
16 greater definity around roles and
17 responsibilities in the different programs.
18 Most recently, I was at the
19 entrance and exit briefing that was conducted
20 by the GAO who is doing an intense review
21 right now on all of the case management
22 programs across DoD and VA. And in the exit

1 conference, the surveyors indicated to the
2 leadership at the new Walter Reed that they
3 were initially finding that there was greater
4 clarity around the roles and responsibilities
5 of all of the programs and that they were
6 seeing less duplication of efforts.
7 MS. CROCKETT-JONES: Do you ever
8 coordinate efforts with other programs? Is
9 there like a methodology used for contacting
10 the other folks who do case management and
11 coordination?
12 MS. WEESE: Absolutely.
13 Absolutely.
14 Because the role of a Federal
15 Recovery coordinator is to track and make sure
16 that things are getting done. So that also
17 means that the role of the Federal Recovery
18 coordinator is to be in touch with the case
19 managers in the different programs that are
20 providing care and services for these
21 individuals. So in addition to talking to
22 their client once every 30 days, they have to

be in touch with the case managers, with RCCs, with the wounded warrior programs and all of the different individuals that are taking care of these folks as they are transitioning through. So that's part of it.

MS. CROCKETT-JONES: Are there any challenges there that could be facilitated and make for better contact? Or are you finding that that happens well?

MS. WEESE: I think that over time what we have done in the program is to really facilitate a network amongst all of the programs. And that's been a big focus of what we've done.

And that's also what we do in terms of our ongoing education and training and so forth and so on is we go to provide inservice and education to other case management wounded warrior programs, so forth and so on. And we invite them to come and do the same for us. So we really try to keep that line of communication open between all of

1 us.

2 Are there areas for opportunity?

3 I think there always are opportunities as we

4 work.

5 CAPT EVANS: And so, Denise, for

6 the past year and a half, we've worked with

7 the RCCs, the FRCs, the case managers and

8 social workers. We're not done with the

9 group. But we've come a long way to clearly

10 define the roles and at what point of care

11 should that member enter into that wounded

12 warrior roadmap. And actually the marines and

13 WTB, they've worked a roadmap together to even

14 further define that and take it down to when

15 you're a single amputee, a double amputee, a

16 triple, at what point do you enter into that

17 wounded warrior care.

18 So lots of work to be done. But I

19 think we've come a long way. We had to bring

20 in some experts -- the Lean Six Sigma team --

21 to kind of get us back on track and not fight

22 in the room. But again, I think the GAO

1 report is going to show that we've moved in
2 the right direction.
3 One of the things that we hear
4 from the warriors, too many people knocking on
5 my door. I don't know who really has the
6 belly button for discharge planning. And so
7 I think we're at a point at Walter Reed
8 Bethesda to say who has that belly button.
9 MS. WEESE: Thanks, Captain.
10 Okay. So these are the
11 eligibility criteria that were given to the
12 program when it stood up under the SOC back in
13 2008. And when you look at these criteria,
14 you'll see that they are very broad
15 categories.
16 The reason that they were written
17 this way was to give the program flexibility
18 then to take a look at the individual service
19 members and veterans and make a more
20 definitive determination as to who actually
21 qualifies for the program. And we rely upon
22 the expertise of the Federal Recovery

1 coordinators in their evaluation process to
2 make those determinations. These are the
3 categories.
4 Next slide.
5 We were asked to discuss
6 performance data. And what we have worked on
7 in the program itself is to make sure that
8 what we are bringing to the table is actually
9 relevant to the clients themselves since these
10 are the people that we are working for. So we
11 conducted our initial client satisfaction
12 survey back in 2010. The next one will be
13 conducted this year in 2012.
14 And after we got the results back,
15 what we have done at the program level then is
16 to take a look at the results and focus our
17 efforts around making sure that our clients
18 actually have a copy of their federal
19 individual recovery plan -- the FIRP. We have
20 worked in close association with eBenefits to
21 make sure that individuals who are enrolled in
22 eBenefits can get a copy of their FIRP

electronically, not just in paper. So we made a big emphasis on that.

We have also worked to strengthen to make sure that Federal Recovery coordinators are contacting clients and their caregivers every 30 days and also working on what it is that we provide in the program in terms of training and making sure that FRCs are up to date on all of the latest information on the benefits and that they have all of the clinical knowledge that they need to carry out their care coordination as well.

MSGT MacKENZIE: And was that 80 percent satisfaction rating amongst how many clients of the total number that qualified for an FRC? I mean, how many people actually came in with this 80 percent rating based on how many the FRC program is actually caring for? And then how many folks are qualified for an FRC but don't or denied one?

MS. WEESE: Okay. So the survey was conducted at the time in 2007. And each

1 client who was in an active status was
2 contacted. And there were multiple efforts
3 made to contact each one of those clients.
4 So the 80 percent came from the
5 population of clients that we surveyed.
6 Nobody else was surveyed at that time.
7 MSGT MacKENZIE: How many of the
8 clients that were active actually responded to
9 your survey is what I'm getting at.
10 MS. WEESE: I'll have to get you
11 those numbers. I did not bring the actual
12 numbers with me. But I will provide those.
13 MSGT MacKENZIE: Okay.
14 DR. PHILLIPS: Ma'am?
15 MS. WEESE: Yes?
16 DR. PHILLIPS: Did you just deal
17 with the veterans themselves or did the
18 families get involved?
19 MS. WEESE: In the survey or in
20 the --
21 DR. PHILLIPS: In the survey and
22 in general.

1 MS. WEESE: Okay. So for the
2 purposes of the survey, we surveyed the
3 clients themselves. We asked them if they
4 would like to have their caregiver surveyed.
5 If they said yes, then the caregiver was
6 contacted. But we made sure according to the
7 rules and regulations that we only contacted
8 those individuals who said that we could
9 contact their caregiver because we did not
10 have authorization to contact the general
11 public.
12 DR. PHILLIPS: In general, are the
13 caregivers intimately involved with your
14 process?
15 MS. WEESE: Yes.
16 MS. CROCKETT-JONES: I'm looking
17 at your numbers, and -- I have calculator
18 skills -- 865 active clients and 25 FRCs is 35
19 to 1. That's the ratio you're running on. Do
20 you have a target?
21 MS. WEESE: Well, that's an
22 interesting question. And it is something

1 that we have spent a lot of time talking about
2 in the program and also discussing with our
3 colleagues as well.
4 We are looking at developing a
5 workload intensity that over time looks at the
6 intensity of services that we are providing
7 for clients. Because what an individual needs
8 right after injury versus what they need one
9 year, two years, three years down the road are
10 very different. So what we're trying to do is
11 to come up with the methodology that is going
12 to look at how we actually assign clients
13 based on the intensity of services that they
14 need, not necessarily a ratio of 1 to X number
15 in the program itself.
16 There's a lot of discussion in the
17 industry itself about what the average
18 caseload ought to be for a case manager. I
19 actually was part of a committee that was
20 looking at this at the VA. And we met with
21 the national representatives from the Case
22 Management Association for Nurses and the Case

1 Management Association for Social Workers.
2 And both of those organizations agree that
3 there is no national standard for what is a
4 ratio -- the number of patients per case
5 manager -- but that it depends on how
6 individuals are utilized in individual
7 facilities and parts of the sector itself.
8 MS. MALEBRANCHE: Carol, just
9 because I was thinking about something on this
10 too, but you also work with a number of case
11 managers and your clients are at different
12 stages of acuity.
13 MS. WEESE: Yes.
14 MS. MALEBRANCHE: So you're not
15 the sole case manager like saying 1 for 40 for
16 some very significantly ill. When they're in
17 the acute phase, you would have a spinal care
18 case manager that you would work with in
19 coordinating, right? And then some are going
20 out?
21 MS. WEESE: That's correct.
22 MS. MALEBRANCHE: So I would think

1 I guess the only thing that I'm trying to
2 clarify is that I think it probably varies
3 with this group as opposed to case managers
4 because they're coordinating a number of case
5 managers. And at one point in time I believe
6 one of our patients had said -- from the VA
7 patients -- I need a case manager for case
8 managers. I want one of those FRCs. And I
9 remember that her difficult was helping her
10 know which case manager to go to.
11 So I just wanted that for
12 clarification. So when you start talking
13 ratios and acuity, there's a little
14 difference, I think.
15 MS. CROCKETT-JONES: Can you tell
16 me how many of the 25 are nurses and how many
17 are social workers?
18 MS. WEESE: It's almost a 50/50
19 split.
20 MSGT MacKENZIE: And I'm going to
21 jump on a terminology thing here.
22 We continue to find that our

1 spouses -- our family members -- are some of
2 the most impacted people in the overall long-
3 term care, especially in critically wounded
4 situations. Now what was your definition of
5 a caregiver when you say that -- and what
6 defines whether you can talk to them or not
7 based on the service member's response?
8 I've had several as a liaison
9 where you couldn't talk to the service member.
10 So you had no choice but to talk to a
11 caregiver. But I mean, who makes that call?
12 Are they just a spouse, or are they actually
13 a caregiver? And if they're in the capacity
14 as a caregiver, doesn't that afford them some
15 level of discussion beyond just a spouse or
16 mom hanging around? And are you addressing
17 the differences?
18 MS. WEESE: Right. So that's a
19 good question and there are different levels
20 of caregivers. And we really allow the client
21 to tell us who their designated caregiver is.
22 The program perspective is that we

1 are supposed to be working with the client
2 themselves. If they designate somebody to us
3 as the individual that they want us to work
4 with, we will do that. But we really need to
5 get that from the client themselves.
6 MSGT MacKENZIE: Because once
7 again, if they're the caregiver which
8 qualifies them as a certain level of care
9 they're providing for that service member,
10 then that's a difference between mom hanging
11 out in the room or the caregiver.
12 MS. WEESE: Right. Yes.
13 MSGT MacKENZIE: And if that
14 caregiver status is defined when we start
15 looking at caregiver benefits, are you telling
16 me if the service member says no but this
17 person qualifies to receive caregiver benefits
18 that you're still not going to talk to the
19 caregiver is the guy says no?
20 MS. WEESE: So if he says no
21 because he wants us to work through his
22 identified caregiver or --

1 MSGT MacKENZIE: You made a
2 blanket statement.
3 MS. WEESE: Okay.
4 MSGT MacKENZIE: And I'm trying to
5 get clarification on your blanket statement
6 which is if this person is quantified as a
7 caregiver of said service member -- so his
8 wife is the caregiver. That's a terminology
9 put out there based on a certain level of
10 support that they're providing to that service
11 member. So --
12 MS. WEESE: So let me clarify.
13 We work directly with our clients.
14 If they want us to work with a caregiver, then
15 they need to tell us and designated who that
16 is. Otherwise, our initial contacts and every
17 time we work with the individual, the Federal
18 Recovery coordinator is contacting the client
19 themselves unless they tell us that they want
20 us to contact somebody else.
21 MSGT MacKENZIE: Okay. And then
22 if the service member can't speak, then that's

1 okay to go to this other person? Who
2 determines who you go to?
3 MS. WEESE: That would be
4 negotiated between the Federal Recovery
5 coordinator and the client and the health
6 team.
7 MS. MALEBRANCHE: Mack, if I can,
8 one thing. I know kind of what you're getting
9 at because they do have a lot of clients that
10 don't.
11 But I think one thing that might
12 not be familiar to this group, in the VA in
13 all our records, we have a power of attorney
14 or a next-of-kin designation. And it's easily
15 on our electronic health record on that very
16 first page. So if someone needed to speak --
17 a provider, for example is looking at a
18 patient and in the past it's more of the
19 geriatric -- but you would go to that power of
20 attorney. The two caregiver programs -- which
21 I know we had a briefing on sometime back --
22 the service member receives a certain stipend

1 for caregiving and they choose who they have
2 to give it to. In the VA, there's criteria.
3 But there is this power of
4 attorney. And if a patient can't speak, then
5 you would go to the next-of-kin that's listed
6 on that record to go for what you need. And
7 sometimes it's not necessarily the mom.
8 Sometimes it might be the sister. And we've
9 had that in some of our clients that we've had
10 in the past.
11 So I'm not sure if that gets to
12 it. But I did want to mention that because
13 one of the things about our electronic record
14 that we find very useful is that particular
15 component. It might not always get to it
16 though.
17 MS. WEESE: I think that's it,
18 barring any questions.
19 LTC KEANE: Ma'am, I have a
20 question.
21 MS. WEESE: Yes?
22 LTC KEANE: If a service member

1 has a VA caregiver designated, wouldn't you be
2 free to talk to them?
3 MS. WEESE: If the individual has
4 given us permission to speak with them, we
5 can. However, for privacy, our work is to be
6 conducted with the client themselves.
7 MS. MALEBRANCHE: Carol, lastly,
8 how many clients do you have that are unable
9 to speak or give that authorization of your
10 total number?
11 MS. WEESE: Relatively few.
12 MS. MALEBRANCHE: But there are
13 some?
14 MS. WEESE: I'd have to go back in
15 make a determination on how many there are.
16 MS. MALEBRANCHE: But there are
17 some but that's not inhibited your ability to
18 --
19 MS. WEESE: Yes. Most of our
20 individuals who want us to work with a
21 caregiver or some other identified power of
22 attorney or a fiduciary have asked

1 specifically that we work that way.
2 It's very difficult to run a
3 recovery plan with an individual to help them
4 identify their goals and where they're headed
5 and what not if we're not working with the
6 individual themselves.
7 MS. MALEBRANCHE: Okay. Because I
8 do recall that there was somebody that ---
9 initially when this program first start that
10 I think the state or there was a legal person
11 identified as the person who could determine
12 all things to be done for a patient that
13 couldn't speak. And there was an issue that
14 went to court over family members. So there
15 was something there too.
16 MS. DAILEY: Real quick, Carol.
17 In your population, the legislation set it up
18 and Dole-Shalala set it up that you would be
19 taking care of the most severely wounded, that
20 they would be your clients -- the people who
21 were not able to communicate -- correct -- who
22 were so severely disabled that they were

1 depending on the people around them for their
2 care?
3 MS. WEESE: So when Dole-Shalala
4 came out with their original recommendations,
5 if I go back and read it, it says that we are
6 to take care of service members and veterans.
7 When the real determination was
8 made about which kinds of clients were going
9 to come the Federal Recovery Coordination
10 Program actually started when the RCC program
11 stood up under NDAA 2008. And back at that
12 time when the RCC program stood up, there had
13 to be a determination made then as to which
14 the service members and veterans would go to
15 the RCC program and which ones would go to the
16 FRC program.
17 So category. Categories were
18 developed at that time. And the determination
19 was made then that those individuals who were
20 considered to be category 3, those which are
21 the most severely wounded, injured and ill, or
22 those who are not expected to return to active

duty would be the ones that would come the Federal Recovery Coordination Program.

MS. DAILEY: Okay. Thank you very much.

MS. WEESE: I appreciate your time.

MS. DAILEY: Okay. We're ending here for the day. We reconvene tomorrow at 8:00 a.m. with our public forum section.

(Whereupon, at 4:59 p.m., the above-entitled matter went off the record.)

A

abbreviated 268:2
ability 91:2 106:18 107:2 108:9 109:18 152:18 160:18 201:10 239:12 240:1,7,7 240:10 252:11 263:4 270:13 277:18 327:12 348:5 367:13 426:3 427:3,12 432:20 465:17
able 14:1 27:22 28:22 37:19 44:1 46:4 47:13 52:16 57:14 59:6 60:13 62:3 73:21 82:15 83:20 90:4 95:1 196:10 235:10 239:16 241:3 242:21 248:6,7,12 249:6 251:2 270:11,20 282:5 287:16 288:2,5,6 310:16 316:18 320:5 327:1 330:17 333:5 353:17 359:14 361:9 374:22 389:2 403:17 420:20 425:1 466:21
above-entitled 69:12 227:20 355:12 438:2 468:11
above-knee 249:7
above-the-knee 198:17 216:4 242:16
absence 170:9 394:15 436:10
absolute 42:6
absolutely 126:20 132:15 136:13,20 137:6,10,11 145:15,16 171:21 209:12 212:5 251:5 285:12 301:14 340:16 341:1 342:8 344:10 354:22 359:20 360:6 421:2 434:10 445:1 449:12,13
abuse 392:7
academic 198:9
academies 64:6
Academy 401:12
ACAP 333:14
accept 127:14,16 152:9,20 153:6,10 213:7,14 376:22 403:17
accepted 376:20
accepting 152:17
access 15:9,21 89:11 90:21 116:20 141:2 181:8,10,14,15 186:11 291:18 294:6 325:14 330:11,12 334:17 347:14 395:1,5 402:11
accessed 402:17
accessible 9:22 322:11 405:12
accomplished 4:6 73:5 229:20 232:18
accomplishes 325:1
account 57:7 60:10
accountability 203:15 204:1 211:22 212:4,8,9 367:17 384:14 400:17 401:3
accountable 120:20 121:5,7,18 137:16 175:18 176:8 185:20 186:4 202:1 203:4,5 209:6 212:5 213:16 330:5 400:20
accounts 134:16
accumulate 95:15 249:14
accumulated 198:15
accumulating 250:3
accumulation 127:17
accuracy 412:3
accurate 35:15 322:20 360:10
ACER 278:16
achieve 113:4
achieving 203:16
acknowledge 421:2
acknowledgments 61:21
acronym 154:19 322:5 328:9
acronyms 259:1,14
act 15:16 115:14
Acting 2:14 4:20 437:13
action 19:7 99:4,6 214:1 218:11 312:3 315:9 409:18 417:10,12
actions 98:19
active 12:10 24:21 64:10 65:13 72:12 145:11 216:5 236:11 243:5 272:16 279:9 283:20 289:13,17 290:7 293:6,6 294:6 295:2,8 296:3 297:9 298:7 299:2,13,17,18,21 301:15,16 302:10 302:13,14 307:6 309:16 337:15 342:6 344:9 383:6 383:17 384:3 385:16 386:1,14 386:20 391:2,12 391:17,18,21 393:1,3,14 419:9 441:16 455:1,8 456:18 467:22
actively 253:12 278:15 281:6 309:21 310:2 382:19 385:21 432:9
activities 59:16 62:16 170:5 231:19 286:1 328:21 338:2,8,18
activity 3:6 69:1 130:1
actual 22:20 24:2 64:18 98:5,6 122:10 124:14 135:19 144:8 224:2 272:6 348:15 455:11
acuity 275:2,4,11 275:13,16,19 277:2 284:21 285:5 286:3 287:9 458:12 459:13
acuity-based 211:4 280:16
acute 90:18 277:19 458:17
ad 225:19
ADA 192:10
Adams 1:22 200:14 231:8 318:2,3 332:5,5 334:12 337:22 339:12 340:15,19 341:10 344:7 345:1,9 346:3
add 19:20 58:14 62:18 91:2 121:21 183:6 191:14 203:21 206:6 208:16 221:2 304:11 305:14 313:5 371:3 386:3 395:11,13 397:17
added 76:21 117:13,17 118:2 118:11 171:15 237:3,8
adding 45:16 316:19
addition 77:15 126:5 235:4,15 248:22 276:11 290:15 317:16 387:11 430:18 449:21
additional 76:5,13 187:12 192:17 235:7 254:15 324:11 348:11,16 358:5 360:21
Additionally 27:8 445:11
address 228:14 230:9 231:1 323:19 332:9 355:21 358:14 362:12 364:16 380:22 383:15
addressed 20:10 400:10
addresses 84:5 315:12 391:17,18 393:16 424:6
addressing 131:3 228:21 460:16
adequacy 383:18
adequate 384:6 408:2
adequately 191:11 359:10
adjudication 152:7
adjust 279:16,20 427:3
adjusted 7:21 295:14
adjustment 152:19 279:8
administration 3:4

4:22 66:16 403:6 403:12
administrative 160:1 324:10
administratively 39:3
admission 173:8 193:7
advance 343:8
advantages 54:1
adversarial 134:21 146:12
advertised 225:2
advertising 225:3,6
advice 33:9,9 163:2
advised 79:5,9 377:18
advisement 409:22 410:6
advisor 292:3,17 384:18
advocacy 408:4 423:12
advocate 256:7 260:5 339:3 371:18 373:17 381:20 423:16,20 424:1,21
advocates 155:17 254:4 255:20 256:10 257:14,15 360:7 362:4 400:4 430:8 436:7
advocate-level 254:13
aeromedical 73:20 74:16 75:2 76:6 76:10,14 103:18
aeromedically 74:1 78:13,22
aerovacced 74:5
AF 360:16
affairs 4:18,21 6:10 39:2 59:19 69:9 71:11 99:18 101:20 129:22 130:5 132:3 154:5 194:12 197:4 230:18 439:8
affect 64:7 322:22
afford 152:12,22 153:17 154:22 213:9 360:20 460:14
afforded 27:9 361:11
Afghanistan 232:8
AFI 363:11 366:15 367:15 399:1,16 399:19 404:21 412:17 413:3,9 436:5
AFIs 407:16
afloat 85:19
AFMOA 2:4 386:5 386:16 387:6,15 388:6,8 389:15 408:11 414:16
AFPC 363:22 375:5 389:18 411:9 421:8,10,13 431:20
afraid 24:8 163:18
AFSC 361:9 375:1 376:10
AFSO 385:15 391:2 399:22 421:14
AFSO-21 363:19
afternoon 37:18 38:10 41:7 49:12 156:3 160:8,15 210:11 229:3 232:22 292:1 319:9 356:6 384:17 414:15
afterward 100:11
AFWIC 368:10
AFWICMs 385:5
AFW2 362:3 366:11 368:22 370:22 371:18 372:1,14 373:7,20 374:4 379:21 380:4,16 381:12 381:13,15,20 400:2 407:3 412:17 413:1 423:10,11,16,19 423:21 424:1,2,12 425:19 430:8 431:2 436:7
AFW2s 424:4
agencies 63:11 333:6 381:10 439:8 441:8
agency 2:4 120:18 358:9 361:19 384:4 430:2
agenda 42:12 131:7 131:8 228:19,19 349:16 356:2 425:10
agent 121:5 131:21 137:16 139:6
aggregate 325:18
aggregated 115:15
aggressive 169:3 176:17 219:5 248:19 301:21 329:8,12
aggressively 155:14 178:20
ago 28:14 88:7 104:6 138:13 250:12,19 256:16 258:16 267:14 295:5,16 321:10 351:17 352:1 391:5 400:3 440:14
agree 121:11 153:20 154:13,14 155:1 192:16 199:12 211:12 218:11,11 219:13 249:19 251:5 252:2 275:3 383:22 395:15 458:2
agreed 117:13 170:12 193:5 197:7,19
agreeing 48:18
agreement 276:13 315:20
agreements 5:12
agrees 211:3 264:19 357:15 402:19 408:5
ahead 18:3,3 43:13 89:8 128:4 172:7 190:21,22 207:18 219:15 252:20 285:11 300:11 314:18 317:2 337:20 339:13,14 358:14 367:7 438:6
aid 417:20
aiming 220:16
ain't 336:12
air 2:4,6,21 3:17 6:20 34:13 41:17 41:22 42:3 60:16 72:14 80:14,15 84:10,11,22 85:5 87:9,14 91:10 122:15 123:15 124:12 165:8 173:11 317:9 355:9,19,20 356:9 356:12,13,20 357:14 358:8 360:18 361:9,12 361:13,18,21 362:9,21 363:20 364:1 365:14 366:11 369:10 373:11,17 377:4,8 383:2 384:1 387:9 390:8 391:3 392:2 395:4 396:7,14,16 396:20 397:1,2,3 397:4,6,8 398:6 399:8,10 401:14 401:16 402:19,21 404:11 405:4 407:11 408:5,22 409:7,22 411:12 420:2 425:10 426:14 427:8,17 429:14,17 434:13
airborne 252:5
aircraft 213:9
airlifted 86:9,11
airman 134:22 146:9 361:17 362:11,16 365:9 365:17 373:20 376:2 379:20 401:4 402:3 428:11,22
airman's 407:10
airmen 360:21 361:4,8,17 364:8 382:6 390:15 396:9,17,22 397:7 403:9 413:5 425:13,14 426:7 431:6,7
Alexandria 1:10
algorithms 158:21
aligned 30:16 250:13 356:20
allergies 153:13
alligators 185:4
allow 40:9 235:5 263:4 311:6 334:21 340:9 345:11 351:10 361:4 460:20
allowed 21:19 117:9 340:20 345:20
allowing 301:22 335:21 336:1
allows 326:11
alluded 253:10
alluding 380:18
all-services 114:3
alteration 395:20
ambulatory 199:3
ameliorate 126:2
America 285:21

American 5:21
amount 8:13 15:22 119:2 154:3 243:20 245:13 275:8 299:14
amounts 149:15
amplify 265:22
amputated 252:13
amputation 196:6 216:4 242:16
amputee 144:22 145:1 196:11,11 198:17 234:13 249:7 358:18 451:15,15
amputees 277:9
analogy 175:10 256:9
analyses 100:4
analysis 113:15 116:6 119:4 120:1 133:19 134:18 135:4,15 136:5 151:3 277:11,22 281:10
Analyst 2:4
analytic 102:20 103:2
analytics 250:8
analyzing 103:4
Andrews 365:11
and/or 250:7 319:17 324:8,10 326:3,4
anecdotal 62:1 171:1 202:12
anecdotally 183:1
anecdotes 222:9
announce 65:5
announced 195:5 225:13
announcing 60:22
annual 133:10 152:15 229:21 346:19
answer 10:17,19 81:22 82:1,21 93:21 122:19 125:13 131:20 136:17 157:20 169:18 177:7 210:19 224:10 239:1,9 241:9 250:4,21 260:8 261:14 265:9 278:10 295:9 297:3 300:4 306:4 311:6 337:11,18 339:6 351:12 357:4,7 364:22 393:20 394:12 397:22 404:9 405:2 411:7,12 429:16
answered 403:20
answering 331:16
answers 92:20 107:12 113:19 206:22 335:4 338:22 356:15,16 357:5
anticipate 61:11 176:6 286:14 287:22
anticipating 421:16
Antonio 4:14 7:11 34:13,21 146:1 185:12 257:4 266:2 272:2,4 286:17 303:8 306:7 365:11 368:19 373:12 398:17 408:12 412:1
anxious 139:5 143:15 160:22 215:20
anybody 101:11 170:20 291:3 403:14
anyplace 198:13
anyway 406:10
AOR 365:10 378:9
apart 251:20 263:10
apnea 153:12
apologies 306:15
apologize 350:22 390:19 438:4
apparently 83:10
appeal 273:7 274:8
appeals 279:4
appear 127:2 229:14 356:3
appears 448:14
appetite 155:13
applaud 288:21
applicability 123:4
Application 415:2
applied 97:5
apply 141:11 246:7 246:20 300:20 302:12 369:18 376:21 377:1,2 400:10
appointment 21:12 21:16 83:18,19 312:18 329:4
appointments 27:13 114:19 294:7 297:8 326:9 328:20 387:2 426:8 428:18
apportioning 289:2
appreciate 54:17 162:10 173:5 247:2 284:20 289:5 313:21 314:5 315:9 319:10 349:6 350:20 433:9 435:9 436:21 438:7 468:5
approach 61:7 64:2 138:20 145:22 195:8 231:17 414:20,21
approached 410:13
appropriate 181:15 190:5 253:4 264:20 265:5 273:13 346:15 383:20 404:20 408:3
appropriately 264:7,9
approved 168:3 363:20 429:17 431:14
approximately 92:18 95:5,7 234:7 315:17
April 40:5 45:17 72:2 415:19
area 11:16 14:11 56:1 58:10 109:9 110:20 116:3 149:10 154:7 178:15 179:14 210:1 216:22 293:7 371:1 379:1 385:5 413:10
areas 15:14 38:4 75:13 96:7 107:15 118:18 120:8 179:4 180:1 187:10 230:2,12 333:4 361:2 378:4 422:8 451:2
arena 394:9
Arkansas 295:16
arm 252:13 425:2
ARMED 1:4
armor 271:6 272:17
arms 42:8 146:19 199:8
Army 3:14 4:20 6:19 21:7 28:4 29:16 34:11 35:16 37:1,13,14 57:22 60:16 95:8 116:19 125:6,8 127:1 173:10 177:5 178:15 179:3 180:3,13 200:20 201:2 204:18 208:14 228:13,22 229:16 230:1,3,8 230:10,17 232:3,4 238:16 249:2 255:18 256:18 259:3,16,22 260:12 264:11,16 269:12 270:7,12 277:9 292:2,5 304:14 305:4 307:22 316:13 317:8,10 318:15 320:13,15,22 322:1 328:17 329:9,12,20 333:12 335:3,9 336:22 337:1 342:9,12,15 347:9 352:1 358:13 368:6 407:9
Army's 35:22 91:14 92:10 122:12 155:13 228:14 229:10 231:13,22 251:6 256:18
Army-centric 138:20
Army-wide 286:21
arrangements 316:9
arrive 77:11 308:18 349:20
art 164:22 168:7 169:13 218:21
article 21:15 71:14
articles 28:10 71:4
articulate 287:16
artillery 272:17
artilleryman 271:6 353:16
artillerymen 257:8 263:19
artist 340:2 341:2
ASA(M&RA) 1:24
Ashton 63:19
aside 75:12
asked 5:11 23:7,8

70:16 71:9 100:22 112:2,3 129:9 162:13 163:15 164:14 209:22 214:17 233:6,13 253:1 256:16 264:6 273:5 289:9 300:10 307:18 327:15 332:9 350:5 354:9 359:15 440:6 453:5 456:3 465:22
asking 10:21 60:1 67:13 112:5 121:17 171:18 190:11 205:19 232:20 245:3 262:8 311:17 328:22 339:4 352:16 387:3 395:20 444:4
asks 430:13
aspect 58:11 89:9 187:21 357:2 359:17
aspects 16:9 43:17 309:12 356:22 359:5 364:3 371:9
assembly 390:22
assess 71:7,13 76:22 77:2,13 112:12 274:9
assessed 75:4 77:17 104:6 317:21
assessment 1:23 77:21 85:9 154:20 195:11 254:21 265:10 278:9 302:4 318:7
assessments 77:9 78:15 80:18
asset 33:19
assets 192:4 271:9
assign 324:9 457:12
assigned 27:12 89:15,20 117:21 219:17 359:22 425:15 439:21
assignment 365:13 369:19 414:3
assignments 333:8
assigns 393:10
assimilating 49:6
assist 227:16,18 318:1
assistance 33:15 142:7 176:22 265:9 275:8 291:19 292:16 293:7,8 373:21 413:1,12 417:21 434:16
assistant 1:24 2:19 99:17 101:19 156:6 174:20 197:20 229:11 230:16 233:3
assistants 32:21 47:4 142:14 189:11,15 194:18 214:8
assisting 346:13
associated 48:2 154:16 288:20
association 133:20 453:20 457:22 458:1
assume 207:18 254:9 265:1 273:14 359:19 411:2
assumption 128:16
asterisk 137:9
asthma 153:12
Atson 296:12
attack 314:5
attacks 167:6
attempt 248:19
attempted 98:20
attend 62:10
attended 7:15
attendees 106:21 418:14
attending 426:7
attention 29:14 418:11 419:1 436:17
attorney 463:13,20 464:4 465:22
audiences 205:19 396:19 397:5
audit 278:6 284:13
augmentation 408:9
Augustine 44:3
authoritarian 176:3
authority 121:2 139:8,9
authorization 345:15,21 456:10 465:9
authorizations 429:19
authorized 337:14
authorizes 37:15
authorizing 393:11
automate 28:15
automated 28:17 37:18
automatic 372:11
automatically 304:7
automating 37:3
automized 244:5
availability 326:1
available 35:14 67:11 69:21 77:6 114:13,19 115:6 115:20 193:3 234:3 237:14 262:20 276:18 292:13,22 293:12 310:17 316:8 319:17 323:13 324:3,5 325:3 333:20 334:7 340:11,22 362:8 362:12 397:14 398:13 402:16 404:13 405:22 407:1,8 408:17 410:16 415:7,13 418:1,1 420:16,17 428:3 445:17 446:14
availed 206:10
avenue 182:10
avenues 309:7 344:15 363:9
average 106:10 113:3,7 144:8,17 321:8 326:20 457:17
avoids 54:14
awaiting 72:13
aware 19:13 21:18 90:14 230:6 234:20 331:13 334:8 384:10
awareness 61:9 160:20 215:7 331:7 396:13,21 397:3
awful 22:7 43:10 92:9 139:21 209:18
awfully 11:20
AW2 178:17 254:4 255:10 256:8 257:15 258:13 343:13
AW2s 184:11
A-F-T-E-R-N-O-... 228:1
A-1 356:21 360:16 363:20 377:4
A-1S 357:1
a.m 1:11 4:2 69:11 69:13 138:8 468:9
A1 34:16

B

b 7:22 38:19 68:20 179:16 180:14,17 208:4
babysitting 33:11
back 6:1 11:13 14:18 22:1 30:3 42:20 44:4 47:18 49:2,15 52:6 53:20 66:22 69:8 72:18 74:3,20,21 75:6,7 78:4,4 81:15 83:17 85:7 85:8 89:6,21 90:15,16 91:16 95:1 101:10,12 103:4 106:8 112:8 115:3 117:11 118:11 119:6 120:1 121:1,8,16 121:19 125:2 128:18 131:14,16 132:10 137:1 140:7 146:1 147:4 150:16 155:15 157:10,14,17 158:14 160:5 164:20 166:22 168:6 170:21 181:12,16,18 185:5 187:16 188:5 190:12 193:6,15 198:6 200:5 202:15 204:7,15 217:8 228:4 236:4 248:17 251:18,18 260:14 270:20 277:14 280:10 282:2,18 283:17 284:1,11 287:14 288:4,8 293:19 296:2,9 297:14 299:18 300:18,20 301:4 302:3,13,14 303:5 306:17 308:7 313:13 323:7 332:4 334:15 335:15 349:18 353:5 354:12 363:10

365:10,12 368:14 378:3,13 379:8 381:11,13 391:5 392:10 393:2,3 394:2 405:18 411:8 415:19 416:11 425:20,21 428:18 437:19 438:5 440:4 446:18 447:3 451:21 452:12 453:12,14 463:21 465:14 467:5,11
backed 104:5
backfills 271:17
background 101:2 276:9 381:15
backlash 173:17
back-up 349:3
bad 10:17 71:18 109:6 420:4
Baghdad 167:5
bait 309:5,17
balance 13:2,3 50:10 151:1,2 286:4 338:17
Balboa 162:6 193:10
ball 276:17
Ballroom 1:10
bam 69:17,17,17
band 109:2
bandwidth 23:13 198:5 210:4
bank 223:11,16,20
Bannick 1:23 39:1 69:9,19 70:3,7,12 70:14 82:19 84:13 86:13,17 87:5,15 88:6,11,21 89:6 90:12 91:21 92:4 97:9 98:6,22 99:10 100:15 101:17,22 102:8 102:19 103:13 105:1 106:15 111:13 113:9,16 114:22 115:8,21 116:9,11,18 117:5 117:13 119:11 120:6 122:3 124:4 124:17,20 126:20 127:6,10,14,16 128:7,9 129:22 130:18 180:9
barracks 192:10
barring 464:18
base 2:7 19:4 41:18 42:1 47:21 59:18 60:2 121:15 123:15 143:4 160:20 186:2 189:5,20 192:14 277:2 326:16 382:11 397:10 402:21 407:11 440:22
baseball 221:12
based 16:4 27:4 28:22 34:22 49:22 53:3 98:19 137:18 203:21 218:14 227:1 236:21 237:4 241:1 247:7 247:10 273:19 275:18 279:8,20 279:21 280:16 285:16,20 286:1 302:4 307:21 325:8 367:2 373:13 385:13 387:22 395:19 424:1 427:3,14 430:8 431:1,11 454:17 457:13 460:7 462:9
baseline 167:11 201:22 204:21
bases 141:16 188:14 192:19,22 405:6 420:20,21
basic 105:6 106:3 106:17,19 108:14 280:18,20 326:16
basically 12:21 13:2 22:10 24:14 26:19 52:16 60:17 60:21 62:20 66:21 110:1 113:12 129:11 133:20 147:5 170:8 197:16 211:3 228:12 245:7 250:12 273:21 292:18 310:21 322:18 329:2 332:3 356:19 374:21 393:18 404:10 427:19,20
basics 244:9
basis 38:3 74:14 94:11,14 99:16 107:8 125:17 169:6 219:19 234:1 254:10 265:7 320:9 322:3 381:21 415:5 416:15
battalion 16:15,20 31:10,18 32:3 244:13 269:4 271:4,15 272:11 272:15 287:17 308:7
battalions 346:11
battle 259:3
battlefield 252:9 268:19 278:14 280:8
BCT 44:4,14
bean 279:15
bear 177:18 278:10 281:12
beat 207:3 240:4 252:20 321:9 350:3 379:4
beating 243:1
bed 75:9
bedside 240:3 241:4,17 248:13 256:14 313:19
beef 410:21
began 98:17 136:11 415:18
beginning 11:18 92:9 94:10 157:19 247:22 334:15 373:7
begun 369:1 421:12
behalf 34:4 45:3 61:19 139:10 163:21 200:20 233:2 438:15
behavior 194:17 238:18 312:16
behavioral 24:7 232:12
believe 36:5 56:19 57:21 68:6 228:10 228:21 233:21 250:5,21 251:20 252:14 253:11 255:2 267:10 275:11,22 287:1 302:6,15 317:1 365:7 370:3 395:21 406:18 425:22 430:12 459:5
believes 249:1
belly 452:6,8
belong 272:8
belongs 272:12,13
Belvoir 342:10 343:10
benchmark 134:12 137:13
benchmarks 246:17
beneficial 43:19 426:5
benefit 219:18 246:10 305:7,8,8 305:8 407:14
benefits 2:4 30:13 136:18,19 137:4 147:1,2 149:8,13 220:13 305:22 311:15 313:11 316:21 362:7 384:10 390:17 439:6 454:10 461:15,17
Berry 1:24 228:9 228:13 230:15 231:21 232:21,22 233:2 236:14,15 237:7,19 239:9 242:12 252:21 264:4 273:2 289:6 293:22 299:11 302:6,15 306:12 315:11 317:1,20 319:7
best 8:8 17:19 18:9 18:17 27:17 33:6 40:19 98:11 140:3 150:6 235:18 237:8 265:15 289:21 291:20 309:18 320:15 348:10,15 354:17 396:10 422:18
bet 137:20 139:4 181:20 187:15
Bethesda 7:4 90:4 192:6 277:8 278:3 308:20 314:17 452:8
better 38:5,7 57:10 58:18 105:13,15 105:16 133:3,4,4 133:5 138:18 139:18 142:20 150:13,20 160:18 176:16 178:5 185:17 189:13 193:13,17,17,18 200:17,21,21 201:4,16 204:16 204:17 212:7 221:19 223:3 226:19 239:16 283:7 306:20

308:5 354:1 378:20 395:17 410:12 416:9 450:8
beyond 11:6 45:20 46:3 73:9 85:20 100:5 132:5 170:10 243:6 432:13 460:15
BG 2:17 229:2 243:10 249:17 251:13 252:17 255:15 256:2,4 258:14 261:8 262:10,13,18 263:12 265:22 269:22 270:4,8 271:11 272:9 273:1 277:4 281:2 282:12 288:7 289:4 291:8 294:10 297:12 299:19 301:18 303:6 307:5 308:4 308:13,22 312:2 313:12,16,21 314:15,22 315:2 327:21 328:2,7,12 331:20 336:3 339:9,14 345:22 348:20 349:11,14 349:17 350:1,7,14 350:16 351:4 354:19 355:1,4
bias 82:11 123:20 123:21 124:9,11 127:3
big 14:15 18:18 54:22 68:5 145:9 148:18 161:18,18 185:3 187:21 191:17 210:2 351:16 416:5 418:13 450:13 454:2
bigger 422:5
biggest 299:1 401:19
bill 152:15 161:22 206:8 345:13
Billy's 170:18
binders 5:14 191:3 194:16
bit 6:6 9:16 16:7 38:22 49:13 52:2 52:18 54:7 58:22 60:12 63:13 65:12 67:7 68:10 80:9 81:20 94:17 95:3 100:21 101:5 113:21 172:10 182:1 210:8 227:10 242:1,5 244:5,7,8 266:1 269:15,16 280:3 282:4 285:5 303:16 362:2 380:13 401:9 423:18 427:6
Black 366:10 369:11,13 370:17 373:10 376:13,19 380:14 397:16 424:5 431:16,18 432:3 434:17,22 435:11,21
blank 200:11
blanket 462:2,5
blind 132:15 133:16
block 52:22 183:4
blog 58:13 61:12,13 65:13
blooming 288:17
blow 125:1
blurb 67:4
board 60:18 72:13 96:11,12 110:2,6 127:1 158:15 196:15 231:18,18 253:13 298:22 304:3 316:18 335:4 340:1 362:9 370:14 375:4 376:18,20 377:1 380:5 407:22 410:3
boat 185:4
bodily 437:17
bogey 148:5
bolts 304:5
bonafide 65:16
book 39:11 151:20 261:15 271:7
books 8:1 46:17
boots 85:16,22 265:8 346:7
boots-on-the-gro... 443:3,11
borrow 278:19
boss 251:1 258:17 270:9 288:15 353:11
Boston 48:4,4,6
bottleneck 142:12
bottom 93:17,18,22 105:11 107:3,19 111:1 122:13 125:3 126:17 192:11 266:16 427:2
bounces 97:18
bow 26:12
box 23:17 210:7
Bragg 257:18 277:12 285:18 286:8
Braggs 123:14
brain 219:3 232:13 234:14 378:16
branch 1:22 64:11 73:13 231:9 332:7 424:11,15
branches 60:14
brand 183:16 267:10 414:3
branding 168:12
Brave 336:6
breach 136:20
break 69:7 327:19
breakdown 79:21
breakout 10:5
breakthrough 179:1,3
breakthroughs 179:2
break-in 175:21
brewing 270:15
brief 41:8 133:7 178:11 213:22 215:5 217:10 233:5 255:22 308:18 356:13 401:11 438:13,21
briefed 9:7 248:2 273:14 354:5 358:13 391:4 401:4 411:21
briefer 39:1 128:5
briefers 228:17 356:1
briefing 3:14,18 8:1 69:10,19 100:11 101:1 160:7 178:9 285:9 319:6 357:3 412:14 448:19 463:21
briefings 50:9 56:13
briefs 18:8 361:20
brigade 28:8,16,20 29:8 42:20 48:19 244:13 278:4
brigades 93:3 346:12
Brigadier 228:5 229:9 251:4
bright 213:17
bring 13:8 37:13 40:7 43:19 46:2 47:2 51:9 63:5 128:22 189:4 192:2 201:15 214:21 231:15 245:2 247:4,6 248:20 259:14 285:8 292:10 302:14 353:20 436:16 437:19 441:1,4,16 451:19 455:11
bringing 43:4,5 48:8 154:9 268:16 284:17 339:3 350:20 419:1 437:11 453:8
brings 147:3 339:1
British 183:21 195:4
broad 47:22 122:1 452:14
broaden 17:11
broadened 104:2
broader 120:15
broad-based 324:22
brother 161:18 340:2
brought 13:6 15:1 15:7 32:9 35:21 91:21 159:4 214:3 215:22 222:20 224:7 226:7 302:13 304:3 352:5 393:1 410:14
Bruce 6:20
BRUDETTE 2:1
BS 297:3 337:11
BSI 378:8
bubbling 294:15
buddy 259:3
budget 34:22 102:18 139:8 141:21 142:4
build 39:21 204:13
building 40:10 154:19 192:6 194:3 247:19 315:4 352:7
buildings 155:10
builds 195:14
built 32:3 161:3 197:7 439:14

bullet 4:7 172:13 393:7 400:9 423:18,21 424:5
bump 267:1 303:16
bumper 281:4
bunch 297:3 302:1 352:6
Burdette 130:19 131:11 134:1 136:1,16 137:5,8 137:20 139:4 141:13 144:2,11 144:18 145:15 147:14 149:7 151:13 153:9,20 154:12 155:19 156:13 158:13 159:9 160:10,14 166:20 170:12 171:21 172:8 173:4,21 174:2,6 175:12 176:9 177:14 179:10,21 181:20 183:13 186:17,19 187:15 188:10 189:7 191:20 192:5 193:5 194:11 196:20 197:19 199:11 200:3 202:20 203:2,8 204:2 205:12 206:19 207:10 208:2 209:11 211:9,14,16 212:1 212:4 213:14 214:21 215:4 217:1,21 218:8,19 219:13 221:10 224:3,8,13,18,22 226:20 227:12 285:11
Bureau 6:4 292:6 292:21 293:4 390:8
business 4:12 7:20 45:12 58:6 162:7 188:16 195:17,17 318:5 344:12 380:13
busted 339:21
busy 422:20
button 6:6 224:15 452:6,8
buy 142:16 147:8 189:15 214:7 391:7

C

C 2:21 70:10 180:14,17 426:22 427:14
cadre 20:21 22:20 24:2,3 207:6 240:20 265:3 266:18 271:21 277:10 278:16,21 279:5,12
Caf 315:3
calculates 285:19
calculator 275:13 275:20 456:17
calendar 47:19 201:20
California 174:21 267:18 287:2 294:3 297:7
call 26:12 49:21 88:14 165:17 166:2 171:5,17,18 172:1 180:3 182:20 201:1,17 207:21 296:20 363:21 373:5 375:3 385:20 432:15,16,20 433:17,18 434:16 436:15 443:20 444:10 447:12,17 460:11
called 28:17 31:12 72:16 139:16 223:11 246:1 293:17 368:10 445:13
calling 61:6 103:6 180:13,18
calls 23:17 40:18 168:5 182:14 292:15 381:21
Cameron's 187:22
camp 7:17 8:2,4,6 9:3,21 14:18 40:2 140:11 159:14,17 174:21 272:18 354:17 355:1
campaign 28:14 225:6 231:2 305:16 309:11
Campbell 140:10 156:6 174:20 258:15 271:13 277:13,16 353:1
campus 159:16
canceled 41:1
cancers 167:6
capability 323:15
capable 322:10
capacity 61:20 277:17 425:16 460:13
CAPE 154:18,19
Capital 268:6 271:20 272:5 277:6 343:3
capped 80:20
capsule 438:21
CAPT 1:16 7:2 89:14 159:11 255:2,9 256:1,3 258:3 308:15 316:14 451:5
captain 5:4,6 7:2 56:4 160:22 268:11 303:9 317:5 452:9
capture 63:18 107:9 189:3 196:13
car 374:9
Caravello 279:3
card 33:8
care 1:3,25 2:2,20 2:22 9:5,13 19:5,5 34:18 70:1 71:9 73:12 75:21 76:20 77:1,2,3,5,14,20 78:21,21,22 79:3 79:6,6,8 81:5,6 93:8 100:1 104:5 104:8 106:20 112:4 114:3 120:20 130:21 134:22 141:1 146:22 147:10,15 150:2,15,17 167:9 168:14 172:1 173:9,10 177:22 181:8 193:8 201:18 213:2 219:18 220:7,9 229:12,17 230:3 231:6 232:1,9,11 232:14,16 233:15 234:1,13,14 235:1 235:6,12,16 238:19 240:17,22 246:4 248:11 254:7 255:7 256:4 256:20,21 258:21 259:8 264:20 274:15 282:9 285:14 289:12 290:1,11 292:14 294:6 298:22 299:18 300:15,17 304:4,19 305:6 310:10 329:1 330:12,14,16 331:18 337:14 339:22 341:13 345:18 353:2 355:20 356:9,12 356:21 357:1,1,2 357:14,17 358:18 359:4 360:2,19 362:3 364:1,3 371:5,7,14 372:5 373:11,18 379:9 383:3,6,10,12,12 383:16,19,20 384:2,7,7,8 385:18 386:12 388:10,11 391:11 392:1 393:3 395:1 395:5,6,7,7,17,18 395:18,22 396:1 398:6,9,17 400:1 401:17 405:19 412:21,22 425:2 426:1,5 428:22 429:20 430:4,22 431:1 432:5,9,13 435:10,14 436:6,6 437:18 438:21 439:6 440:13 442:5,19 443:8 444:14 445:16,18 446:11 449:20 450:3 451:10,17 454:12 458:17 460:3 461:8 466:19 467:2,6
cared 433:18
career 1:22 209:16 209:17 231:10 246:13,14 259:21 332:6,19 333:17 338:8,18 346:15 347:12,16 375:7,8
careers 361:5
careful 64:2
carefully 66:3 185:16
caregiver 396:4 456:4,5,9 460:5 460:11,13,14,21 461:7,11,14,15,17 461:19,22 462:7,8 462:14 463:20 465:1,21
caregivers 408:4 454:6 456:13 460:20
caregiving 464:1

cares 282:11
caring 238:12 397:2 431:3 454:18
Carol 2:14 437:13 437:20 448:3 458:8 465:7 466:16
Carolina 106:16
carpet 313:22
carpets 168:13
carried 102:3
carrier 213:10
carry 151:17 160:3 276:18 454:12
carrying 83:9
Carson 36:15 138:14 140:11 192:9
cascading 329:14
case 18:14,16 19:3 19:8,22 25:5,20 26:16,20 27:11 108:2,5 117:18,21 117:22 118:1 160:17,20 161:20 162:9 213:2,2 234:17 235:9 238:3,17 240:15 240:20 243:17 246:5 265:3 274:14,22 275:1,6 275:12,17 281:17 282:10 283:5 285:15,20,21 286:12,17 287:20 302:2 314:8 328:6 330:17 331:9,10 371:5 380:17 383:4 384:5 386:19,21 388:11 415:10 420:5 424:16 430:16 441:16 445:16 448:21 449:10,18 450:1,18 451:7 457:18,21,22 458:4,10,15,18 459:3,4,7,7,10
caseload 432:8 457:18
cases 244:13 301:11 337:12 341:21 394:13 408:15 417:13,15 420:7,22 421:1 423:2 432:8 435:3
case-managed 26:16
casualties 188:22 405:8
casualty 378:21
catch 157:15
catching 45:10 69:18 282:16 283:18
categories 452:15 453:3 467:17
category 11:8 108:7 122:1 447:11 467:17,20
caused 417:15
causing 26:4
caution 433:14
cautions 44:2
CBTU 47:19
CBWTU 49:4 281:5 294:3
CBWTUs 250:1 269:21 277:1 280:7 291:22 295:1
cell 5:8 7:3 83:9,10 83:21 385:10,13 385:21 386:5 387:5,6,8 388:8 390:21
cells 328:10 386:16 388:7
census 80:12 86:6 103:11
center 5:9 19:21 244:16 328:10 336:15 364:4 366:12 399:9
centers 33:15 90:9 189:4 190:12 198:21 214:16,22 215:8 216:21 218:22,22 291:19 328:11,11
central 74:7 91:5 410:20 421:6
centralized 89:11 90:14,21
centralized-type 170:4
centrally 419:11
centric 139:18 141:3 143:13 146:21 148:11
ceremony 225:12
certain 26:21 30:22 85:19,21,22 97:1 129:14 196:7 218:7 219:9 299:14 335:6 349:3 378:15 405:14 414:1 431:12 435:4 461:8 462:9 463:22
certainly 38:1 50:1 68:15 80:13 100:15 122:11 158:20 165:18 209:2 251:8 264:11 284:20 354:1 359:11
certification 412:5
certified 30:9
cetera 12:11 66:14 218:16 242:19
chain 27:2,16 329:15
chair 136:12
chairpeople 163:8
chairperson 218:1 218:2,3
chairpersons 218:10
chalk 354:3
challenge 38:9 146:18 165:21 166:21 167:22 289:18 309:15 359:2 363:3
challenged 167:8 414:13
challenges 43:1 417:7 450:7
challenging 309:22
chance 94:8 175:21 257:5
change 88:3 98:1,5 107:11 110:13 128:2 133:15 155:7,12 186:10 218:1,1,9 280:3 320:10 345:11 372:10 373:16
changed 6:11 103:22 104:21 107:3 116:20 117:9
changes 95:22 105:5,19 120:12 137:13 281:8 396:20
changing 155:13 268:8
channels 186:2 225:2 329:10
chapter 204:8
characters 67:3
charge 118:21 119:9 156:14 263:11 307:15
Charles 1:11,14
chart 122:9 143:6
charter 56:15 120:7
chartered 136:1 189:8 445:13
charts 94:22 132:12 148:3
check 5:11 23:16 52:12 149:18 152:10 155:2 158:5 185:2 299:4
checked 52:22
checklist 444:9,17
Chiarelli 138:4
chief 1:22 2:13,21 4:20 21:7 49:18 147:22 231:10,13 238:1 264:16,16 269:2 337:1 355:19 358:7 445:12
Chiefs 194:14
chief's 148:1
childcare 33:11
chime 369:12 411:20 431:17
choice 303:4 460:10
choices 342:7
choose 49:22 299:12 340:13 464:1
chose 57:18 334:5
chosen 141:19
christened 136:2
Christian 1:17 7:8
Christmas 200:17
Chu 75:17
chunk 380:7
circled 151:3
circumstances 417:15
cited 182:3
city 21:21 345:4
civilian 22:1 78:5 163:3 166:12,13 183:18 248:10 333:10 335:5 336:2 360:16 383:18 384:6 394:3 429:19
claim 146:15
claimed 144:16 145:2 150:13,16 157:14
claims 424:9

clarification 459:12 462:5
clarified 340:18
clarify 382:17 459:2 462:12
clarity 210:20 261:22 263:16 449:4
Clark 2:3 408:7,10 408:11 409:9,12 410:2 411:1 412:15 414:13,16 418:10 419:5,13 419:15 420:14 421:11,20 422:1 425:5
class 152:17,21
classes 333:15 335:8 342:3
classification 361:2
classified 190:17 190:19
clear 10:17 178:4 253:6 266:21 273:7 295:2 305:9 340:7 364:4 428:6
clearly 17:17 24:22 45:1 331:16 350:18 353:13 451:9
clerks 324:10
clicking 224:15
client 439:21 440:1 442:4 446:5 448:10 449:22 453:11 455:1 460:20 461:1,5 462:18 463:5 465:6
clients 442:9 443:16,18 445:5 446:21 453:9,17 454:5,15 455:3,5 455:8 456:3,18 457:7,12 458:11 462:13 463:9 464:9 465:8 466:20 467:8
climate 264:8,13 265:5 268:9 269:8
climb 167:20
clinical 196:13 233:22 234:16,18 237:1,3 238:5,6 238:14,16 240:16 241:22 242:5 248:4,8 266:7 287:19 346:22 356:22 358:8,18 395:8 439:4,16 440:17 454:11
close 55:5 130:11 145:5 148:5 160:6 278:12 279:6 290:5 388:21 453:20
closed 311:3
closely 29:15
closer 54:4,8 185:4 290:8
closes 312:9
club 299:21 337:17
Clyde 257:18
CNOR 2:14
coached 201:6
coast 146:9
code 223:7 292:9 292:11 293:11 361:10
codes 361:12
codification 436:11 437:3
codified 167:19 362:22 436:1,2
codify 436:4
CoEs 218:12
cohort 80:13 91:13
cohorts 76:5,13 78:9 79:5 81:4 84:14 85:1 103:20 104:14 107:10
coincide 59:15
coincidentally 92:8
COL 1:24 2:8,9,13 236:15 237:7,19 237:22 239:5 240:11 241:20 247:21 252:21 264:4 273:2 285:12 287:13 289:6 292:1 293:17,21,22 299:11 300:12 302:6,15 304:11 306:12 315:11 317:1,20 319:7,9 327:5 328:11 329:5 330:18 355:18 356:5 358:6 359:20 360:6 363:1 364:14,18 365:6 366:2,7,17,20 367:1,20 369:6,13 370:17 371:2 372:8,15,18 373:1 375:14 376:1,5,12 376:19 377:10,14 377:22 379:10,16 379:22 380:9,14 382:3,15 384:15 384:17 385:4,14 386:9 387:6,14,20 388:1,6,15 389:9 389:12 390:5 391:1,16 392:11 393:15,22 394:8 394:17,20 395:12 396:2 397:19,22 399:6,12,18 401:8 402:13 403:10 404:22 405:17 406:12 407:18 409:3,13 411:10 412:12,20 413:6 413:11,18 414:1,4 414:11 424:5 425:7,9 426:11,19 427:1 428:13 429:3,7,12 431:18 432:2,3 434:2,22 435:11,13,21 436:13,19 437:5,8
collaboration 155:21 236:6 320:14 321:20
collaborative 238:6 331:9
collaboratively 234:6 238:7
collapse 128:1
collapsed 94:14
collate 349:9
collated 50:16 68:15
collating 196:19
colleague 6:7
colleagues 49:15 133:13 138:18 191:6 237:20 440:12 457:3
collect 42:6
collecting 299:3
collection 349:7 385:6
collectively 416:8 422:17
college 22:4,8 342:2
colonel 4:20 7:5 20:17 26:2 228:9 228:12 230:15,20 231:12,21 232:20 232:22 233:1 236:14 237:22 239:8,9 242:12 245:18 255:17 260:13 271:5 281:14 282:18 285:4 290:20 292:2 295:21 296:12 301:18 316:14 319:8 352:5,5 355:16 356:11 358:4,7 364:12 366:10 368:17 369:11 373:9 376:13 384:15,18 395:11 395:14 397:16,18 403:12 411:6,17 412:16 421:15,15 431:16 434:17
colonels 352:6
color 172:20
Colorado 138:14
combat 28:8,17 42:20 48:19 299:6 361:4 372:15,17 372:19,20 374:10 374:11 376:2 377:11,12 378:1 379:15,20 381:7
combat-injured 365:9
combination 227:4
combine 166:3,17 416:15
combined 386:6 404:1 414:22
combines 110:9
combining 221:5
come 30:2 35:12 37:2 41:6 44:4 66:12 91:11 97:17 111:16 117:11 121:19 140:7 154:2 155:7,15 158:3 166:10 167:8 170:20 181:16 185:5 187:16 188:5,22 189:1 209:13 212:9 217:8 221:13 232:21 249:9 262:22 267:11,12,15,20 269:5 278:15 288:7 295:6 299:17,18 300:20 300:21 301:4,5,9 301:11 304:1 313:12 316:12 326:16 335:4,6,7 335:13 351:9

353:5,7 354:11,12 359:10 363:2 370:14 376:15,17 381:13 385:2,6 393:3 406:3 438:13 441:6,9,18 447:3 450:20 451:9,19 457:11 467:9 468:1
comes 150:12 187:22 188:12 189:6 193:6 205:9 217:13 242:18,20 266:6 282:21 286:21 320:3 358:15 364:5 374:10 424:17
comfortable 251:21
coming 26:13 30:17 34:22 35:9 37:17 41:5 49:2 76:11 77:12,21 81:1 82:22 83:2,3 83:11 84:18 89:22 113:1 119:6 130:20 160:11,12 178:13 190:11 206:9 238:2 256:17 262:1 267:9 268:3,22 279:21 280:11 288:4 295:6 300:14 339:11 342:18 351:3 352:13 364:7 381:11 429:11 433:21 436:22 438:7
command 14:19 27:2,16 29:3 33:16,17 34:1 228:9 229:11 231:9 250:7,17 251:13 252:2,11 264:8,13 265:1,5 266:6,12 268:8 269:8,20,21 271:21 272:21 273:15 274:1 279:1 282:22 297:18,18 300:1,6 312:20 320:7 321:1,3 329:11,15 329:21 332:8 338:4,7 343:9 349:5 382:10
commander 5:21 16:21 22:22 29:9 192:14 228:8 229:10 244:12,12 244:13,14 259:20 263:2 266:2,4,4 268:14,18 269:4 271:2,3,4,12,15 272:8,12,13,13,15 272:19 277:17 287:18,18 288:2 295:4,12 298:7 308:7 322:13 323:20 329:3,16 331:11 333:21 334:18 337:9 403:5 417:11 424:13 427:2,7,10
commanders 9:12 29:9 37:10 59:18 138:10 265:1 267:9,14 268:9,10 273:14 297:20 321:22 322:11 323:14 325:3,13 326:5,12 329:11 329:13 330:5 336:6,11,20 352:15 401:22,22 402:1 426:15
commander's 29:12 302:16 324:16 331:7 334:4 338:14 426:6 427:7
Commanding 2:17 6:3
commands 258:9
Command's 230:11
commend 63:9
commendable 418:5
commending 229:19
comment 8:19 16:13 202:16 351:14
commented 33:18
comments 17:6 20:10,19 38:12 49:20 93:9 113:20 119:16 123:3 136:11 208:17 230:2 364:20 431:20
commission 162:20 168:11 189:17
commissioned 101:9
commitment 350:19 396:8 432:13
committed 150:22 258:16,17 284:17 403:2
committee 43:2 44:19 45:3 64:19 162:19 163:7 181:7 187:6,10 248:22 438:19 457:19
common 12:16 57:19 102:9 172:4 173:5 234:5,9 445:3
communicate 268:8 287:17 326:4 466:21
communicated 288:1 307:6
communicates 382:8
communication 24:14 209:1 265:12,21 294:16 295:10 297:4 378:20 396:4 399:15 400:12,14 401:6 450:22
communications 12:8 62:9 400:13
communities 58:2 396:22 397:10
community 7:9 34:16 53:2 55:19 56:8 57:2,21,22 60:20 62:13 165:13 166:12 188:2 215:7 226:10 286:9 296:13 397:8 440:4 441:8
community's 166:14
community-based 41:15,21 42:1 44:7 45:1 47:20 48:6,11 49:1 52:21
comorbid 242:19
comorbidities 198:18
companies 345:13
company 9:12 11:3 223:2 257:4 266:1 268:14 322:1,12 329:14 368:1
comparatively 62:12
compare 94:4 122:12,15 125:18 125:21 126:8 127:22 226:1 248:7
compared 61:2 62:12 87:4 97:7 126:18 276:2 294:5 325:9
comparing 141:3
compassion 266:16 269:12,15 335:15
compensations 227:6
compete 361:5
compilation 69:3
compile 40:6 123:10
complains 314:21
complaint 25:21
complaints 25:14 159:12 207:6 410:8
complementary 442:18
complete 9:13 27:10 77:10 79:19 80:16 86:2
completed 5:14 78:1,17 110:5 203:13 248:2
completely 9:17 46:21 182:6 192:16
completes 85:13
completion 85:12 205:17
complex 173:9,9 193:8 337:14 339:22
complexity 37:20 379:19
compliance 179:14 322:16,17
compliant 192:11 430:14
complications 14:19 357:22 379:3
component 48:15 289:13,17,18,22 290:7 291:3,6 293:2,6,6 298:18 298:20 299:3,4 300:13 301:1 302:8 305:20 383:16 389:19 392:9 393:12,19

440:19 464:15
components 99:20 246:7 289:7,11,15 305:20 387:8
COMPO-2 45:3
COMPO-3 45:3
comprehensive 20:4 51:13,16,21 52:5 69:21 91:22 200:5,10 236:2 246:11 253:2 258:6 307:7 371:13 383:3,5 445:7
compressed 69:16
compression 144:20 145:1 215:14
comprising 106:11
computer 23:11
concentrate 193:2
concept 139:17 215:5
concern 32:15,19 66:5 104:19 120:18 192:12 258:11
concerned 9:5 14:8 33:4 109:5,11 134:8 151:22 159:19 176:11 276:4 373:9 448:4
concerning 24:6 59:7 229:15,22 232:1
concerns 18:19 44:22 58:4 108:16 159:13 358:12
concert 244:10
concise 324:17
concluded 250:11
concluding 93:9
conclusion 208:12
concrete 220:20 222:7
concurs 395:4
condition 77:19 150:13,16 157:14 158:11 248:4,6,15 300:19 313:9 325:7 326:4 357:22
conditional 262:19 415:6,12 422:22
conditions 144:16 145:2 146:16 152:8,18 153:10 232:12 234:9 242:19 251:22 252:10 312:20 361:11
condition-specific 357:14
conduct 445:10
conducted 4:14 230:13 265:7 448:19 453:11,13 454:22 465:6
conducting 231:17 347:1
conduit 56:12 65:10 347:7
conference 296:10 339:10 342:10,11 343:5,8,15,16 345:13 346:19 418:13 449:1
confidentiality 5:12
conflict 19:9 194:5 194:16,22 232:7
confused 152:3 423:18
confusion 22:15 24:12 151:17 154:14 313:6 364:5
conglomerate 390:9
Congress 37:14 66:6 164:1 228:16 229:21 356:1
Congressional 221:5
conjunction 27:2 27:15 359:12 395:8
connect 23:12 207:14
connected 149:13 175:5 428:8 443:6
connecting 62:7 222:12 226:16
connection 406:22 433:3
connections 68:5
connects 221:22
consensus 52:2
consider 124:8 179:15 263:8
consideration 287:1
considered 85:22 147:6 467:20
consistency 159:2 165:6,11 172:12 173:1,2 174:18 182:16 194:10
consistent 159:8 171:4 172:3 184:20 185:17 205:4 360:10
consistently 253:6
consolidate 66:17
consolidated 385:10
consolidation 222:5
Constance 1:16 5:5 7:2
Constantine 1:15 6:14,15 59:2 86:8 91:4 176:19 294:2 297:6 298:15 314:7
constrained 340:19
constraint 14:9
constraints 232:6 380:8
construct 214:10
construction 191:15
consultant 238:2,3
consuming 418:20
contact 16:1 17:4 25:2 30:6 59:18 64:5 84:2 149:19 260:22 311:2,14 312:1 362:6 403:5 431:7,11 432:16 432:19 433:14 442:8 447:20,22 448:1 450:8 455:3 456:9,10 462:20
contacted 455:2 456:6,7
contacting 309:15 449:9 454:5 462:18
contacts 462:16
contain 234:20 236:5
contains 253:17,18 322:6
continue 68:8 97:6 130:7,13 151:9 154:10 166:2 208:4 217:7 274:9 306:19 360:18 361:5,9,13,15 409:15 416:8 417:3 418:2 425:15 430:12,22 431:7 432:12 434:18 459:22
continued 35:14 76:6 80:14 153:6 379:8 384:7 392:6
continues 362:14
continuing 173:13 221:17 393:11 426:15
continuity 188:21 194:10 222:1 282:9 385:10,13 386:5 387:5 419:7
continuously 431:8
continuum 134:2,5 174:14 259:8 269:14 280:15 310:10 312:15,19 371:5 372:5 395:2 432:5 436:5,6
contract 103:8 130:2 194:1 221:12 303:22,22 348:12 366:3
contracting 194:9
contractor 102:20 103:2 419:6,10
contractors 189:21
contracts 235:5 303:20 304:2
contradictory 308:2
contrast 57:9
contrasting 24:20
contribute 31:20 361:13
contributed 419:2
control 14:19 234:11 269:20,21 415:22 416:6 418:21 422:8
CONT'D 2:1
conventional 61:3
conversation 53:12 241:3 298:5 304:13 337:8
conversations 240:22
conveying 236:1
Cook 8:10,11 17:13 354:16
cooperated 31:17
cooperating 60:17
coordinate 449:8
coordinated 403:16 439:18
coordinating 373:19 458:19 459:4
coordination 2:16 5:8 7:3 172:1 321:20 363:5,12

363:14 381:4 397:21 399:5,8,10 432:18 437:12,15 437:21 438:8,16 438:20,21 439:16 440:10 442:13,20 445:16,19 446:11 449:11 454:12 467:9 468:2
coordinator 219:18 220:8,10 255:8 373:11,19 398:7 401:17 407:5 445:9 447:5 449:15,18 462:18 463:5
coordinators 17:1 256:5,21 258:21 341:11 346:6 347:7 371:7 384:8 388:11 400:2 405:19 412:22 439:2,10,20 440:15,21 441:11 441:14 443:16 453:1 454:5
copies 142:9,10 197:22 261:16,16 350:10
copy 50:5 159:21 160:1 325:11 453:18,22
copying 160:5
cornerstone 168:16
Corporal 165:9,10 171:8,8
corporations 342:21
Corps 5:5 7:17 9:9 35:11 67:21 68:1 68:2,5 91:19 174:22 177:3 368:7,9 431:9
correct 10:15 23:4 42:21 63:1 66:15 91:7 112:20 113:16 116:18 124:4 166:10 171:12 188:17 218:18 255:5 299:15 343:20 366:9 368:19 370:18 372:8 375:13 376:18 377:21 379:6 380:1 404:15 412:20 421:8 446:6 458:21 466:21
corrected 344:19
correction 147:16
corrective 417:10
correctly 142:1 190:13 191:1 192:15 199:20 208:18 209:20 429:11
correlation 135:21
corroborate 92:13
cost 1:23 103:7 153:18 154:20 158:9
costed 154:18
costing 153:1 158:19 206:18
costs 147:10 150:3 156:10 158:13 189:10 209:22
council 26:21 118:15
counsel 345:18 348:5
counseling 118:8 253:22 318:7 403:14 405:15
counselor 304:7 403:22 406:6
counselors 12:11 315:16 316:6 318:12 347:9
counsels 18:11
count 409:8
countermanded 19:6
counterparts 297:10 384:3
counters 279:15
country 166:6 281:18 343:14
county 345:4
couple 40:11 53:22 57:3 64:15 68:13 86:18 131:17 140:13 162:16 163:11,12 222:6 226:6 256:15 270:15 276:20 331:22 346:18 348:10 371:3 400:2
course 18:18 34:17 68:18 123:9 235:19 240:20 254:6 264:13 265:2,16 266:2,11 267:9 268:14 273:13,17 275:6 286:17 290:17 326:21 389:21
courses 19:6 234:17 265:4 303:8 327:7
court 466:14
cover 13:5 22:5 75:19 100:21 153:15 234:8 413:4,10
coverage 378:19
covered 115:13 147:1 187:2 378:14 436:20
covers 22:4 90:15 412:21,22 413:13
cowboy 336:13
Co-Chair 1:11,12 1:14,14 6:21
co-chairs 4:8 70:4 282:5
co-located 74:7
CPG 238:22
CPGs 234:2,7,12 235:4
CPT 182:8
crafted 66:3 245:19 332:17
crafting 40:10 55:1
Craigslist 58:8 59:15 65:1,6
crates 162:3
crawl 134:1 175:9 223:8
crawl-walk-run 134:5 148:22 174:14 175:14 205:12
create 31:18 93:20 98:9 243:19 244:16 311:4 426:10,13
created 23:4 65:15 72:5 152:16 199:10
creates 170:10
creating 311:2
creation 198:11
credibility 51:20
credit 184:8,9 190:10 214:5
crisis 395:3
criteria 172:16 173:8 273:5 274:9 409:1 435:1,2 445:6 452:11,13 464:2
critical 41:14 47:6 132:4 147:17 148:2 163:10 181:2 201:7 282:8 360:5
criticality 210:17
critically 259:16 460:3
Crocker-Jones 229:7
Crockett-Jones 1:12,14 4:10 6:22 7:1,13 9:18 15:17 22:14 23:18 32:5 50:3 59:3 62:19 70:6 88:8 130:17 181:22 186:6 219:14 255:6 285:8 310:19 449:7 450:6 456:16 459:15
cross 148:11 270:13
crossed 184:18
crossing 24:17
crosswalk 260:6
crosswalked 260:3
cross-program 92:1
cross-service 92:1 104:16
cross-survey 92:1
Crown 1:10
CRP 9:21 182:8 185:21 200:14,15 200:22 201:17 202:19,22 203:1,4 203:5,7 206:12,17 207:20 209:17 220:14
CRPs 202:2,5 203:13 204:22
CRP/CTP 382:20
cruise 435:17
crunch 54:15
CSM 1:15 6:3 171:12 173:18 174:1,3 193:21 302:18 303:19 334:11,13 338:21 392:2 393:6 394:5
CTP 9:19 18:21 22:15 23:1 201:2 206:17 220:15 242:13,14,15 243:11,21 244:15 244:21 245:20,21 247:3,5,19 253:9 258:5 261:17,18 332:18 350:10
CTPs 236:19

248:20
cultural 169:11 311:19 396:19
culture 167:16
cumbersome 244:7
cumulative 72:22 108:21 109:16 116:22 122:6 123:6 126:1 127:15,17
curious 82:13 298:18
current 66:16 103:8 114:7 125:18 130:2 220:17 276:22 302:7 307:3 398:10
currently 45:11 199:10 219:10,16 220:18 221:1 260:5 291:14 366:5 368:4 384:20 387:15 389:14 391:14 399:2 408:14 421:7 431:4
customer 199:17 215:11 219:5
cut 34:2,7 347:21 392:11
cuts 33:21 34:14,22
cutting 161:15 388:4,5
Cyprus 195:7
C-O-N-T-E-N-T-S 3:2

D

D 1:15 131:9
dad 293:8
Dailey 4:3,11 5:10 13:7 14:2 16:13 26:7 31:7 35:19 38:16 45:5 46:16 48:3 51:7 52:19 53:11 54:21 68:19 69:14 91:7 127:8 127:12,15 128:3,8 128:11 131:12 160:7,13 186:18 187:1,4 227:14 344:3,6 349:2,13 349:15 350:4,12 350:15 355:15,19 404:18 411:11,16 411:21 412:16 413:3,9,16,19 414:2,5 437:16 448:3 466:16 468:3,7
Dan 243:11
Danny 245:18 308:9,22
dark 40:5 47:8
Darryl 2:17 228:6 229:9 248:18 267:15
dashboards 29:8
dashed 104:13
data 28:7 38:3 40:3 41:13 42:1,7,8 50:12,16 73:3,8 76:8 78:11 80:9 82:5 86:5 87:17 88:7 89:8 92:6 94:15 95:9 98:2,7 98:8 99:7,14 100:2,13 101:6 103:4 106:8,11 111:7 114:13 115:3,13,17 116:8 117:10 122:10 123:6 126:6,11 128:1,11,13,18 132:4,12,20 133:7 133:15 137:10,12 137:18,21 138:3 138:11,16 141:3 143:3 190:15 191:4 196:5,13,19 198:12,14 235:15 247:16,19 248:1,5 249:14 250:3,9 303:15 349:7,9 359:9,11,13 372:2 385:5 416:17,19 453:6
database 89:11 90:14,15,22 103:3 199:9 322:4,19 323:3 324:22 325:11 368:5
databases 161:6 368:3
data-driven 249:4 249:15 357:13
data-gathering 40:1
date 83:7 231:15 441:12 454:9
dated 393:9
Dave 5:20 10:13 50:22 160:10,15
DAVID 1:19
day 28:1,20 96:6 114:4 141:22 142:1 146:16 150:13 176:2 204:5 261:19 262:2 277:5 284:15,16 338:16 343:5 351:1 416:9 468:8
days 29:1 68:13 74:5 76:10 134:11 146:7 148:3,4 150:8 156:18,19 161:21 243:21 262:2,2,15 265:17 329:18,18,18 335:9 342:12 346:18 354:5 388:14,18 389:4,7 393:20 415:11 418:15 443:17 445:10 447:18 449:22 454:6
DCoE 214:22 216:8
DD-214 33:10
dead 379:4
deal 64:7 104:7 117:19 123:17 176:6 177:12 455:16
dealing 43:10 168:4 407:2 412:9
debate 114:21
deceased 413:5,6
December 7:16 131:6 164:1 228:15 253:18 350:13 355:22 393:9 431:20
decentralized 360:1 412:10
decide 44:21 50:17 153:14 247:14 300:14,22 304:18 313:7 375:6 447:13
decided 56:21
decides 239:20
deciding 158:4
decision 42:18 43:2 100:3 129:20 130:14 224:11 233:16 335:2 360:2 362:10 369:15 370:10 375:11 376:8,22 381:18 392:21 421:6,10,17
decisions 133:4 197:14 273:7 370:7
declaring 226:5
declination 304:17
decline 300:15 305:6,6 420:3
declined 96:22 111:2 301:5,9
declining 305:22
decompression 195:7
DECOs 199:13
dedicated 330:10
dedication 350:18
deep 164:13 246:1 298:4
deeper 248:5
DEERS 83:5
defaulting 177:9
Defense 1:1,23 30:15 69:22 71:6 83:5 99:17 101:8 101:19 119:6,22 119:22 133:8 139:1,11 154:5 163:22 178:3 180:16 212:6 216:11 218:22 439:7 441:7
deference 15:11
define 85:17 115:10 171:19,20 320:15 323:22 451:10,14
defined 84:14 264:7 334:19,19 461:14
defines 460:6
defining 430:20,21 435:22
definitely 10:15 64:21 66:4 110:15 111:2 254:1 374:11 378:10,22 380:10 422:15
definition 73:18 166:12,14 168:3 170:9,14 181:9 183:11 193:7 332:13 460:4
definitions 85:15 169:5 183:16 193:15,16 206:17
definitive 452:20
definity 448:16
Def's 120:18
degrees 141:17
DeJONG 1:15 6:3 6:4 171:12 172:21 173:18 174:1,3 193:21 302:18

303:19 334:11,13 338:21 392:2 393:6 394:5
delay 42:18 43:2 277:2 278:11 438:5
delayed 245:7 349:8
delaying 21:10
delays 367:2
deliver 255:13 291:5
delivering 184:20 185:20 258:9,13
delivery 121:2,7 258:6 383:19 433:22
demand 121:1 279:20
demanding 199:17 215:11
demob 300:14 302:21 303:9 305:18
demobilization 301:10
demoed 287:4
demographics 225:7
demonstrate 51:20
demonstrated 287:8
denied 454:20
Denise 13:5 14:21 38:15 43:22 46:11 48:16 53:9 54:17 129:16 186:22 187:3 348:14,22 451:5
densities 190:5
dental 322:7
dentists 304:1
deny 377:4,4
depart 77:10
department 1:1 30:15 35:4 69:22 101:8 104:20 119:6,22 139:1 147:5,10 153:22 154:4,5 187:9 320:14,22 352:1 439:7 441:6
departments 147:16 149:5 154:2 213:21
Department's 210:19
depend 130:13
dependable 18:15
depending 72:12 91:2 94:19 111:7 467:1
depends 458:5
deploy 426:17,18 427:5
deployability 323:16
deployable 29:18 426:16 427:4
deployed 75:6 85:17 298:21 417:17
deployers 86:22 87:14 88:2
deploying 36:12 190:20
deployment 3:9 71:10 74:11,14 81:7 84:18 85:10 86:1 87:18 112:8 118:5 284:10
deploys 87:2
depressed 136:21
Deputy 6:18 156:6 174:20 190:10 213:21 217:18,20 304:14
DES 8:10 16:5 114:7,10 132:16 137:10 375:13 376:18 380:21 405:5 420:1 421:7 421:9
describing 312:19
deserve 357:17
deserves 184:7,9 396:1
designate 461:2
designated 183:7 255:7 383:1 460:21 462:15 465:1
designation 463:14
designed 139:16 143:14 209:5 269:2,3 322:9 323:14 326:19 332:20 394:6,6 442:17
desire 148:20 422:16
despite 360:22
detail 113:10 261:21 263:5 353:8 418:11
detailed 114:8,15 115:13 119:13
details 357:8
determination 301:17 375:2 452:20 465:15 467:7,13,18
determinations 305:12 453:2
determine 106:13 211:7 236:10 254:15 317:22 466:11
determined 135:5 301:2 394:2
determines 463:2
determining 275:16 409:16
devastating 232:10
develop 71:12 83:13 102:21 226:9 235:10 238:21 285:18 357:13 360:19 407:20 433:9
developed 44:12 72:1,10,11 238:7 275:14 286:1 323:7,9 324:13 363:4 371:13 384:12 443:20 467:18
developer 56:6
developing 103:3 234:7 236:6,12 242:15 285:6 365:2 368:4 442:6 444:15 457:4
development 56:8 92:5 112:16 238:14 364:21 431:14
diagnosis 234:4 378:2,16,17
dial 133:1,2
dialogue-type 164:7
dichotomy 10:6
Dickey 395:14
did-you-know 309:11
Diego 90:4 162:6
diem 14:6
Dietrick 403:11,12 404:5,15
difference 98:1 149:6 157:22 316:15 320:10 417:2 423:15,22 424:7 459:14 461:10
differences 70:22 153:6 172:15,16 460:17
different 9:17 12:7 45:9 49:13 70:17 72:14 80:3 85:14 112:17 116:12 117:1 118:17 119:7,21 139:21 166:15 167:13 172:21 173:8 196:2 201:1 204:17 205:1 212:2 240:13,13 246:7 255:15 280:17 289:19 309:12 341:16 344:17 346:17 363:11 365:20 376:6 380:13 381:10 428:10,11 441:5 447:3 448:17 449:19 450:3 457:10 458:11 460:19
differential 85:12 85:15
differently 80:9 201:12,13 375:19
difficult 20:6 23:8 23:9,9 45:19 51:15 148:15 152:5 165:3,16 169:10 170:11 173:12 207:13 410:5 459:9 466:2
difficulty 251:10 378:1
dig 209:3
digging 418:16
dignity 269:11
dimension 58:14
dinnertime 181:3
direct 346:18
directed 198:8 294:15
direction 128:17 144:6 166:16 184:13 226:18 452:2
directive 21:6 221:4 442:15
directly 90:5 163:8 178:9 239:21 381:19 412:9 462:13
Director 1:25 2:1 2:15 5:7 6:9 32:17 70:7 130:20

155:21 160:11 437:14
directorate 2:11 270:6 385:19 398:17 430:5
Directory 219:21 220:6,12 222:2 223:4,10,13,19,22
directs 253:16 393:9
dirt 266:5,5 267:5 267:6
disabilities 318:9 318:21
disability 2:5 12:17 72:16 89:10,13,16 90:19,20 96:10 104:9 112:6 113:1 113:4 114:5 115:10 118:19 119:2 120:5 122:6 140:21 141:1 144:9 146:5 147:11 151:10 159:6 231:5,14 300:7 327:17 331:1 353:9 354:7 424:10,15
disabled 466:22
discharge 452:6
discipline 169:4
disclosable 28:7
disconnect 44:10 331:6
disconnects 44:6 151:9
discount 127:18
discovered 286:9 412:4
discretion 338:15
discuss 17:22 70:20 70:21 96:4 102:3 130:5 137:17 230:18 233:10 356:9 421:14 429:22 453:5
discussed 61:11 152:6 230:12 358:20 399:22 417:21
discussing 457:2
discussion 10:16 45:6 84:16 102:4 212:16 213:4 289:7 448:12 457:16 460:15
discussions 212:13
disease 198:10
disparage 279:10
disparity 299:6 303:11,13
disqualifying 159:5 159:7 361:10
disrepair 71:19
dissatisfaction 151:12
disseminated 264:9
disservice 419:20
dissipate 189:3
distribute 66:2
disturb 75:11
dive 298:4
divest 398:11
dividends 194:21
division 2:12 26:11 26:18 27:6,10 28:2 31:11 63:15 277:17 374:7
divisions 278:1 279:9 328:13
division-wise 27:21
divorce 134:19
doc 240:11 243:18 244:10 256:19 268:17 269:2,5 270:17 271:5 272:18 353:14,15
docs 268:16 304:7
doctor 6:17 157:3,4
doctors 26:22,22 142:17 189:12 195:10 214:8 247:8 303:22
doctrine 185:10 211:10 321:1
document 46:22 184:3 201:7 236:3 246:1 253:12 339:17
documentation 340:7
documented 229:20 414:10 442:14
documents 46:20 51:16,22 168:2 273:11
DoD 1:11 8:16 12:2 35:1 64:4,18 76:20,22 77:4 118:17 125:21 129:3 131:5 133:12 136:9 151:11 152:4,13 153:7 154:9 155:5 157:3 158:1 159:18 161:11,16 174:8 190:19 198:13 201:12 203:22 211:3,13 216:9 217:3,20 218:2,3,11 237:4 257:13 315:15 341:12 357:19 382:17 383:8 394:22 404:8 407:21 408:6 409:15 430:14 448:22
DoDI 171:22 176:12,16 178:19 179:12,19,22 211:17,17 213:13 280:13 301:15 382:22 383:1
DoDIs 179:7
DoD's 218:3
DoD-level 254:5,17
DoD/VA 111:11 153:16 158:8 238:6 241:22
dog 376:8 421:9
doing 9:3 12:5 38:5 38:6 39:5 54:7,13 61:1,2,4 63:9,14 70:19 72:19 76:18 95:17 111:17 125:21 126:10,15 151:3 156:17,19 175:22 181:2 182:3 184:2,8 198:6,6 201:16 206:4 216:6,7 217:5 222:15 226:5,7,18 227:8 229:16 239:11 247:2 278:12 280:20 284:9 286:14,15 289:21 290:13 296:15 297:17 299:7 303:7 313:1 339:5 341:18 353:15,15 373:8,15 380:13 386:7,8 392:4 400:16 406:8 414:18 416:16 426:3 433:10 440:11 443:4,7 448:10,20
DOL 333:16
Dole-Shalala 439:12 466:18 467:3
domains 92:17,22 94:5 246:12,14
dominant 168:14
dominating 394:16
door 311:3,12,18 312:9 452:5
dormitory 191:16
dotted 184:19
dotting 24:16
double 196:10 216:3 451:15
doubt 137:14 149:14 176:17
Dover 398:15
downgraded 379:7
download 207:7,8
downloadable 208:8
downrange 259:8 259:12
downstream 48:5 142:11 157:8 202:12 259:12
downward 97:13 108:13 110:18
dozen 401:18
DPAM 421:18
Dr 6:16 7:10 18:2 19:18,19 22:21 24:5,16 25:11 27:19 29:19 32:14 33:5 39:1 49:10 50:21 51:6 59:11 60:8 63:8 65:11 69:9,19 70:3,7,12 70:14 75:17 82:19 84:13 86:13,17 87:5,15 88:6,11 88:21 89:6 90:12 91:21 92:4 97:4,9 98:4,6,22 99:10 99:18 100:15 101:17,22 102:8 102:19 103:13 105:1 106:12,15 111:13 113:9,16 114:11,22 115:2,8 115:18,21 116:1,9 116:10,11,18 117:5,13 119:11 120:6 121:11,21 122:3 124:4,17,20 126:20 127:6,10 127:14,16 128:7,9 129:22 130:18 156:8 157:21 169:2 180:9 183:6 192:17 203:20 206:16 207:2,11 209:21 210:21 211:12,15,20

212:3 236:14,16 237:16 239:3 251:4 252:15 284:19 287:6 288:21 308:11 343:19 344:5,18 345:3 359:16,21 364:12,15,19 366:1,6 384:12 391:9 409:5,11 418:4 419:3 435:8 435:12,15,19 438:14 444:8,18 444:22 447:7 455:14,16,21 456:12
draft 366:15 367:5
drafted 415:3
drafting 399:20
drag 146:12
draw 67:19
drawing 391:6
drawn 103:17
draws 232:8
drill 303:18 351:22
drive 165:12 170:22 172:3 187:11 193:16,17 193:18 195:16 249:4,15 275:5
driven 188:15 331:2
drives 206:1
driving 174:17 175:1 201:17 208:12 434:14
drop 81:17 171:10 176:1 388:21
dropped 85:5
drove 233:14
DTM 274:21
Dudeck 245:17,18
DUDEK 309:2
due 290:16 361:10
duplication 448:12 449:6
duties 27:1 42:22 71:17 105:6 106:19 107:2 108:1,9 109:18 180:13,17 392:14 426:6
duty 24:21 26:15 27:5,17 72:12 145:11 159:7 216:5 233:19 236:11 243:5 294:6 296:3 297:9 298:7 299:13,17 299:18,21 301:15 301:16 302:10,13 302:14 338:16 342:6 344:9 360:12 369:2,4,14 369:17 371:10 383:6,17 384:3 385:16 386:1,15 386:20 388:22 391:3,12,17,18,21 392:19,22 393:1,3 393:14 394:2,3 419:9 426:2 432:13 468:1
dynamic 10:2 199:7
dynamics 12:6 19:3
dysfunctional 26:6

E

E 228:21
eager 143:10
earful 315:5,7
earlier 6:6 15:6 54:14,19 80:11 173:19 189:11 214:16,18 216:1 222:19 255:2,21 287:15 288:9 294:12,22 373:3 373:13 414:16 422:3,10 423:12 429:22
earliest 47:10
early 19:11,16 110:12 371:15 410:7 420:1 441:20
earth 163:19
easier 57:17 221:8 289:1
easiest 73:19 196:12
easily 463:14
easy 11:21 61:2 120:10 165:18 171:7
easy-to-read 324:15
ebbs 281:2
eBenefits 149:19 226:14 453:20,22
eBenefits.gov 221:21
eclipsed 226:13
EDES 146:4
edge 161:15
edict 165:18 171:10 173:16
educate 259:22 306:20 396:18
educated 362:6 382:12
educating 196:21 361:22
education 1:22 15:3 20:21 22:4 206:14 231:10 259:21 302:18 332:6 333:11,12 342:1 346:15 347:9 374:1 401:10,20 408:3 418:11 441:3,11 450:16,18
educational 16:9 30:12 402:9 440:19
effect 81:20 126:1,4 127:18 158:18 205:17
effective 9:15 37:21 60:5 62:7 136:15 368:13 370:9 396:4
effectively 9:8 213:19 368:6 370:15 400:16
effectiveness 46:19 205:7 367:18
effects 81:12
efficiencies 430:6 430:10
efficiency 143:22
effort 4:13 66:17 135:11 136:3 318:11,18 364:9 386:7 391:2
efforts 55:18 56:9 56:22 64:16 66:10 69:3 71:7 175:8 188:21 214:14 221:8 231:16 367:3 448:12 449:6,8 453:17 455:2
eight 94:3 114:17 418:6
eighth 353:18
either 27:14 61:21 67:5 90:3 110:19 165:2 200:11 213:5 233:19 250:6 266:2 268:12 269:14 288:3 295:20 296:9 338:19 342:1 365:11
elaborate 300:11
elbow 157:9
elective 21:7
electronic 9:20 29:1 160:2,9,17 161:12,15,20 205:2,4 206:20 210:5 291:7 325:7 325:10,13,15,22 463:15 464:13
electronically 201:10 323:13 454:1
element 148:9 151:5 190:1 249:2
elements 323:21 333:19
eleven 194:3
eligibility 83:5 435:1,2 442:12 445:6 452:11
eligible 333:7 338:4 338:4,8,11,12
eliminate 149:8
eliminating 184:5
elimination 227:3 429:18
Elmendorf 406:7
email 39:20 68:7
emailing 61:5
emails 39:20
embarked 329:7
embed 194:17
embedded 257:15 257:18
embraced 167:17
embracing 167:15
emergencies 115:5
emergency 21:8 437:17
emotional 148:20 246:13
emotionally 320:18
emphasis 454:2
emphasizes 183:10
employed 434:4
employee 189:16
employers 342:19 343:15 397:11
employment 30:7 315:13 318:8,22 333:14 342:11,16 343:6,18 344:4,14 344:16 347:13 365:20 374:1 402:16
employment-rela... 30:9

empower 259:22
empowered 16:22 258:21
enables 324:8
enabling 332:21
encompass 334:14
encourage 344:10
encouraged 402:20 403:15
encouragement 240:9 404:19
encouraging 239:17
ended 54:2 139:20
endorsed 165:4
endure 252:3
enduring 232:4,14 396:8
enforce 179:19 339:2
enforced 180:5,7 180:11
enforcement 31:13 208:20 209:9
engage 442:4
engaged 15:5 102:16 284:3 373:4
engaging 249:10 382:18
enhance 37:12
enhanced 137:2 330:12
enhances 426:1
enhancing 34:3
enjoyed 8:6
enlisted 20:20 30:22 80:2
enormous 155:14
enroll 446:16
enrolled 453:21
enrollment 83:5 445:5 446:4
ensure 230:10 233:13 253:3 254:7,22 257:9 264:7,18 273:5 274:10,13,16 276:1,8,12,14 289:9,22 320:17 322:15,17 331:12 360:10 362:6,16 383:19 384:5,13 391:13 395:1 402:15 403:3 408:1
ensured 195:21 250:12
ensures 231:3 322:19 396:3
ensuring 234:22 253:8 290:4,12 321:19 382:19
entail 14:6
enter 451:11,16
entire 60:20 66:14 131:12 145:9 183:16 358:21 382:20
entirely 14:22 166:15 373:6
entities 398:13
entitled 301:14,16 384:10
entitlements 362:7 394:11
entity 316:20 331:8 418:16
entrance 273:5 448:19
entrepreneurship 206:13
entries 59:4
entry 65:1 221:6
environment 39:21
environments 31:19
EOD 425:21,21 427:10
eProfile 323:5 324:21,22 326:11 326:18 327:9 427:17
equal 263:9 289:17
equation 195:9
equipped 410:16
equivalent 82:9 289:13
era 232:6
eradicate 185:11
erratic 122:18
escalates 147:11
escalating 28:4,7
escaped 372:13
especially 30:11 32:16 74:8 95:14 120:4 179:14 190:2 199:14 226:1 245:13 313:14 321:13 363:3 460:3
essence 104:20 121:4 124:10
essential 136:13
essentially 192:3 197:18 375:4 417:22
establish 231:16 236:8 448:1
established 56:11 56:16 64:3 273:6 274:8,18,21
establishing 198:10
estimates 81:1 247:17
estimation 201:19
et 12:11 66:14 218:16 242:19
ETA 349:20
ETI 316:4
European 222:21
evac 84:22
evacs 80:14,15
evacuated 74:2 78:13,22
evacuation 73:20 76:10
evacuations 76:7
evacuees 74:16 75:2 76:14 103:19
evaluate 79:11 98:13 380:11 383:18
evaluated 97:12 376:9
evaluating 51:22 156:9
evaluation 1:23 2:5 3:11 72:17 89:10 90:19,20 91:12 96:10,11,12 104:9 110:2,6 112:6 114:5 118:19 119:4 120:2,5 122:7 146:5,17 158:12,15 231:5 231:14,18,18 300:7 327:17 353:9 354:7 362:9 375:2 407:22 441:17 445:8,10 453:1
evaluations 70:8 131:5 361:3
Evans 1:16 5:5,6 7:2,3 56:4 89:14 159:11 255:2,9 256:1,3 258:3 308:15 316:14 451:5
evening 40:18
event 65:7 115:9 384:22 391:2
events 12:7 58:10 65:2 167:2,3 363:19 399:22 432:18
eventually 17:19 404:7
everybody 5:3 38:17 45:10 67:11 91:7 166:7 167:10 171:11 201:14 202:18,22 203:1 203:16 204:3 208:7 229:4 248:20 261:6 263:9 351:5 401:15 438:5 441:12
everybody's 68:14 188:14 245:8 445:2
everyday 295:22
everyone's 228:7 263:16
everything's 124:2 151:18
evidence 62:1 241:1,6
evidence-based 248:8 249:15 357:20 395:7,16 395:19,22
exacerbation 395:3
exact 183:1 252:12
exactly 100:18 105:2 119:1 210:12 243:13 314:15 364:6 365:16 368:15 393:7 406:2 426:2 426:21
examine 181:18
example 21:4 65:3 67:1 101:2 103:15 105:15 110:20 114:17 117:8 120:17 136:14 142:3 178:15 180:2 192:5 195:8 206:2 238:15 262:6 267:11 362:1 392:18 401:9 444:19 463:17
examples 98:18 99:1
exceeding 80:22
Excel 286:11
excellence 141:18 167:11 184:5,6 204:21 214:16 215:1,8 216:21 218:22 219:1

excellent 27:20 33:12,12 183:13 229:19
exception 80:2
exceptionally 12:5
exceptions 100:18 376:13,14,15,17
excess 170:19
excited 5:4 288:13
excluded 75:5,8
exclusive 76:17 257:17
excuse 5:20 41:5 53:18 260:14
executing 134:12 170:16 171:3 347:4
execution 154:21 170:22
executive 2:14 6:9 66:16 118:15 131:21 139:6 155:20 437:14
exercised 190:18
exercises 363:19
exhaustive 137:11
exist 58:5 60:22 235:8
existence 234:13
existing 179:17
exists 162:19 183:1
exit 448:19,22
EXORD 329:20 330:20
expand 75:18 194:1 242:4
expanded 76:4,13 104:1
expanding 194:9 254:12 257:1 258:17
expansion 188:12
expect 35:2 87:11 197:2 218:15 242:21 245:16 247:7 262:8 316:11 333:13
expectation 150:18 197:12 216:11 240:19 241:2,5 242:2 243:8,18 245:5 264:22 366:21
expectations 196:7 196:15,22 197:17 201:4 216:2 242:10 244:3 261:19
expected 197:16 235:18 275:21 357:18 467:22
expecting 190:7 349:21
expedient 81:15
expedited 146:4 330:14 424:14
experience 11:17 59:3 75:20 81:8 96:15 106:22 109:6 110:1,7 114:1 118:8 186:12 193:19 196:4 204:13 220:1 221:19 236:21 247:8,10 247:20 249:5 260:21 410:3
experienced 310:20
experiences 61:15 117:1 427:12
experiencing 76:1
experiential 79:13
expert 230:21 243:11 375:5 395:15
expertise 85:20 192:4 238:12 394:11 452:22
experts 99:13 230:11 354:16 356:15 357:6 382:12 441:6 451:20
expires 130:3
explain 258:3 316:21 356:18 363:2 390:15 398:2
explained 109:20 302:19,20 304:10
explaining 361:22
exponentially 64:14
exposed 319:19
expound 207:3
expressed 108:17 162:8 294:4
extend 210:5
extended 388:19
extensive 71:15 190:9 275:7 439:5
extensively 321:4
extent 71:13 81:8 95:11 104:1 317:12
extenuating 417:14
external 363:5,12 363:13 397:8 399:10
extra 39:3 58:14 65:7,10
extras 151:21
extravagant 415:17
eye 94:22 122:9
eyes 48:22
eye-saving 21:8
e-profile 28:18 29:7
E4 26:3
E5 26:3

F

F 356:3
FACA 64:19 163:19
face 43:1 58:15 166:22
Facebook 56:16,21 57:4,18,22 59:14 60:9 67:7 222:13 265:18 309:7 397:13
facilitate 240:22 241:3 426:7 450:12
facilitated 450:7
facilitates 396:3
facilities 71:8,18 92:12 95:16 111:15 112:17 123:9 126:8 127:20 170:17 458:7
facility 31:12 32:2 71:19 75:9 126:13 138:9 271:3 287:2 404:1 407:9,9 441:21
fact 29:21 34:2 40:15 44:16 85:17 97:10 117:20 147:21 166:9 181:13,14 203:6 232:7 256:15 266:10 270:17 273:13 289:11 301:22 303:7 304:14 310:3 328:7 339:2 359:8 375:20 378:17 380:3 394:12 426:13 434:8,11
factor 151:11 156:10
factored 158:11
fail 147:21 148:8 148:10
failure 433:15
fair 181:21 303:6
Fairfax 1:10
fairly 210:12 420:2
fairness 120:16,21 226:21
fall 11:7 36:6 199:1 263:10 278:13 280:1 340:3
familiar 56:5 138:19 325:12 409:6 463:12
families 12:6 20:12 33:7 149:15 198:1 230:5 244:3 259:2 290:22 291:6 296:5,12,17,20 307:6,20 308:17 309:13 310:16 311:2 312:6 313:10 335:12 339:3 342:18 357:16 358:16 364:8 368:16 370:11 396:10 397:6 439:1 442:5 455:18
family 5:7 7:3 8:22 9:2 15:18,21 16:14 17:1,4 33:15 47:1 118:9 135:1 137:9 147:1 150:17 151:22 167:7 181:3 183:19 193:13,19 201:6 208:8 216:3 220:4 246:13 257:10 259:17 264:3 290:9 291:18 292:12,19 292:20 293:7 298:12 303:3 306:21,22 307:4 307:15 308:1 309:4,15 310:6,8 314:2,3,6,10 315:5 343:2 359:2 362:13,13,16 365:18 378:12 382:19 396:5 397:3,7 408:4 413:7,13 444:1,14 460:1 466:14
family's 261:3 310:2
Fanning's 318:4
fantastic 184:6 192:9 221:22

327:14
far 14:16 64:2 70:22 134:13 140:4 148:6 157:7 176:10 177:19 191:4 195:18 197:4 201:4,11 209:3 215:10 220:19 237:5 276:4 304:3 344:14 365:1,6 368:13 373:8 374:8 378:20 384:20 386:10,19 386:22 387:20 388:1 390:11 398:6 437:17
farther 172:10
fashion 352:4
fast 39:15 140:20 145:20,22
faster 142:11
father 336:2
fault 321:15
favorable 106:3 107:16 109:14 110:13 113:17 116:14 119:17 122:21
favorably 96:22 107:14
feasible 287:3
February 1:7 39:9 71:5 72:1 315:13 360:17 384:22
federal 2:15 21:20 67:6 333:6 342:20 343:22 344:12 345:6 405:19 437:11,14,21 438:8,15,19 439:2 439:8,10,20 440:9 440:15,20 441:7 441:10,14 442:6 442:12 443:15,21 445:8,19 447:5 449:14,17 452:22 453:18 454:4 462:17 463:4 467:9 468:2
FedEx 161:22
FedExed 162:4
feed 65:19 67:17 71:22
feedback 9:2 12:4 41:20 117:4,11 132:14 206:5 295:20 410:4 411:4
feeds 57:13
feel 11:8,9 12:13,21 58:15 77:3 181:14 241:14 251:6 273:12 359:13 395:16 435:16 446:12
feeling 182:6 202:11 332:3
feels 211:5 427:4
felt 20:4 50:9 202:11
fewer 125:10 221:18
fidelity 129:13
fiduciary 465:22
field 71:13 72:18 128:20 134:6 139:18,19 140:7 143:11 148:12 253:20 264:10 265:8 288:17 319:20 352:15 368:5 375:7,9 407:6 411:5
fielding 103:6 136:3
Fifteen 409:6
fifth 122:16 272:1,1
Fifty 351:20
fight 135:1 221:15 451:21
Fighter 333:6 334:6 341:14
figure 126:14 143:5 144:4 153:16 180:20 189:9 364:6
figured 84:15
figures 64:20
figuring 154:19,21
file 160:18 161:16 161:20
files 197:22 383:4
fill 18:22 87:3,4 93:14 202:22 207:20 408:7
filled 5:12 33:3
filling 201:5
fill-out 203:18
final 54:4 159:1 195:15 432:7
finally 71:12 78:18 398:18
financial 33:9 292:12
financially 332:21
find 13:2 23:22 28:9 50:1 78:19 115:3 141:17 143:21 156:21 198:13 202:15 209:3 213:4 223:8 224:11 228:22 237:13 263:20 279:5 301:7 303:2 311:9 316:6 323:3 328:22 336:20 337:5,12 341:19 342:1 353:18 360:4 364:7 367:13 373:16,21 426:3 459:22 464:14
finding 88:20 89:7 129:6 361:15 367:12 449:3 450:8
findings 51:19 141:5 230:7,9 290:19
fine 169:15
finish 288:10
finished 45:11 134:4 314:18
finishing 42:13 132:9 177:16
Fink 156:1
firm 225:4,19
firmly 273:6
firms 210:3
FIRP 443:20 444:12 445:3 447:18 453:19,22
first 11:15 13:13 15:19 30:6,14 39:7,10 40:8,12 46:4 56:19 63:9 69:19 80:15 83:1 84:21 87:7 93:1 102:2 132:9 134:6 134:20 149:8,17 152:1 156:14,16 157:16 164:18 175:14,16 177:2 177:16 180:10 184:15,16 188:13 189:5 190:14 192:2 204:2 217:6 233:12 236:18 248:2 278:20 281:9 288:14 309:9 334:21 336:4,5 337:18 357:12 385:9 392:12 393:6 401:13 417:5 441:20 463:16 466:9
fiscal 56:9,10,17 59:21 232:6
fist 221:15
fit 199:2 418:17
fitness 246:12
fits 98:11
five 55:9,21 69:4 70:19 76:6 78:9 79:5 81:4,4 84:14 93:10,11,12 94:2 96:16 100:22 103:19 104:14 107:9,17 108:5,11 109:17 110:8,11 124:7 139:14 140:8 147:19 219:2,5,6 271:19 284:16 286:6 300:8 346:8 355:10 417:16 427:19
fives 98:8 105:14 108:22 109:15
five-point 93:15,19 105:12 107:22 108:2 111:2
fix 18:5 142:13 181:3 210:3 268:20 287:11 294:9 299:7
fixed 135:13 157:6 416:21
fixing 185:5
flag 214:2
flat 110:18
flavor 171:9
FLETC 31:13,16 32:2
flew 223:1
flexibility 452:17
Flight 403:5
FLO 378:12 413:13
flood 400:14
floor 352:7
Florida 44:4,7 162:5
flounder 382:9
flow 191:22 398:18 398:19
flows 281:3
flyers 60:1
FMG357 279:14
FOA 363:18,21 385:20 387:8 398:12 430:5
foci 351:16
focus 11:6 18:12

20:8,13,19 40:3,3 46:21,22 47:12 50:6,13 51:3,9 56:18 57:1 58:19 59:22 62:2 65:4 68:22 75:21 79:8 96:6 143:18 163:9 214:13 257:7 260:16 290:21 331:17 415:21 422:3,6 450:13 453:16
focused 74:15 75:14 77:16 114:4 136:3 148:8 261:6 318:6 346:13
focusing 108:19 402:2
foggy 374:18
folded 162:20
folder 9:11
folks 5:15 10:6 13:21 16:8 21:11 22:7 32:9 49:20 89:22 153:1 188:8 203:10 205:8 216:10 224:12 251:19 256:16,20 259:10 277:6 288:10 291:22 294:6 295:5 297:14 312:16 313:16 317:13 318:8 341:14 351:2 352:6 355:7 359:18 367:13 368:18 370:21 372:2 374:21 375:18 379:5 384:21 386:13 387:18 389:4,14 391:18 393:17 432:9,10 435:6,7 436:22 441:3 449:10 450:4 454:19
follow 13:16 57:11 60:9,19 70:11 116:2 160:15 184:17 214:19 218:13 351:7 423:5
followed 34:20 162:15 180:1 357:20 375:21 385:12 421:13
followers 57:8
following 60:13 63:19,20 71:4 222:15 330:1
followup 141:7 362:13
follow-on 52:7 331:22 409:14
follow-up 45:13 54:6 80:15 83:19 88:20 239:7
food 309:6
football 263:14,14 263:15
forbid 252:7
force 1:3,9 2:4,6,13 2:21 3:11,17 4:17 6:21 7:16 30:4 34:14 41:10,18,22 42:3 48:21 49:21 55:21 56:11 58:16 60:11,16 61:20 66:20 72:14 84:11 84:11 85:5 87:9 87:14 91:10 123:15 124:12 129:17 131:12 165:8 168:11 173:11 195:4 228:14 229:8,15 229:19 230:18 231:15,16 282:4 306:10 317:9 347:21 355:9,19 355:21 356:9,12 356:13,20 357:15 358:8 360:18 361:9,12,14,18,21 362:9,21 363:20 364:1 365:14 366:12 369:10 373:11,17 377:4,8 383:2 384:1 391:1 391:3 395:4 396:16,20,22 397:1,2,3,4,6,7,8 399:8 401:14,17 402:19,21 404:11 405:4 407:11 408:5,22 409:7,22 411:12 413:20 420:2 425:10 426:14 427:8,17 429:14,17 431:19 434:13 445:14,20
forces 1:4 48:4,7,9 48:10 53:1,4,14 85:19 321:2 329:11,21 330:5
Force's 122:16 355:20 396:7,14
foremost 334:21
foreshadow 190:8
forestructure 280:1
forever 178:16 210:7
forget 140:17 154:18 312:17
forgive 227:9 372:12
form 119:9 150:21 205:5 217:12 325:18
formal 51:2 288:8
formally 141:9 242:9 255:20 313:13
format 9:20 323:8
formation 334:20 335:20
formats 321:22
formatting 415:6 415:12 422:22
former 151:18 171:14 266:14
forms 77:9 85:13 204:17 255:16
FORSCOM 38:5
fort 7:17 18:1 26:8 31:8 35:5 36:6,14 36:16 45:11 48:14 48:14 123:14 138:13 140:10,10 162:4 190:20 192:9 257:17 258:4,8 267:20 271:13,19 272:4 277:12,12,16 285:17 286:8 297:16 303:10 342:10 343:10 345:5 353:1,2
forth 160:5 319:20 428:18,19 450:17 450:19
forum 58:21 217:17 468:9
forums 178:4 296:13 448:13
forward 155:7 164:10 184:15 194:15,19 208:15 213:8 214:11 240:6 276:18 335:22 430:1
forwarded 375:13
forwards 421:9
Foster 257:18
found 5:13 9:9 21:17 23:21 35:11 44:5 70:20 83:8 83:20 85:11 89:9 96:16 142:12 212:16 225:1 237:9 275:15 288:14 296:15 337:5 369:16 390:15
four 69:2,4 70:17 73:8 76:4,13 85:1 87:13,13 91:6 93:14 94:2 107:17 108:4 110:10 139:14 140:8 167:17 189:16 198:18 205:1 212:19 259:13 295:16 319:16 409:10 427:18
fours 98:8 105:14 108:22 109:14
fourth 100:20 122:16
four-plus 241:16
FRAGO-4 35:21
framework 240:18
frank 165:15 179:13
frankly 201:12 406:17
FRANKS-2 290:15
FRC 176:14 258:22 447:15 454:16,18 454:20 467:16
FRCP 3:20
FRCs 405:18 406:17 445:9 451:7 454:8 456:18 459:8
free 198:4 333:10 465:2
frequency 262:16
frequent 260:22
frequently 281:20 281:22 282:11 308:12 311:16
fresh 69:19
FRG 307:13
Friday 304:14 398:14
friendly 223:9
friends 49:15
front 5:13 39:8 108:17 221:20 251:2
front-runner 222:4
fruit 177:18 193:2 281:12

fruitful 64:13
frustration 154:15 294:4
fuels 186:16
full 27:5,17 28:16 28:20 44:17 53:1 147:1 148:13 266:18 285:9 291:18 317:22
fully 30:16 245:6 373:4 431:14
full-time 189:15
fun 221:15
function 181:2
functions 430:4 437:18
fund 121:18
fundamental 323:2 325:2
funded 366:1,4 419:11
funding 130:13 139:2 366:2
funds 130:2 366:4 366:4
further 22:3 202:9 235:16,17 245:4 442:1 451:14
future 187:11,12 260:1 285:7 290:17 344:21 353:6 385:3 446:19 447:21
fuzzy 416:22
FY 110:14,19 429:17

G

G 437:15
Gadsen 255:17
gain 430:11
gained 430:7
gainfully 434:4
gaining 430:10
gal 284:13 303:8
game 24:10 321:7 370:14
Games 174:22 175:4
GAO 91:13 448:20 451:22
gap 136:18,19 137:4 147:2 308:21 382:5
gaps 149:8 381:1
Garden 225:12
gate 96:13
gatekeepers 336:7
gates 167:1 329:18
gather 62:4 368:13
gathered 40:4
geared 296:1
gee 216:15
GEN 5:2 6:20 8:5 10:4 12:3 13:19 15:10 16:3 17:6,9 24:12,20 30:19 34:10 36:20 38:11 38:15 43:7 46:11 47:16 52:1 53:6 53:22 66:5 67:12 86:17 87:9,21 88:19,22 104:15 112:20 113:12 123:18 124:6 126:21 129:4 130:15 133:18 135:14 140:12 143:17 144:7 147:3 149:3 159:1 159:10 169:12 188:8,19 191:13 191:21 196:1 197:8 210:10 214:12 218:12 219:9 221:2 226:20 228:3 242:3 244:20 246:22 269:18 270:2,5 271:8 272:6,22 293:15 293:20 306:1 310:11 313:4 314:20 319:2 327:3,6,22 328:4 328:15 331:15,21 347:18 348:22 350:17 354:14,20 355:3,6 362:19 366:14,21 374:17 375:15 376:4,7,15 377:6,12,15 385:7 386:4 387:4,12,17 387:21 388:3,13 389:6,10 390:2 393:18 394:14,18 399:14 403:19 404:10,17 405:2 406:4 409:18 410:18 411:6,15 421:5,19 427:16 436:9,14,21 437:6 437:9 438:4
general 2:17,19 6:19,21 11:14 36:10,21 48:19 57:20 62:10 65:6 66:18 73:10 99:19 101:3 105:2 107:12 110:11 116:2,20 119:1 123:3,16 125:13 126:16 130:4 131:21 134:2 136:17 138:4 139:4 141:14 143:1,9 144:12 145:16 147:15 151:1,14 154:12 158:6 159:9 161:9 178:11 179:11 180:12 181:21 183:14 184:7 186:4 189:8 193:22 194:13 199:11 200:19 204:7 218:20 219:13 221:18 227:12 228:6,18 229:1,9,12 230:21 233:1 238:4 248:14 249:20 250:2,5,10 251:14 251:22 252:2 258:15 264:17,18 265:14 268:6 270:9,12 271:13 283:11,11 284:4,5 287:14 289:20 292:3 305:17 330:11 342:13 345:17 346:21 351:17,19 352:10 352:18 353:10,22 388:7 420:12 455:22 456:10,12
generalities 237:17
generalize 145:18
generally 15:20 36:8 145:18
generals 66:7
General's 92:11 250:8 351:15
generated 14:12
generates 143:20
generically 243:15
gentleman's 210:14 214:13
gentlemen 4:4 39:17 46:8,17 68:20 69:8 128:4 128:12 186:18 227:15 228:4 285:10 356:7
geographic 115:11 274:4
geographical 14:3 14:5,11
geographically 111:20
Georgia 159:16 162:4
geriatric 463:19
Germany 123:15
getting 9:16 12:8 12:19 15:9 31:3 33:21 35:10 42:12 42:14 47:5 52:2 58:2,17 59:22 60:18 74:18 75:13 84:12 118:8 121:13 128:20 136:8,9 150:22 156:16,20 159:15 182:5,19 183:3,5 184:13 185:7 188:14 191:4 205:11 210:8 219:11 220:1 221:6 227:16 237:11 239:21 248:4 254:22 261:14 280:2 290:1,2,5 294:7 297:8,10 298:11 305:19 313:10 316:9 321:16 331:5 349:17 370:4,20 388:19 405:14 406:14 410:6 414:8,10 436:2 443:1,8,12 443:13 446:13 448:15 449:16 455:9 463:8
get-a-job 223:15
get-go 389:3
GI 206:8
Giess 438:14
gigantic 158:16,18 158:22 380:6
Gingrich 147:22
give 23:1,5 35:6 37:10 38:3 51:16 55:20,21 79:4 98:18,22 100:2 101:10 103:15 112:12 116:5 117:8 122:20 124:16 127:19 129:20 136:14 140:22 161:11 167:10,11 174:11 175:20 187:13 197:11,17 199:21

220:11 235:22 239:12,13 240:1,9 240:18 243:11 267:11 271:7 291:11 295:20 296:8 297:3 300:2 305:7 311:11,14 311:15 315:5 320:16 326:22 348:14,14 354:10 389:2 401:8 422:21 437:12 438:15 441:11 444:20 447:19 452:17 464:2 465:9
given 9:11 25:13 28:20 60:21 67:7 83:19 120:21 158:6 187:6 242:18 243:7 316:1 348:1 351:20 359:8 452:11 465:4
gives 29:8 44:13 47:19 51:19 54:5 54:8 132:3 182:9 196:14 245:5 270:13 307:1
giving 28:16 31:1 177:20 311:1 319:11,13 343:1
glad 5:22 6:1,12 30:20 51:5 191:6 229:21
gladly 115:14
glossary 176:11
go 11:13 12:16 18:3 18:3 21:9,20 22:8 22:12,13 33:20 39:12 41:4 43:13 47:18 49:22 50:1 51:6 52:21 57:16 61:18 66:12 68:12 69:17 70:5 83:17 89:21 90:3 91:16 93:6 99:16 101:12 115:3 120:1 125:1 126:12 128:18 134:14,19 138:3 141:16,20 143:6 146:1 150:16 152:7 154:7 157:14 158:4,9,14 159:20 161:22 162:11 163:16 164:13 165:9 168:1,2,2,6 169:17 172:7 177:4,6 180:7,10 182:13 185:3,14 189:13 191:4 192:2 193:10 195:13 196:16 198:6 199:9 200:3 200:17 202:15 203:9 204:7,20 206:14,14 207:18 210:18 218:6,6 223:12 225:21 226:22 234:19 235:2 240:1 244:21 245:9 248:16 250:20 251:19 252:16,20 257:5,17 261:12 265:7 270:12,16 274:6 276:15 277:8 279:11 283:22 285:11 292:8 293:10,12 294:22 295:15 298:2 300:10,17 301:3,12,13 303:2 303:17 304:12,18 304:22 305:10,12 306:11 310:4 312:22 313:2 314:18 316:4 317:2,2 319:3 320:12 322:8 324:18 329:3 337:20 339:12,14 340:4 350:2 352:21 353:8,17 354:16 356:4 357:3 358:14 361:21 363:10 367:7,22 371:4 375:1 376:9 379:8 383:5 394:2,19 401:1,11 402:4 407:12 418:5 423:9 427:14 430:12,20 435:16 437:17 438:6 440:2 441:17 442:13 443:21 444:10 446:1,18 447:6,17 450:17 459:10 463:1,2,19 464:5,6 465:14 467:5,14,15
goal 134:12 143:14 148:4 151:5 173:6 204:22 208:11 226:15 280:14 332:19 341:18 342:4 361:15 387:7 416:5,9 419:6 425:19
goals 142:21 197:6 236:8,10 239:14 246:19 259:19 276:9 280:17 333:17 346:15 360:3 416:11 417:8 418:3 443:19 466:4
goal-setting 246:20
God 252:7
godhonest 336:8
goes 11:6 17:20 51:8 84:16 89:6 99:15 121:16 135:15 148:6 177:19 215:10 226:2 281:6 287:13 292:13 314:1 335:15 344:14 366:9,10 381:10
going 4:7 7:14 8:6 19:12,13 20:14 23:6 24:9 34:6,9 34:18 35:4 41:6,7 42:4,5 45:12,18 45:19 46:1 47:21 51:14 55:1,8,20 68:11 69:14 71:7 75:22 76:7 80:6 82:4 83:11 84:15 85:20 90:3 94:12 95:2 100:7 101:15 103:9,14 104:12 105:17 106:8 107:8 118:6 126:14 130:7,8 132:20 133:14,15 135:1 142:4,5,16 143:7,20 144:14 145:4,5 146:1,13 146:18,20,22 147:21 148:22 149:17 150:9 152:3,8,21 158:12 158:14 159:22 160:5 163:7 164:5 164:9 165:14 168:10,21 170:5,6 171:16,17,19 172:5,22 173:15 174:10,16 175:3 177:6,11,12,18 178:10,18 181:22 182:20 189:2,3 191:3 192:1,2 194:5,20 196:9,16 199:12 202:6,7,9 203:20 204:20 206:11 207:17 208:3 209:16,18 210:11 213:8 214:11 215:13 216:20 219:15 220:21 221:14 224:14,15 225:4 227:17 228:11 233:9 236:7 239:12,15,22 240:4,6 241:15,18 242:12,13 243:4 243:20 245:9,22 246:17 247:13,18 248:17 252:12 254:14 265:10 266:12 268:20 269:7,8 270:16,19 277:12,13,14 279:7,18,20 280:19 281:11 282:2 283:16 284:11 286:18 290:6 294:19 298:21 300:6,15 300:16 301:7 302:9 304:18 311:6 315:15,18 315:21 316:2 317:4,4 318:13 319:2,7 323:7 324:1 327:17 333:13 334:14 335:3,19 336:12 336:12 337:2,4,11 337:16,19 339:10 339:21,22 340:1 341:8 342:13,22 347:20 348:8 349:20 351:1,21 352:14,22 354:2,4 354:4 355:17 357:7,9 363:13,22 365:16 367:5 368:12,15 369:17 371:12 372:12 374:22 376:9 381:18 385:20 393:8 398:8,16,20 403:15,21 404:2 404:12,20 405:9 406:3,20 407:5 409:20 410:21 411:19 412:14 413:3,9,22 414:5

414:6,17 416:18 423:7 424:22 428:5,17 430:19 432:12,14,22 433:17 437:9 441:13 443:18 447:2 452:1 457:11 458:19 459:20 461:18 467:8
good 5:2 9:1 12:10 14:9 16:4 17:2,10 26:11 30:17 31:6 42:1,3,16 45:2,5 48:21 49:8 53:13 56:2 58:16 63:7 75:13 82:17,20 84:3 86:5 87:5 88:11 107:16 109:6 117:6 120:22 125:14 131:11 137:12 162:9 174:11 185:2,16,17 191:9 193:12 194:21 195:12 197:21 202:5,10 203:19 204:6,10 205:11 205:15,17,18 208:22 209:8 212:14 214:10 224:8 229:3,4 232:22 236:20 239:3 258:18 263:18 275:15 279:6,14 282:14 283:1,21,21 286:9 286:10 288:14 292:1 315:7,7 319:9 350:8 352:10 356:6 369:7 380:10 384:17 392:18 413:19 414:9,15 420:15 447:17 460:19
goods 192:20
google 28:10 210:2 222:20
Gordon 162:4
gotten 129:12 182:14 410:12 411:4
Gould 190:10
government 63:11 66:18 152:9 153:15,19 154:4,8 155:3 158:7 189:15,22 342:20 342:22 344:13,13
go-to 18:11,15
grade 148:20 149:4 149:5 174:9 225:5
grader 178:21
grading 148:13
granularity 132:20
graph 125:2
graphs 119:8 124:10
great 31:4 95:11 115:4 126:15 150:3 151:16 152:2,2 156:17 160:14 164:16 178:12 202:21 208:19 209:2 221:11 226:8 261:21 289:8 294:10 364:10 381:22 428:15
greater 265:20 388:17 448:16 449:3
greatest 226:13
green 1:11,14 5:2 6:20,20 8:5 10:4 11:14 12:3 13:19 15:10 16:3 17:6,9 24:12,20 30:19 34:10 36:20 38:11 38:15 43:7 46:11 47:16 52:1 53:6 53:22 66:5 67:12 86:17 87:9,21 88:19,22 104:15 108:22 110:12,15 112:20 113:12 119:1 122:7 123:17,18 124:6 126:17,21 129:4 130:15 133:18 135:14 140:12 143:17 144:7 147:3 149:3 159:1 159:10 169:12 188:8,19 191:13 191:21 193:22 196:1 197:8 210:10 214:12 218:12 219:9 221:2 226:20 228:3 242:3 244:20 246:22 269:18 270:2,5 271:8 272:6,22 293:15,20 306:1 310:11 313:4 314:20 319:2 327:3,6,22 328:4 328:15 331:15,21 333:9 347:18 348:22 350:17 354:14,20 355:3,6 362:19 366:14,21 374:17 375:15 376:4,7,15 377:6 377:12,15 385:7 386:4 387:4,12,17 387:21 388:3,7,13 389:6,10 390:2 393:18 394:14,18 399:14 403:19 404:10,17 405:2 406:4 409:18 410:18 411:6,15 421:5,15,19 427:16 436:9,14 436:21 437:6,9 438:4
Green's 107:12 116:2 123:3 125:13
Greg 231:12 255:17 296:12 351:18 352:2
GREGORY 2:13
grew 165:1
grief 149:16
grill 227:9
ground 42:15 66:22 85:16,22 175:5 265:8 312:8 346:8
group 11:6 20:1,19 40:3 46:21,22 47:12 52:3 53:7 65:5 68:22 76:5 76:15 85:20,21 99:13 100:1 166:18 353:22 375:10 398:21 401:22 417:11 427:7 437:2 451:9 459:3 463:12
groups 10:5 18:12 20:9,14 40:3 50:6 50:13 51:3,9 58:19 59:22 76:19 81:4 118:18 127:22 143:18 166:3 290:21 425:18
grow 360:19
growing 302:20 312:16
growth 338:19
guarantee 182:22 210:1
Guard 6:4 22:3 30:11 41:4,5,6 42:19 43:18 44:10 44:13 48:2 145:11 272:16 279:10 282:19 283:10,15 283:17 284:1 291:10,17 292:2,5 292:5,14,21 293:1 293:4 295:2,7,12 295:17 296:4 299:20 303:21 304:14 337:15 384:2 385:21 387:9 390:1,6,8 391:3 392:3 399:3
guess 10:8 37:1 43:7 44:18 47:16 59:9 61:2 62:11 63:2 67:9 120:4 129:4,13 158:14 174:6 215:21 216:7 285:1 375:18 381:6 405:20 419:20 420:9 423:17 425:1 428:5,21 431:5 459:1
guessed 84:8
Guha 222:21
guidance 216:21 253:15,15,20 329:21 345:19 363:8 367:6,9 394:15 399:20 405:1 422:7
guide 323:12,13,18 442:15
Guideline 358:18
guidelines 233:22 234:2,15 235:6,7 235:22 238:5,7,15 238:16 240:17,17 240:18 241:21,22 242:6,6 248:8,9 360:3 395:9 408:6
guides 253:16 324:11
guiding 234:1
gun 353:17,18
gunner 353:17
Gunnery 171:8
guy 222:20,22 268:3 271:1,7 284:13 299:3 301:12 312:5 340:5 429:1

461:19
guys 8:19 9:8 17:7 56:7 166:16 171:17 176:20 239:17 240:2,7 241:18 280:9 285:6 360:5 367:14 394:19 407:16 435:9
G-1 278:14 281:6 288:5 318:3 321:3 321:4 332:6
G-357 321:4
G1 1:22
G3 251:17

H

HA 70:8
hair 314:12
half 28:13 30:21 164:11 217:2,3 267:2 278:2 295:1 418:15 427:18 451:6
halls 160:16 298:10
halt 436:15
hammer 176:1
hand 6:2 33:1 86:14 182:12 228:8 263:13 283:22 347:10,10 349:19 401:15
handbook 442:15
handicapped 191:16
handle 269:7 390:10
handled 49:2,7 375:19
handles 389:15
handling 381:16
handoff 276:6,7
hands 26:6
hands-on 443:3,11
handy 385:6
hand-off 373:6
hanging 193:2 460:16 461:10
happen 172:5 173:16 174:5 224:16 252:8 253:22 392:16 446:7,9
happened 54:16 114:15 122:2 135:19 144:9 146:16 148:18
happening 20:15 35:6,16 52:13,14 140:5 220:18,22 239:20
happens 188:5 191:7 195:19 214:20 259:9 297:7 305:13 374:13 450:9
happy 4:17 45:6 52:20 69:18 81:21 102:11 135:8 140:22 147:12 164:12 168:22 183:20 187:16 188:3 227:8 447:22
Harbor 91:17
hard 45:2 50:5 51:12,18 159:20 164:18 169:3 178:21 235:19 257:11 279:11 303:18 325:11 400:4 417:2
harder 169:16
harmony 147:21
harsh 382:7
hat 152:13
hate 131:18 145:17 411:2
head 40:13 53:6 170:19 272:2
headed 466:4
heading 431:22
Headquarters 48:5 48:8,9,11 53:1,5 53:14 321:3
heads 184:15,17
heal 305:11
healing 240:14
health 1:23 2:3,9 4:22 6:9 24:8 39:2 69:9 71:9,10 71:11 74:11,14 75:20 76:1,20 77:9,13,21 78:2 78:15,16,19 79:1 80:17,18 81:5,6 85:9,10 87:18 93:8,8 94:18 95:12 99:18 101:19 104:4,8 106:20 112:4 114:3 118:5,14 129:22 130:5 132:3 141:1 194:11,17 195:9 195:11 197:3 210:5 232:12 238:18 312:17 383:19 384:6 395:6,15 439:6 442:5 444:14 463:5,15
healthy 326:8 403:4
heal/treat 330:8
hear 29:10 30:20 31:3 32:7 41:10 42:19 43:4 44:20 49:19 52:13 53:4 62:14 151:9 159:12 183:8 203:21 210:11 220:20 223:17 230:10 245:1 258:13 281:20,22 283:4 290:21 308:11,16 334:22 452:3
heard 18:20 21:13 24:19 32:12 33:14 34:8 50:10 131:1 153:8 207:4,4 208:1,5 220:5,7 251:18 255:3 258:12 296:8,14 358:11 359:1 371:19 376:16 390:18 423:11
hearing 6:5 43:8 52:17 181:5 219:4 255:10
hearken 166:22
hearsay 49:14
heart 161:4 167:6
hearts 184:15,17
heavily 302:22
heavy 69:15 136:5 148:18
HEC 102:4,5,7
held 14:17 58:10 138:5
help 9:8 59:8 73:2 102:20 118:10 142:15 161:19 188:3 189:13 190:2 199:18 215:12 219:6 223:4 236:12 239:16 240:21 242:2 243:8 245:8 250:8 259:10,15 271:22 276:1,14 280:5 286:4 296:21,21,22 304:6 317:5 318:21 323:14,22 325:17 326:6,7 337:9,21 338:15 342:1 344:14 376:14 406:20 417:5 418:2,18,22 434:19 448:5 466:3
helped 118:2,10 223:6 226:8 238:21 268:3
helpful 20:1 24:19 29:22 30:4 51:4 63:14 100:9 128:21 156:12 219:12 243:5
helping 16:6 33:9 76:22 197:4 319:14 434:18 459:9
helps 89:1 115:21 187:10 197:13 236:8 259:11 286:12
Henry 2:9 37:17 230:20
Herbert 407:6
hesitate 434:18
hesitation 43:8
hey 60:22 155:11 157:8 175:21 177:5,5 201:7 206:2,13 212:12 267:15 303:11 315:8 337:6 381:14
Hi 408:10
Hickey 161:9
hierarchy 204:14
high 30:16 107:5,5 108:3,4 118:19 132:11 142:8 185:19 267:11 434:12
higher 80:7 81:16 81:19 84:6,8 107:6 132:18 143:9
highest 36:5 264:15 264:21 362:17
highlight 53:16 123:18 124:5,9 396:7 423:4
highlighted 440:8
highlighting 133:22
highly 107:14
high-risk 27:9
Hill 256:15
HIPAA 310:15

313:6
hire 159:22 211:18 212:17 317:5 406:19
hired 91:11 421:13
hiring 178:17 184:10
historical 35:7
historically 194:4
history 164:20 276:9
hit 69:14 164:14
hitting 156:19 235:1
Hodge 421:16
Hoffman 352:7
hold 42:4 71:16 72:8,11 76:2 93:2 103:16 106:20,22 112:3 175:18 176:7 186:3 202:1 213:16
holding 185:19
holdover 72:12
holds 296:12
hold-over 93:2
holistic 157:18
home 23:11 66:22 175:2 200:17 226:4,11 300:14 300:18 301:12 304:18,19 305:1 305:10,11 341:3
honest 134:19 142:9
honestly 15:12 64:14 220:3 305:21 418:10
honor 396:9
honorable 258:14
Hood 271:13 353:2
hope 131:17 157:15 158:20 220:20 229:4 400:18 430:11
hopefully 17:11 32:18 63:1 277:22 309:10 317:16 320:10 364:4
hoping 61:14,17 62:17 382:10
horizon 262:4
horizons 263:6
horse 379:4
hospital 75:9
hospitality 131:13
hospitals 90:5,7
host 132:1
hosted 343:9
hosting 342:9
hot 69:15 436:18
Hotel 1:10
hour 38:22 39:2 148:1 164:11 296:3 304:15 315:6 355:10
hours 24:4 139:15 140:8 261:20
House 30:18 345:14
household 309:10
housing 191:16 292:12
hover 97:6
hovering 111:6
hovers 97:15
how's 202:7
HR 271:20
HRC 304:22
hug 200:13
huge 44:10 145:14 162:3 212:2 309:15 392:4 433:15,15,20
human 58:15 62:17 63:4 271:21
hunch 277:15
hundred 134:11
hundreds 126:19
husband 314:10 335:5 336:2 339:4
husband's 312:11

I

ICCs 423:11
iceberg 431:22
ID 33:8
idea 35:10 36:22 48:21 116:7 124:13 143:18 165:6 182:10 196:12 206:18 245:14
ideas 35:6 68:14 155:7 220:21 237:17,18 291:4
identical 256:7
identification 381:2
identified 18:10 26:15 104:4 141:8 241:13 318:16 327:11 347:12 348:15 374:21 381:1 424:12 439:13 440:13 442:20 443:19 461:22 465:21 466:11
identify 17:18 120:11 224:12,14 344:15 392:17 417:13 418:8 442:10 466:4
identifying 15:13 26:12 127:13
IDES 2:13 26:13 27:3,8,15 36:13 36:15,18 89:13 111:10 112:10,10 112:14,16 113:6 131:16,22 132:8 133:13 137:1,3 138:15 139:16,18 140:16,16 143:21 144:10 145:19 148:17 149:17 156:2 196:22 212:15,17,22 214:7 299:9 300:10 302:7,9 315:18,21 316:1,2 318:14 327:18 329:6 330:7,7,13 330:22 335:10 348:7,18 351:15 351:18 403:15 404:3,12 405:5 406:9 408:3,11 410:3 412:15 417:4 422:6 423:15 424:1,8,22
ignorant 132:16
ill 1:4 3:8,17 11:7 25:16 84:19 163:6 163:10 171:15 194:6 230:4 234:10 238:10,12 249:22 277:19 278:18 295:3 337:16 342:16 343:1,11 361:20 362:5 374:8 386:14 389:19 396:15 398:19 413:7,8 424:13 425:11 438:22 445:14 458:16 467:21
Illinois 284:12
illness 241:8
impact 35:3,20 98:20 428:17
impacted 277:1 460:2
impart 320:6,16
implement 139:20 205:20 208:9 290:18 307:2 316:10
implementation 38:2 111:10 137:16 156:2 164:4 168:21 233:7 312:7 325:10 391:6
implemented 227:2 273:16 361:2
implementers 198:12
implementing 140:3
implements 267:6 271:2
importance 162:8 181:1 183:10 187:19 263:10 311:22
important 41:9 58:3 62:2 63:22 64:8 120:11 155:8 180:19 181:6 184:22 262:17 263:8 266:14 290:22 295:8 321:5 358:2 400:6 420:11
impossible 123:22 170:3
impressed 8:13 15:12
impression 22:22 23:6 181:5
impressions 51:2 128:19
impressive 8:17 215:18 222:17,19
improve 117:12 120:3 121:2 206:1 206:3 230:3 348:17
improved 110:21 111:12 207:17 418:9
improvement 15:14 121:1 137:13 379:1 419:2 422:4,15
improvements 139:19
improving 107:7 138:12 208:13
inactive 447:12
INCAP 392:7,8 393:21,22 394:5,6

394:9,13
incentivize 243:19
inception 125:20
inches 46:18
incline 416:3
include 46:5 50:15 233:16 234:10 254:2,4 292:11 305:2,3 333:5 395:18 409:16
included 77:22 183:17,17 236:9 404:20
includes 274:21 323:18 391:2 413:4 436:6
including 73:12 119:14 219:20 346:20 387:9 429:18
inclusion 172:17
inclusive 391:20
incoming 280:8
inconsistencies 186:8
inconsistent 186:13 186:15
incorporate 45:20 100:3
incorporated 46:19 184:1 195:10
incorrectly 390:19 400:10
increase 97:11,11 105:8 110:16 113:5 324:7 415:18
increased 64:15 85:6 97:1 105:7 106:4 133:21 144:17 147:7 178:8 204:16 225:8 397:3 411:8
increases 419:4
increasingly 132:19
incredible 215:17
independence 362:18
independent 205:1 332:22
Indiana 41:4,4 48:7
indicate 95:19 126:9
indicated 105:4 273:9 289:21 449:1
indication 88:13,16 88:17
individual 34:5 68:14 77:15 78:7 78:20 83:15 93:5 95:13 104:7 119:16 166:11 177:2 198:20 241:4,14 316:15 323:21 326:6,13 332:15 357:21 380:20 381:7 383:2 386:10 390:7 392:16 394:1 404:7 427:15 428:7 434:11 439:17 442:6 443:21,22 444:13 446:10 452:18 453:19 457:7 458:6 461:3 462:17 465:3 466:3,6
individualize 247:5
individualized 197:10 242:18 245:12 439:14
individually 111:18 275:20 324:6
individuals 12:12 27:10 31:11 69:22 75:14 76:11 77:10 79:5,19 83:9,22 112:7 118:7 230:14 234:21 285:3 302:9 315:17 316:11 322:8 339:18 371:12 381:2 386:13 388:9 403:17 410:17 427:9 441:9 443:3 443:5,7 447:11,13 448:6 449:21 450:3 453:21 456:8 458:6 465:20 467:19
individual's 77:17
industry 457:17
infamous 138:5
infantry 272:17
infantryman 271:6
infantrymen 257:8
influence 320:9
influenced 303:1
influences 95:11 273:18
info 19:16 217:9
inform 259:21 306:20
information 7:22 9:16 16:18 17:2 19:16 29:22 33:11 39:19 40:7 42:14 50:8,11 52:5 55:15,17 56:12 57:11,12,14 58:18 62:3,21 63:7 65:14,16 66:1 67:10 70:10 71:20 71:22 73:19,22 77:18 81:15 83:4 86:7,15 91:19 92:14 95:18 99:3 99:9 101:10,16 114:16 115:6 116:16,19 119:5 119:13 120:8 125:15,16 131:9 182:16 186:13 219:19,20 220:11 221:9 236:1,5 237:12,14 253:19 259:4 276:13,16 276:16 305:19 309:8 310:14 311:16 313:11 317:12 319:22 320:1,3,16 321:17 322:7,20 324:8,17 326:17 327:1 339:17 354:10 357:17 358:2,5,16 358:22 359:14 360:11 367:7 368:13 369:4 370:2,5,13,20 371:1 372:22 380:7 382:11,13 400:18,21 401:20 405:21 406:15 411:13 414:22 415:2,20 416:14 420:15 424:3,18 447:20 454:10
informative 324:17
informed 19:10 195:21 198:7 339:7
Ingram 283:11 284:4
inherent 175:13
inherently 333:21
inhibited 465:17
initial 248:3 280:22 367:5 453:11 462:16
initially 373:22 398:4 410:3,14,16 425:17,22 446:22 449:3 466:9
initiate 392:19
initiated 71:6
initiative 29:16 57:16 305:14 315:13 334:5 341:6 398:10 445:15
initiatives 360:14 385:15
injured 1:4 3:8,18 11:8 25:16 84:19 146:6 163:7,10 171:16 194:6 230:4 234:10 238:10,13 250:1 278:18 295:3 299:16,20 337:16 342:17 343:2,12 361:20 362:5 365:10 371:11 374:8 376:2 377:13 378:1,8,9 378:9 386:14 389:19 396:15 398:20 402:3 403:9 413:7,8 425:11 438:22 439:15 445:14 467:21
injuries 144:19,20 199:15 232:10 234:14 299:10 386:18 387:1,22 390:16 392:5
injury 145:1 215:14 219:3 232:13 241:8 337:6 365:15 372:4 378:17,22 392:15,17 429:4 457:8
inpatient 75:8 79:2
input 228:15 306:6 355:22 407:15
inquiry 297:22
insane 157:5
inserted 345:10
inservice 450:18
inside 161:5 222:3 257:15,19 318:5 332:11 334:2,9 353:14
insight 43:12 308:9
insisting 201:9
inspection 267:17 268:2 338:6
inspired 9:1

installation 7:15 33:16,17 34:1 36:19 40:4,20 45:17 50:7 58:7 59:17 61:16 65:3 186:12 220:2 273:17,19 287:10 290:8 321:2 329:13,16
installations 26:10 274:3,5 275:15 315:16 316:7,13 316:17 318:13 330:1 412:6
instance 182:2 277:5 338:5 358:17 415:9
instances 378:15
instantly 160:4
instincts 158:21
instituted 28:13
institutions 38:6,6
instruction 174:9 430:15
instruments 40:13
insurance 305:3
integral 371:7 445:20
integrated 2:4 13:15 90:20 147:17 231:5,14 300:7 353:9 354:7 354:18
integrates 28:18 63:2
intended 39:22 40:2 292:22 326:22
intending 29:20 33:18
intends 185:2
intense 448:20
intensity 285:13,16 285:19 286:3,13 457:5,6,13
intensive 342:15
intent 168:18,19 318:10 396:12
intention 41:19
interact 137:17 263:22 264:1
interacting 440:12
interaction 9:21
Interagency 6:9
interdisciplinary 246:6,9 260:18,20 262:1 296:11 312:9 326:15 331:11
interest 221:5 238:11 306:2 341:20
interested 55:12 285:1 342:2,5 343:17,18 350:9 413:21 414:7 437:3 445:2 446:10
interesting 19:2 72:7 168:12,12,14 311:9 456:22
interface 25:8,10 68:11 178:8
interfaces 166:11
Intergovernmental 4:21
interim 399:19
intermediary 27:14
intermissions 32:1
intern 14:10
internal 397:5 408:16
internally 250:6
internal/external 396:19
Internet 73:6 202:17 224:4,14 286:20 309:18
internship 14:7 344:8 345:6
internships 13:22 14:4 32:3 333:6 344:3,4,5,6,17,22 345:12,12 346:14 348:6
interpret 180:8 336:21
interpretation 337:3
interrupt 75:10 246:22 327:4
interview 16:20 69:1 343:6
intimately 456:13
intrigued 64:22
introduce 4:17 5:18 228:5,11,18 240:21 356:2
introducing 70:5
intuitive 333:21
inundated 309:19
invest 133:3 142:4 142:13,19 143:5,6 405:9
invested 170:19 192:15 201:13 206:21 225:2,10
investing 142:1 189:13 214:6
investment 150:4 151:14,16 193:13 197:20 199:18 212:18 215:16
investments 201:8 225:15
investments-wise 189:19
invitation 215:6 438:12
invite 217:2 450:20
involved 8:14 12:6 20:13 22:12 59:6 96:20 102:21 125:11 156:22 210:9,12 238:19 263:3 316:4 332:4 365:15 381:19,22 382:1 385:22 403:14 424:14 455:18 456:13
involvement 275:8
involves 254:1
involving 57:1
in-process 186:9
Iowa 41:6,6,16,22 42:18,19 43:4 44:13,20 48:9,18 49:11,12,15 53:14
IPO 160:8 161:17
Island 41:17
issue 13:4,20 22:12 23:20 24:1,2 30:3 30:11 89:7 119:19 156:7 157:2 181:1 186:16 284:16 295:11 311:8,19 394:11 409:20 410:13,15 426:10 426:13 466:13
issued 179:19
issues 20:2,13,22 21:1 22:11,20 24:6 27:21 32:8 34:22 41:8,9 48:2 49:17 54:10 61:11 63:6,22 64:6 73:3 78:6 132:8 134:15 170:22 208:5 214:2 258:5 270:15 283:11 284:8,14 322:21 323:18 338:17 359:3 363:11 398:22 447:8
Italian 435:17
item 133:11 310:22
items 39:7 306:4
iterative 53:12
ITOs 313:18
it'll 32:18 125:3 214:11 280:3 304:22 316:1,3 353:6
i.e 408:16 417:16
I/O 305:15

J

January 39:14,16
JEC 162:21,22 163:6,8 171:15 214:1 217:12,17 227:4
Jennifer 170:18 200:13
JG 8:9,11 11:22 17:13
job 21:19,20 30:9 31:18 141:22 146:2 156:20 174:12 182:4,20 194:12 206:15 223:9,20 225:22 254:10 261:11 263:12,13,14,15 263:18 283:1 322:11 343:22 347:4 400:16 402:1 425:16
jobs 21:17 142:8 223:11,16 259:21
Joe 258:19 279:3
John 155:20
join 5:5 340:2
joint 48:4,7,9,10 53:1,4,14 194:13 195:10 217:2 292:6,20,21 318:18 342:10 406:22
JointServiceSup... 293:18
journal 267:7
judge 44:15 224:21
judging 205:7
July 47:14 53:18,18 54:5,9,20 288:12
jump 182:1 202:6 219:15 406:14 459:21
jumping 89:8 131:15 136:12
June 47:13 53:20 53:21 54:5
junior 336:11
justify 123:3

Justin 1:15 6:14

K

K 1:19
Kandahar 167:4
Karen 1:18 4:19 6:8
Keane 1:17 7:5,6 18:4 20:17 24:3 32:20 67:20 68:2 403:8 464:19,22
keep 12:6 37:7,9 69:5 151:3 162:2 170:6 174:17 194:2 240:5,6 251:11 306:18 332:3 334:18 335:19 388:19 441:12 450:21
keeping 198:7 275:16
keeps 284:5 301:19
Keesler 406:7
kept 177:3 351:1
key 32:16 151:5 181:7,10 236:1,3 237:11 249:2 251:6 253:12 254:6 264:13 265:12 268:8 275:11 294:16 352:17 434:20
kicked 167:9 384:22
kicking 291:4
kicks 14:4 176:1
kid 252:4
killed 136:8,10
kind 12:13 13:13 15:7,12 19:11 22:16 27:14 39:13 39:20,21 40:5,13 45:9,13 47:8 51:18 52:22 53:19 54:15 55:1,5 66:11 67:13 92:13 108:7 119:5 126:9 147:4 171:13 176:19 187:13 197:11 211:1 228:6 237:19 239:6 243:14 244:18 245:5 247:6,15 277:14 306:2 327:13 329:4 334:14 335:14 342:3 359:17 368:6 382:9 384:13 386:18,22 391:10 393:14 416:22 426:22 436:17 437:1 438:5 448:6 451:21 463:8
kinds 11:20 176:12 265:16,19 282:7 340:21 467:8
knee 157:2 245:15
knew 23:19,22 366:20 368:8
knocking 452:4
know 5:15 10:12 13:3 17:12 20:14 20:15 23:18 25:18 26:9 32:10 34:3 34:12,20 35:16 43:20 49:20 51:11 51:17 55:11 58:5 58:9 59:1 63:12 68:21 80:4 88:3 89:5 96:13 101:7 101:15 108:6 111:14,16,18 112:15 114:9,12 118:13 120:13,13 124:1,2,13 125:10 131:18 132:5 140:18 143:2 144:8,11,15 145:14 146:1 149:11,16,20,21 149:22 151:1 161:1,19 163:11 163:15,18 165:8 169:17 178:9,16 186:6 198:16 202:6 206:4,16 210:16 216:3,6 217:15,16,16,19 223:19 224:3,5 225:7,10 239:21 240:2 241:16,18 245:6 247:8 250:15,15 257:11 261:15 263:3,16 263:21,22 272:1 277:5 280:2 281:4 296:2 301:10,13 303:17 308:6 309:12 310:4 312:17 326:10,10 326:12 327:12,15 335:8,18 345:8 347:3 348:3 349:11 351:9 353:21 355:8 356:20 359:1 367:14 370:8 375:18 379:1 385:8 388:13,20 393:8 394:12 401:13,16 402:6 410:10 411:1 417:18 419:12 420:11 421:5 422:20 423:19 429:10 433:12,13 433:16 434:11,21 435:22 438:13,19 443:12 446:22 447:4,15 452:5 459:10 463:8,21
knowing 22:17 243:1 365:16 407:7
knowledge 238:11 320:2,3,5,17 324:7 428:9 440:22 454:11
known 169:4 216:12 226:12 277:15
knows 206:13 210:8 259:17 276:8 288:22 292:14 296:2 353:22 354:1 402:10
Knox 36:6 48:14,14 303:10,10
kudos 18:18 25:13
Kushner 63:19

L

label 372:12
labeled 341:5
labor 190:4
laborious 187:8
lack 25:15 239:16 258:10
lacking 33:2
Lackland 2:6
ladies 4:3 39:17 46:8,17 68:19 69:7 128:4,12 186:18 227:15 228:3 285:10 356:6
Lady's 30:6,14
laid 176:15 243:14
laminate 151:18
laminated 151:19 151:19
Lamont 233:3
Lance 165:9 171:8
landed 223:2
Landstuhl 74:6 90:2 365:10 378:13 379:7
lane 34:9
Langley 41:17,22
language 179:5 186:9,16 345:10 345:15 346:1
large 37:14 57:21 62:13 64:3 104:2 112:17 153:7 184:12 198:15,21 249:3 421:3 425:18 427:9
largely 179:22
larger 29:4 125:9
largest 57:22
Larry 156:1
laser-like 327:12
lasted 80:19
lastly 465:7
late 14:22 15:8 36:2 53:18 163:17 288:15 321:6 351:1 355:9 370:14 380:21 417:13,16 421:1 423:2
latest 42:6 253:19 265:15 454:9
latitude 67:8
Laughter 315:1 435:18
Laura 86:16 106:15
law 31:13 155:6,12 155:13 168:4,4,8 168:14 169:15 172:3 174:12 180:16 185:1 208:4
laws 155:4,4
lawyer 32:22
lawyers 142:14 189:12 214:8 321:9,9 350:3,5 410:20
lay 233:6 302:16
layer 316:19 317:15
layers 401:5
laying 263:18
lays 183:17 233:18 253:21 262:3,19 263:5
lead 44:19 197:4 228:13 355:20
leader 180:14,18 182:15 183:7

185:1 204:9,11,12 208:10 243:17 244:10 246:5 255:4,12 257:22 266:6,7 268:22 271:18 278:5 283:5 287:21 346:20,22 347:10
leaders 99:15 130:5 180:3 185:14 200:22 201:4 234:19 258:2 266:12 268:15 271:10,14 277:18 319:14 320:6,15 323:9,11 415:3
leadership 33:22 232:4 244:11 263:1 264:14 270:13 282:5 294:19 295:12,17 298:6 322:2 329:9 342:12 367:8 391:4 397:6 402:10 449:2
leader's 182:3
leading 172:16 173:1
leads 373:10
league 221:12
lean 251:19 451:20
leaning 52:18 67:13
learn 12:1 22:9 140:6,6,9 185:22 217:4 335:5
learned 195:1,3,6 270:20 321:9
learning 175:2,4
leave 28:12 149:16 187:20 267:20 276:15 279:19 349:19 412:17 447:9
leaves 41:15,17
leaving 15:4 311:17
led 52:6 139:22
leeway 427:6
left 33:2 122:4
leg 245:15
legacy 132:16 134:12 136:18 137:10 144:3 157:1
legal 32:21 33:9 142:15 169:5 311:7 345:17 348:5 408:1,2 409:19,22 410:6 410:14 411:9,13 412:3,6 466:10
legalese 321:10
Legion 5:22
legislation 173:20 466:17
legislative 155:7 179:8 218:1,10
Lejeune 7:17 8:2,4 8:6 9:3,21 14:18 15:11 19:12 25:1 140:11 159:15,17 354:17 355:1,2,3
length 132:7 162:14 178:11 248:6
length-of-stay 248:3
length-of-stay-by... 247:22
lessen 168:22
lessons 195:1 270:19
letter 13:11,18 14:12 434:12 447:19
letting 309:12 327:8
let's 133:1,2 134:5 134:6 138:11 150:8,15 152:7,10 153:15 155:6 184:16 185:2 188:8,13 190:3 193:10,11 205:13 205:13,15,18 353:1
level 11:3 23:15 34:6 97:1 98:21 126:7 151:16 160:19 165:11 171:4 174:4 188:16 194:2 196:8 203:14 205:10 208:19,21 209:9 215:19 218:7 241:11 243:9,16 248:13 257:4 265:21 268:11,11 270:19 273:17 275:17 284:4 285:19 295:17 300:1 304:4 322:1,12 329:14 336:20 362:17 363:18 382:11 396:1 407:2,4 410:12 412:8 431:1,12 446:11 453:15 460:15 461:8 462:9
leveled 111:3
levels 22:22 111:12 116:12 132:11 135:3 264:15 270:14 275:2 408:2 460:19
lever 132:4
leverage 196:5
levers 134:6 136:6 138:17
Lewis 277:13
LG 1:11,14
liability 344:2
liaison 100:10 316:16 378:12 407:22 413:13 460:8
liaisons 316:17 317:11,17
liberally 297:21
licensed 439:4 440:16
lieu 375:4
lieutenant 7:5 8:9 8:10 11:22 17:13 20:17 26:2 245:17 271:4 355:16 356:11 364:12 395:14 403:11 411:17 421:15
life 49:18 78:5 360:16 431:6,8,10
lifeline 149:11
lifelines 136:21
lifesaving 21:8
lifetime 435:10,14
lift 148:18
light 330:4 339:1
liked 79:15 132:17
Likert 93:11
likes 56:20 57:6 222:13
likewise 420:7
limbs 219:2
limb-saving 21:9
limit 259:11 344:20
limitation 81:9
limited 26:15 27:1 43:16 67:3 369:18 434:8
limitless 342:7
limits 21:22 340:20 346:1
line 29:12 38:6 42:22 76:7 97:20 97:20 98:9,10 103:17 104:13 105:3 106:8,11 107:2 110:15 111:6,16 132:19 134:3 144:15 177:12 248:20 250:18,18 252:16 266:16 269:18 271:9 272:8,13,20 272:20 310:22 321:22 325:13 326:12,20 329:2 329:10 331:6 354:3 388:22 392:14,19,22 427:2 434:5 450:22
lined 146:2 275:12
lines 94:11 95:2,4 105:17 110:10 135:6 291:22 318:5 336:17
linger 197:18
linguistics 179:6
link 66:10 67:4,21 385:22
linkage 257:19
linked 115:8,11
list 19:1 89:19 258:22 292:10 305:15 424:16
listed 131:4 348:10 349:15 356:1 464:5
listen 196:5 296:7 298:10
listening 118:15 227:8 294:21 296:18 297:5
listings 65:7
lists 19:16
listserv 65:15,17,22
literally 292:8
literature 182:12 241:2,7
little 6:6 7:22 11:6 16:7 38:22 45:7 46:12,12 49:13 52:2,18 54:7,13 54:19 63:13 67:4 80:9 81:20 92:19 94:17,20 95:3 100:21 101:5 113:20 128:6 151:17,19 172:10 176:3 182:1 196:2 210:8 219:7 222:16 227:9

242:1,5 244:5,7,8 245:7 266:1 269:15,16 280:3 282:3 285:1,5 298:3 303:16 355:9 362:2 374:18 380:13 401:9 422:5 423:17 427:6 459:13
live 224:19
livelihood 317:14
lives 149:14 150:2 165:1 320:11
load 23:10
loathe 115:12
local 161:4 170:22 180:1 295:11 342:21 344:1,13 345:12 375:1 376:8 396:22 410:12
locally 171:3 182:14 288:3
located 70:10 291:3
location 9:10 112:11 115:11 227:16 282:21 404:8
locations 9:19 112:10 140:2 278:7 286:7 298:19 339:18 383:21 404:20
lodging 71:18 105:5 106:18
LODs 392:8
logical 339:6
logs 83:18
long 112:17 129:6 147:2,12 150:10 175:7 176:6 187:16 189:10 195:19 197:1 204:5 215:13 240:3,5 241:18 248:14 250:21 251:8 260:8 321:9 362:15 371:17 372:3 386:10,17 387:1 388:2,14 442:10 451:9,19 460:2
longer 45:7 162:19 191:22 335:2,19 349:8 361:8 447:14
longitudinal 104:16
long-term 27:1 92:2 128:13 246:19 385:9
look 8:21 9:14 13:9 15:8 22:6 23:19 26:10 27:18 30:13 30:21 35:8 40:12 42:3 44:3,17 45:2 45:7 46:16 47:18 48:15 52:3 53:13 55:6 57:16 64:17 64:21 66:4 70:18 73:7 80:8 83:17 88:1 95:2,2,8,13 97:19 98:12 99:7 100:13 109:8 112:9,9 114:14 115:16 118:21,22 119:7 126:12,21 131:6 133:20 134:17 135:18 138:11 141:15 143:3 145:9,13 148:2 150:16 157:4 164:20 189:18 193:1 200:15 201:10,16 202:3 204:20 225:22 228:19 237:19 241:6 248:6 249:6 251:10 260:15 284:8 286:2 294:17 297:17 302:3 303:14 330:9 337:6,7 343:16,21 344:1 344:10 345:3,6 347:6 358:17 375:6 402:6 416:21 422:9 435:3 440:11,20 452:13,18 453:16 457:12
looked 12:9 20:16 24:4 34:12 48:13 51:12 77:8 79:2 92:12 112:21 113:6 114:7 126:17 135:22 138:16 157:15 185:16 312:15 432:4,8 433:4
looking 13:17 15:2 34:16 41:20 62:20 65:19 82:7 92:6 98:4 101:13 102:8 118:11 123:22 124:19 140:2 158:20 165:7 194:7 198:10 221:7 236:22 242:8 243:6 247:15 254:11,14 256:13 257:1,22 258:17 267:18 270:18 287:3 290:11,17,18 294:13 306:3 311:20 328:16 333:22 346:14 348:2 349:4 365:20 369:14 389:1 401:3 407:10 422:5 428:21 429:22 430:3,6 431:13 435:7 436:2 445:15 456:16 457:4,20 461:15 463:17
looks 35:1 109:9,13 124:11 126:13 200:11 445:3 457:5
loop 117:4,12 121:1 132:14
lose 24:9 163:9 192:3 194:10 221:14
losing 126:3 433:7
lost 33:8 182:6 245:15 393:14
lot 12:5 22:7 30:5 32:11 43:10,12 51:7,14 54:2 57:17 61:5 64:5 65:9 75:1 83:6,8 84:6 85:19 92:9 94:7,20 96:2 101:13 108:10 122:7 132:13 135:4,10 139:21 159:12,19 166:11 167:3 172:11,12 183:7 185:11 190:17 191:15,15 191:16 195:3,6 198:4 209:18 215:9 216:18 221:5 232:18 250:2 260:6,19 283:4 294:4,21 296:8 297:15 302:22 303:21,22 304:8,9 305:10 306:6 311:10 314:1,3,6,21 317:11 335:1,13 343:7 353:13 370:6 382:1 395:22 398:4,7 410:4 411:4 418:19,20 428:1,9 430:20 431:2,10 433:6 440:17 448:11 457:1,16 463:9
lots 9:20 72:14 94:13 259:1 428:16 451:18
love 91:1 105:16 134:21 164:6 165:5 215:4 381:20
loved 184:1
low 193:1 420:3
lower 80:8 107:20 107:21 110:22 336:19
LT 5:2 6:20 8:5 10:4 12:3 13:19 15:10 16:3 17:6,9 24:12,20 30:19 34:10 36:20 38:11 38:15 43:7 46:11 47:16 52:1 53:6 53:22 66:5 67:12 86:17 87:9,21 88:19,22 104:15 112:20 113:12 123:18 124:6 126:21 129:4 130:15 133:18 135:14 140:12 143:17 144:7 147:3 149:3 159:1 159:10 169:12 188:8,19 191:13 191:21 196:1 197:8 210:10 214:12 218:12 219:9 221:2 226:20 228:3 242:3 244:20 246:22 269:18 270:2,5 271:8 272:6,22 293:15 293:20 306:1 310:11 313:4 314:20 319:2 327:3,6,22 328:4 328:15 331:15,21 347:18 348:22 350:17 354:14,20 355:3,6,18 356:5

359:20 360:6 362:19 363:1 364:14,18 365:6 366:2,7,14,17,20 366:21 367:1,20 369:6,13 370:17 372:15,18 373:1 374:17 375:14,15 376:1,4,5,7,12,15 376:19 377:6,10 377:12,14,15,22 379:10,16,22 380:9,14 382:3,15 384:15 385:4,7,14 386:4 387:4,12,17 387:21 388:3,13 389:6,10 390:2 393:18 394:14,17 394:18,20 396:2 397:19,22 399:6 399:12,14,18 401:8 402:13 403:10,19 404:10 404:17,22 405:2 405:17 406:4,12 407:18 409:3,13 409:18 410:18 411:6,10,15 412:12,20 413:6 413:11,18 414:1,4 414:11 421:5,19 424:5 425:9 426:11,19 427:1 427:16 428:13 429:3,7,12 431:18 432:2,3 434:2,22 435:11,13,21 436:9,13,14,19,21 437:5,6,8,9 438:4
LTC 1:17 2:21 7:5 18:4 24:3 32:20 67:20 68:2 245:17 309:2 403:8,11 404:5,15 464:19 464:22
LTJG 354:16
LU 56:2 59:13 60:11 61:13 63:1 64:1 65:2,18 66:15 67:17,22 68:4,18
lunch 164:12 227:14 229:4,5 315:3
lunches 227:17

M

MA 2:3
machine 212:21
Mack 8:19 10:12 59:2 203:21 377:16 463:7
macked 148:3
MacKENZIE 1:17 7:7,8 8:20 10:14 14:14 68:9 116:13 165:20 175:9 176:4 202:14,21 203:3,9 205:6 208:16 213:11 224:1,6,9,17,20 239:6 241:10 276:19 280:6 298:17 302:11 306:14 307:8 310:1 313:14,18 339:15 340:17 341:4 367:10 369:22 371:21 372:9,16,19 377:20 379:2,14 379:18 380:3 381:5 382:4 390:14 400:8 402:12 406:13 411:19 412:2 426:9,12,21 428:4 428:14 429:5,9 433:5 443:10 444:3,6 454:13 455:7,13 459:20 461:6,13 462:1,4 462:21
MacKenzie's 172:20
macro 141:14 143:5 158:19 160:19 161:8 170:13 215:19
mad 311:9
MADCOM 385:9
magical 109:11
mail 19:15 81:13 82:1 309:8,19,20
mailing 161:22
main 67:18 395:13
maintain 194:8 362:5 383:2 426:15 433:2 442:8,22
maintained 293:4 415:1
maintaining 188:20
maintains 143:12
MAJ 2:3 408:10 409:9,12 410:2 411:1 414:13 418:10 419:5,13 419:15 420:14 421:11,20 422:1 425:5
MAJCOMs 420:17
major 6:4 9:7 20:13,22 21:1 22:11 26:1 29:16 51:9 60:14,15 67:16 75:12 172:21 207:15 221:12 244:18 252:6 266:15 287:9 303:7 309:3 313:2 408:7,10 409:5 412:15 414:16
majority 18:14 302:9 309:4 327:16 389:3,6 425:14
maker 129:21
makers 130:14 132:22
making 41:3 100:3 127:3 128:13 134:8 138:18 141:9 142:9 148:5 165:22 178:4 184:4,18 194:7 197:5,15,22 205:10 206:6 237:14 289:17 304:8 318:14 364:10 374:13 380:18 405:20 414:8 417:2 421:6 421:17 443:5 453:17 454:8
Malarsie 361:18
Malebranche 1:18 4:19 6:5,8 56:4 82:13 101:7,21 102:6,13 118:13 119:20 124:15,18 126:16 144:13 145:7 214:15 215:2,21 217:15 218:5 317:3 419:16 458:8,14 458:22 463:7 465:7,12,16 466:7
mama 312:11
man 169:4
manage 11:18,21 20:22 28:22 29:13 37:11 106:18 107:2 108:9 109:18 240:8 242:9 319:14 328:13 332:6 336:15 354:21
managed 29:4 36:10 205:16 329:9 363:17
management 1:3 3:6 18:16 24:15 27:11 33:16,17 34:1 36:11 117:14 117:18 120:18 130:1 139:7 238:3 240:19 241:2,5 242:2 243:9 249:16 275:1,13 275:22 277:2 285:18,22 286:17 286:19 321:2 328:9 330:21 331:3,10,14 336:14 359:17 384:4 386:19 415:8 432:10 445:16 448:21 449:10 450:19 457:22 458:1
manager 2:6 19:3,8 26:17,20 117:21 118:1,1 234:17 241:1 243:17 246:5 265:4 275:17 282:10 283:5 285:15,20 286:12 287:20 328:6 457:18 458:5,15,18 459:7 459:10
managers 18:14 19:22 25:5,20 213:2 235:9 238:17 239:14 240:21 274:15,22 281:17 362:4 371:6 380:17 384:5 386:21 388:11 429:20 430:17 449:19 450:1 451:7 458:11 459:3,5,8
manager's 240:15
manages 37:18 279:2
managing 29:22 105:6 108:1 275:20 280:15 325:4,17 330:6 359:21 384:21 400:13

mandate 213:5
mandated 383:7
mandatory 88:16 316:3 318:15
manipulate 326:3
manned 170:8
manner 16:12 117:10 174:5 180:8 191:7 324:18
manning 410:15 417:21
manpower 34:21 230:17 277:11,22 281:10 407:21 409:17 410:21 430:2,8,18
map 112:10 246:11 335:8
March 40:4 42:5 45:17,21 46:14 52:4 55:9,11 72:2 162:21 164:3 188:1
margin 197:14
marine 7:17 9:9 35:11 67:21 68:1 68:2,5 84:10 85:4 91:19 146:9 151:18 159:14 174:22 177:3 293:9 368:7,9 431:9,10
marines 60:17 84:8 85:2 86:9,12 124:12 451:12
marked 110:12
marketing 66:14
Maryland 293:12
MAs 313:18
Massachusetts 49:5 390:17
master 7:7 165:7 166:21 172:19 193:15 202:5 204:6 351:18
Masters 440:15
Masters-prepared 439:3
material 42:12 46:6,18 47:9 69:21
materialized 102:10
matrix 139:6
matter 69:12 133:9 166:9 227:20 250:4 289:16 293:10 304:13 310:2 355:13 356:15 357:6 380:4 382:5 401:5 438:2 441:5 468:11
matured 112:11
maturity 180:21
Max 170:10
maximize 37:13 143:22 146:8
ma'am 47:15 70:14 82:12 312:19 334:11 336:17 339:8 343:19 349:11,12 350:1,8 350:8,9,16 352:19 353:19 355:18 356:7 369:22 403:10 413:15,18 414:4,11 418:4 420:14 443:10 455:14 464:19
MCOM 321:2
MCWIC 368:7,10
MD 1:18,19,20 235:6 240:17 241:20
Meade 271:20 272:4
mean 25:5 49:3 51:11 74:2 82:16 87:1 97:14 106:13 119:8 123:20 124:3 127:9 129:8 129:14 142:10 145:11 169:4 170:21 173:10 175:13 176:5,9,15 177:20,20 178:21 179:21 185:7 195:4 199:16 200:12 202:17 205:7 219:4 239:22 242:14 257:10 258:11 279:9 283:12 291:9 294:21 298:13 299:1,22 308:5 314:5 336:8 365:8 372:10 379:3 381:9,20,21 400:14,19 405:4 405:20 406:15 407:2 420:4 427:2 428:15,15,15 429:9 433:7 435:22 436:11 442:19 454:16 460:11
meaning 333:1 430:15
meaningful 127:4 231:11 253:5 332:1,10,14,15 334:1,20 339:20 340:4,6,9,11 341:1,9 348:3 425:12
means 36:8 122:20 124:3 146:21 173:10 193:9 290:6 397:12 410:10 432:12 449:17
meant 94:22 95:1 122:10,11
measure 252:11
measured 137:1
measurement 106:6
MEB 18:10 96:14 96:15,17,20 110:5 110:11,13,15 111:19 114:1 122:13,17 125:9 133:2 136:7 142:16 189:12 247:14 301:3,7,13 369:1,15,16,21 388:21 415:9 416:1,4 417:9 422:9
MEBs 190:3 418:7
MEB/PEB 411:9
mechanism 155:3 185:22 186:7,11 190:18 191:2 214:4
mechanisms 12:7
med 298:22 340:1 380:5 417:11
MEDCOM 250:8 351:19 352:4 353:14,19
MEDCOM's 354:6
media 55:16,20 56:1,8,22 66:22 225:16 265:18 291:7,7 397:11,12 397:13
medical 2:4,11 5:9 6:17 11:20 21:16 26:21 27:21 28:5 28:14,19 29:18 71:16 72:8,11,11 72:13 76:2 77:5 77:18 78:6,14 87:18 88:17 93:2 96:11 99:20 103:16 104:19 106:20,20,22 110:2 112:2 114:19 159:13 170:8 193:8 196:15 211:4 213:2 230:22 231:2,17 271:3 273:22 279:1 292:12 298:22 300:19 310:14 320:13,22 321:6 322:6,7,8,14,21 322:22 323:1,11 323:16 325:4,7,13 325:15 326:3,22 328:8,9,20 329:1 329:10 331:6,7,12 331:18 335:2 336:14 339:22 341:16 358:9 359:4 360:1 362:9 371:5 372:5 375:4 379:5,9 380:16 384:1 385:10 386:4 393:11 426:7 428:18 436:8
medicalese 321:16 321:21 326:19
medically 28:9 29:5 319:4 325:6 338:3,7 352:11 362:10
medicine 169:5 199:5
mediums 296:8
MEDPROS 28:18 322:4,4 323:4 324:5 327:8
Medve 155:20
meet 117:6 132:21 136:4 139:13 140:8 143:3 167:3 183:9 212:11 239:17 244:2 257:13 276:21 278:17 281:21 282:1 335:1 340:10 343:4 383:17 391:12 416:8,8 417:7 418:2 435:5 439:15 441:10 445:6
meeting 4:13,14 39:14,16,18 40:1

40:16 45:12,15 46:5,7,8,10,13,15 48:9 52:7 54:22 67:6 89:19 105:6 108:14 167:4,5 213:12,19,20 246:21 262:5,6 274:10 278:12 280:14,20 290:13 295:14 342:13 350:13 373:15 381:9 408:19 409:1,1 416:10 420:13
meetings 7:20 31:22 39:4 56:13 58:6,20 62:10,22 131:2 133:11 138:21 263:21 314:10 373:12,14 400:1
meets 340:12
member 5:6 44:13 93:13 111:18 139:17 141:2 143:12 146:21 148:10 153:22 154:10 155:2 158:6 168:5,9 169:14 173:3 182:4,5 183:18,19 184:21 193:20 209:14,15 219:17 229:7 239:13,20 253:7 255:14 258:7,9 261:4 279:5 307:1,4,10 309:14 310:9,13 310:13,18 313:20 357:18 362:13 367:19 369:9 370:3,15 373:7 378:3 379:6 382:17 383:4,6,9 393:1 415:13 417:3,5 424:11,12 425:21 427:11 439:22 444:13 451:11 460:9 461:9,16 462:7,11 462:22 463:22 464:22
members 1:4,13 3:8 4:6,16 5:18 10:9 15:3,22 16:17 17:5 31:19 32:16 45:4 47:1,1 50:15 56:3,20 58:1 61:14 71:16 72:6 73:16 74:1 75:20 77:1,22 82:22 95:10 103:16 104:3 112:13 113:22 114:9,18 117:20 119:18 149:9 151:10 161:3 163:1 176:13 181:10 186:10,14 189:1 209:7 210:17 220:5,8 221:20 224:2 238:9 239:15 246:8,9 253:7 254:1,8,12,15 261:1 264:3 275:1 276:14 278:21 289:11,22 310:6 314:3,3,6,8 315:5 317:6 324:9 326:9 342:17 343:3,12 346:12 347:22 367:12 368:16 370:10 384:3,6 389:19 396:16 397:7 402:20 403:2 404:11 409:22 410:5,11 410:14 413:7 422:18 423:13 424:22 431:3 433:12,14 437:16 439:1,15 441:15 443:1 445:18 452:19 460:1 466:14 467:6,14
membership 162:22
member's 381:11 392:20 460:7
member-centric 134:9 151:6
memorandum 315:14 367:6,9 399:20 405:1 406:18
memorandums 363:7,8
memories 45:18
memorized 144:12 145:3 165:10
memory 50:20
memos 101:18
men 80:6,7
mental 195:8,11 395:14
mention 14:21 66:17 114:18 174:19 188:2 419:17 464:12
mentioned 18:12 20:18 36:11 135:16,17 139:14 173:18 189:10 205:1 214:15 222:19 288:8 294:11,22 346:22 352:2 353:4 406:16 413:15 414:15 416:13 422:3,10
mentioning 145:13
mentor 361:19
mentoring 209:1
message 63:21 192:21 250:14
met 1:9 130:4 176:20 180:17 182:5,11,19 183:3 183:5,21 202:16 258:15 281:18 289:11 295:16 398:15 444:2 446:13 457:20
METC 31:5
method 67:10
methodological 82:20
methodologies 86:18
methodology 70:18 73:15 83:13 88:4 101:3,4 109:21,21 449:9 457:11
methods 67:19
metric 307:16 385:12 416:16
metrics 250:9 251:3 274:19 288:16 384:13,19 385:2 386:10,16 386:22 415:3
metric-wise 423:14
MG 1:19 6:18 28:3 30:2 33:14 37:8 42:17 44:2 98:16 99:5 100:9 102:15 103:12 111:9 117:2,8 120:15 121:15 136:11,22 137:7,15 138:19 151:8 153:5,18,21 155:15 179:7,18 180:4 181:4 186:22 187:3,5 198:8 248:17 252:19
MHS 94:18
mic 291:12 308:16
Michael 2:21 355:16
microphone 239:8 260:15
Microsoft 210:2
mid 47:11
middle 53:20,21
mid-June 46:7
mid-May 46:14 47:11
migrate 270:19
Mike 356:11 361:17
mile 292:11
miles 31:14 293:13
milestones 197:7 198:11 218:16 233:17 237:4
military 71:8,8 76:1 79:1 94:18 95:12 111:11 138:9 170:16 191:15 203:12 219:21 220:12 222:3 233:20 264:12 276:15 313:15,19 315:16 318:12 319:1 333:1 360:16 394:3
Milliman 235:6 240:17 241:20 242:6
million 58:1 63:20 103:8,10 152:15
millions 60:21
mind 98:2 149:15 215:22 277:21
minds 11:12 150:6
mine 99:2 120:9 201:16
minimize 326:19
minimum 127:20 443:17
Minister 187:22
minute 152:3 199:13 260:17 281:15 442:14
minutes 55:22 131:17 186:20 207:8 347:20 351:2 355:10 425:8 440:14
miscommunicati... 13:11
missed 4:15 21:12

21:15
missing 380:6
mission 232:14 244:11 263:2 266:4 267:9,13 270:17 271:1,11 272:19 288:2 297:15 298:7 323:15 337:9 427:5 428:17 431:5
missions 222:11
misstating 23:5
misunderstand 245:10
misunderstanding 365:1
mitigating 44:18
mix 84:17 189:21 189:22,22 190:4,4 275:18 276:2
MM 328:8
MMC 328:12
mobile 287:11
modal 81:12,20
modalities 319:17
mode 82:4 169:22 170:1
model 8:16 189:18 194:9 209:19 285:6 286:2,9,18 287:4 407:21 412:10
modeled 156:18
moderate 318:20
modernized 16:5
modified 90:16 111:22 118:4,12 426:6
mom 293:8 460:16 461:10 464:7
moment 86:16 203:18 231:22 372:20 446:1
Monday 55:9,10
money 135:11 154:3 191:10 212:16 213:4
monitor 274:19 322:14
monitored 225:14
monitoring 284:21
monster 134:10
month 73:4,6 74:18 76:8 80:20 85:8 87:8,17 88:6 94:15 105:22 122:19,21 125:18 137:22 149:18 173:9 259:9,9,13 259:13,13 268:22 277:14 278:16,17 297:8 420:22
monthly 38:3 72:19 72:22 74:14 94:11 94:14 99:14 107:5 107:8 125:17 130:9 347:2 415:4 416:15,19 432:15 432:17
months 7:18 42:21 47:6 57:3 64:15 69:2,4,4 73:9 75:17 76:12 78:3 88:7 90:17 112:1 112:12 125:19 148:14 198:18 246:17 247:12,13 249:8,11,11 250:17,19,20 252:13 262:2,3 267:14 284:11 295:5,16 296:16 298:1 337:14 346:8 367:4 418:6 424:19 425:3
morning 5:2 23:13 55:3,4,4 56:2 131:11 138:8
mortuary 398:20
MOSs 30:8
motivation 422:16
mountain 167:20 278:2,3
move 27:3,7,12,15 90:10 128:4 132:4 132:13 133:1,2 134:13 164:10 186:21 188:9 244:4 270:21 278:14 432:10
moved 53:17,19 448:8,8,9 452:1
movement 16:3
moving 16:10,11 128:16 134:9 136:6 138:17 142:11 169:6 178:20 199:4 240:6 264:4 391:9 398:16 402:5
MP 1:24
MPA 2:3 386:14 387:11,16,19,21 388:9,14 389:7,8 389:12,14,16,20 393:2,20
MPAs 387:17
MPP 99:22
MR&A 228:13
MSC 151:15 152:2 415:11
MSCs 198:5
MSGT 1:17 7:7 8:20 10:14 14:14 68:9 116:13 165:20 175:9 176:4 202:14,21 203:3,9 205:6 208:16 213:11 224:1,6,9,17,20 239:6 241:10 276:19 280:6 298:17 302:11 306:14 307:8 310:1 313:14,18 339:15 340:17 341:4 367:10 369:22 371:21 372:9,16,19 377:20 379:2,14 379:18 380:3 381:5 382:4 390:14 400:8 402:12 406:13 411:19 412:2 426:9,12,21 428:4 428:14 429:5,9 433:5 443:10 444:3,6 454:13 455:7,13 459:20 461:6,13 462:1,4 462:21
MSOs 57:5 61:6 64:9
MTF 126:7 138:14 244:12 272:12 287:18 288:4 330:10 352:15 419:7,11 441:20
MTFs 408:13,18,22 410:4,9 414:18 415:6,7,21 416:10 416:14 417:22 418:2 420:17 422:13
multiple 8:17 22:21 144:19 268:7 283:3 309:7 310:17 400:11 440:1 455:2
multi-day 343:9
mute 6:6
mutually 76:16 257:17
MWR 341:17
myriad 363:10

N

n 1:10 124:16 125:2 296:1 298:9,9 420:11
NAFSO 384:22
nail 22:18 55:6
nailed 166:21
name 6:11 8:9 18:10,12 56:5 58:3,9 60:10 222:20,22 245:17 307:14 358:6 361:17
Nancy 1:22 231:8 318:3 332:5
narrative 113:17 119:9,14
NARSUMs 197:1
national 5:8,21 6:4 41:4,5,6 140:4 184:4 185:9,18 188:16 219:20 220:6,12 222:2 223:4,10,11,12,15 223:18,21 268:5 271:20 272:4 277:6 292:5 293:4 343:3 387:9 390:8 396:17 397:10 457:21 458:3
nationwide 140:2 184:21
natural 216:18 391:10
nature 57:9 153:13 341:6 357:21
Navy 5:6 41:13 42:12 45:20 60:16 85:18 124:12 287:2 317:9 407:8
Navy's 91:17
NCA 317:9
NCO 401:12
NCOs 401:12
NDA 152:14
NDAA 345:10 467:11
near 143:13 290:16 385:3
nearly 10:17
near-term 135:12
necessarily 141:7 184:15 328:17 348:18 407:10 457:14 464:7
necessary 51:1 249:14 290:14

328:20 436:4
necessity 395:5
need 8:15 17:18 19:10 40:19 44:17 50:10,17 52:9 54:19 55:7 60:3 63:6 68:15 77:20 80:8 81:5 101:3 121:20 126:14 128:3 155:12 160:2,17,18 161:17 162:9 172:3 176:17 179:19 187:11,19 191:12 196:9 206:1 211:4,10 215:19 217:13 219:6 226:22 240:8 255:1 267:15,16,19,20 271:15 277:6 278:4,19 279:12 283:6 284:2 287:9 290:1,2 293:8 296:21,22 298:3 301:3 304:6 306:19 317:22 320:17 324:16 327:1 330:16 331:19 335:21 336:13 339:2 347:3,15 350:2 351:7,12 353:19 357:9 359:6 365:19 374:11 375:3 378:4,5,19 407:12 411:16 417:3,17 423:5 430:22 432:21 434:16,18 436:10 436:15 437:18,19 439:13 442:11 443:2 447:1,17 454:11 457:8,14 459:7 461:4 462:15 464:6
needed 25:4,17 77:4 91:15 193:12 268:4 288:1 359:13 362:15 363:6 398:5 431:1 431:11 433:1 463:16
needing 104:4
needle 132:13
needs 10:21 20:16 45:2 77:14 105:6 106:3,19 108:14 117:21 146:10 148:21 166:10 168:15 182:5,11 182:12,19 183:3,5 183:12 206:3 211:13 214:1 271:14 273:19 274:10 276:17 287:7,16 289:10 290:13 293:7 325:1 331:13 334:18 340:17 358:3 362:12 373:20 381:18 383:16 408:6 415:15 424:14 430:20 439:17 446:13 457:7
negative 29:20 98:12 108:19 113:22 311:21 411:4
negotiated 463:4
negotiating 155:18
neighborhood 166:7
neither 109:6
Nellis 402:21 403:1 403:2,7,9,22 404:4,6 406:6
network 60:14 290:6 296:13 450:12
networking 64:8
neutral 108:6
never 79:7 89:10 123:13 132:10 220:7 255:12 268:18
new 4:16,18 5:6 76:19 137:12 146:15 149:10 150:16 152:17 155:12 157:13 158:3,10 160:11 162:22 163:5,20 166:9 183:16 204:18 206:9,10 208:14 217:12,17 217:18 267:10 268:3 282:21,21 327:7 345:21 351:16 363:21 385:18,19,20 388:21 398:12 414:3 430:1,11 441:12 449:2
newest 317:5
newly 75:14 382:6
Newport 7:11
news 7:11 279:14
newsletter 265:13 268:12
newsletters 432:17
next-of-kin 463:14 464:5
NGAUS 283:12
nice 31:3 217:9 348:3
Niemetz 282:18 292:1,2 293:17,21 295:21 300:12 301:19 304:11
night 138:7 326:21
NIH 6:17
nine 126:18 250:1 268:13 295:4
ninety-five 134:11
NMA-kind 313:16
nobody's 263:11
nods 53:7
nomenclature 167:16 172:4 173:15 179:14 180:2,20 185:5
non 29:17
nonclinical 357:2 364:2,10 439:16
noncompliance 180:22 214:3
nondeployable 26:19
nonevidence 395:18
nonexcellence 141:18
nongovernmental 397:9
nonmedical 321:14 325:14 359:5,17 362:3 371:8 396:11 429:20 430:16
nonparticipants 341:5
nonparticipate 309:21
nonparticipating 310:3
nonparticipation 309:16
nonreadiness 323:1
nonready 352:11
nonresponse 80:5 91:16
non-DoD 1:12 4:5
non-medical 106:21
non-readiness 28:5 37:11
non-ready 29:13
noon 69:16 187:20
Norfolk 41:11,12 41:14 42:5 45:21 55:7
norm 140:4
normally 311:4
North 106:16
note 31:8 108:12 208:17 405:1
notebook 261:15
notebooks 261:13
noted 18:17 107:1 253:14
notes 46:1 47:5
nothing's 190:16
notice 67:6
noticeable 18:6
noticed 18:9 302:21 419:22 420:12
notices 207:22
Notwithstanding 301:19
November 204:19
NRD's 226:12
Ns 115:15 124:22
number 14:16 21:5 30:8 31:15 71:6 73:11,22 83:18 87:3,19 104:2 109:11 118:16,17 122:16 123:20,21 124:9,11 125:9 127:3,21 131:2 138:5 144:19 145:2,10 148:15 149:20 150:9,14 150:19 151:4 153:3 168:22 169:7,8 172:19 178:4 188:9 210:15,21 230:7 232:9 247:11,12 274:22,22 278:18 281:4 359:9 366:15,16 390:10 405:6 419:8 428:8 454:15 457:14 458:4,10 459:4 465:10
numbers 35:7,8,9 35:10,12,14,20 49:2,6 66:7,8 80:22 82:16,17,17 83:6,21,22 84:3,5 85:5 86:22 87:22

94:13 98:5,6 123:16 124:1,14 126:2 144:16 188:22 189:1 190:19 206:22 274:14,20 275:5 275:18 299:8 300:2 307:22 390:13 405:7,10 419:18 420:1,5,19 421:3 427:9 455:11,12 456:17
nurse 5:5 18:13 19:3,7,22 25:20 26:16,20 27:11 234:16 235:9 238:1,2 240:15,20 243:17 244:10 246:5 256:19 265:3 268:18 269:2,3,5 285:15 285:20 286:12 287:20
nurses 268:17 286:11 439:4 440:16 457:22 459:16
nursing 286:20
nuts 304:5

O

OASD 70:8 71:10 73:10 75:17
obfuscated 124:20
objections 306:10
objective 289:1
objectives 259:19
obligation 212:11
observation 315:10
observations 229:22 270:20
obsessed 150:14
obtain 73:21 90:13
obtaining 102:22
obvious 135:18 350:20
obviously 8:20 31:4 68:10 110:17 157:16 235:21 282:9 313:7 327:10 334:3 345:16 371:4 375:17 392:15 407:3 423:2
occasional 202:13 209:4
occasionally 90:6
occasions 400:11
occupational 18:16 347:8
occur 34:15 216:18 254:1 410:22
occurred 112:16 392:22
occurs 78:3 384:14
October 57:4 69:5 183:15,22 204:19 223:19 225:22
offer 217:10 340:5 425:12 428:9 435:10 446:18
offered 339:20 377:7,7,8 445:5 446:4
offers 324:4
office 2:2 14:13 23:10 71:10 74:11 87:18 92:10 99:20 102:17,20 130:21 162:2 168:13 230:16,20 261:12 274:1 292:19,22 302:1 341:14 356:13 365:14 384:9 399:6,21 423:19,22 424:2
officer 4:21 80:2 378:12
officers 20:20 25:22 99:6 100:19 407:22
officer-high 23:15
offices 59:19 73:12 85:11 101:22
official 62:15 66:21 313:15,19
officially 369:10
offline 63:13
offset 80:9 408:17
offsite 250:11 380:15,15
offsiting 432:4
oftentimes 81:19
of-stay 248:7
oh 23:8 33:21 251:14 256:2 272:2 308:13 336:12
OIP 267:16 268:2 294:11,15 338:6
OIPs 295:20
okay 38:15 39:12 45:5 52:7,19 53:11 54:21 55:13 70:6 79:17 88:11 88:22 101:21 102:13 104:17 116:10 122:5 126:12 128:9 130:15 135:7 137:7 140:21 141:1 159:10 162:10 164:16 169:13,15 176:16 178:22 180:14,15 188:8,10 195:14 200:5 202:18 203:9 218:5 228:3 239:5 250:16 252:19 256:2 264:4 271:17 272:22 273:2 278:8 293:12 298:15 313:6 315:11 319:7 328:4,15 331:15 337:22 338:21 339:17 344:18 348:19,22 349:14 350:1,7,8,8,16 354:19 355:6 363:1 365:6 366:2 372:10 373:16 374:15,16 375:15 377:15,19 380:9 381:10,15 382:15 382:16 383:14 392:2 394:8,18 397:22 404:17 409:3,11,14 411:15 413:16 419:14 421:19 422:1 423:8 429:12,14 436:12 436:12,21 437:4 437:16 444:3,6 448:2 452:10 454:21 455:13 456:1 462:3,21 463:1 466:7 468:3 468:7
old 138:1 166:3,4 223:1
once 21:2 49:7 52:10 55:15 57:11 57:12 81:17 96:12 191:21 205:8 220:5,10 301:22 335:1,17 370:12 377:2 406:19 443:17 449:22 461:6
ONED 366:4,4
ones 85:15 89:16 105:8 109:1 118:20 165:10 167:12 192:1 204:16 205:15 234:5 321:14 338:11 387:15 388:18 423:3,3 441:6 442:21 467:15 468:1
OneSource 219:21 220:13 222:3 226:13
one's 164:18
one-on-one 69:1
one-pager 200:16
one-stop 33:6 260:11
one-week 260:2,3 269:1
ongoing 236:22 251:11 254:10,21 308:19 364:9 367:22 430:3,9 441:2,11 450:16
ONL 419:11
online 62:14 66:19 207:13 225:15 323:13
onpost 333:7 334:3
onsite 43:11 265:9
onward 104:13
on-post 346:14
on-the-ground 44:5
open 23:9 58:17 65:4 206:13 450:22
opened 212:15
opening 155:16 323:7
operate 209:9 277:19
operating 34:5 408:14 430:2
Operation 2:4 333:5 334:6 341:14
operational 84:17 85:18 112:8 270:14 332:12 333:18,22 334:18 398:5,8 425:11
operationally 322:10 398:22
operations 2:6 56:6 245:19 251:17 358:8 396:18 403:6 408:11
opinion 345:17
opinions 61:18
opportunities

14:10,10,15 31:5 206:11 226:16 227:10 254:19 266:13 324:5 334:1 340:21 342:16 360:22 365:21,21 425:12 451:3
opportunity 138:21 199:22 229:6,14 233:4,19 299:17 310:22 311:11,21 319:11 334:6 342:3 343:4 344:11 358:11 416:18 451:2
opposed 116:22 333:10 459:3
ops 363:19
opt 338:12
option 299:14 302:17 316:1 345:11 394:1 434:1 446:5
options 233:18 360:11 362:7 369:2,5 370:9,15 371:10,16
orange 107:2
order 29:12,17 62:5 121:19 143:9 218:9 322:10 338:1 352:2,13 353:6 361:16 368:14 393:1 444:16
orders 86:1 298:21 299:1,3,10 313:15 313:19 351:22 352:4 386:15,17 387:19,22 388:4,5 388:10 389:8 392:6,10
org 293:19
organization 33:13 264:12 265:14 275:10 282:18 430:11
organizational 267:17
organizations 64:4 64:4 265:6,11 274:17 397:9,10 458:2
orientation 234:18 266:7,8 269:1 308:17 346:21,22 441:2
original 467:4
originally 39:22 40:21
Orlando 44:8
Orr's 44:20
OSD 75:17 165:18 237:12 256:1,2 258:12 360:14
OSD-level 201:12
OT 246:8
OTSG 2:9
ought 52:9 198:18 198:22 249:8,8,10 457:18
outbrief 431:21
outcome 249:16 357:18
outcomes 195:15 197:1 198:16 215:12 218:16 233:17 235:18 239:11 249:5 288:19
outfit 183:20
outflow 432:1 433:1
outpatient 79:3 93:7 112:4
outputs 264:2
outrageous 20:9 207:22
outreach 7:9 18:10 55:19 56:9 432:18
outreaching 55:22
outside 12:1 14:5 14:11 36:9 188:6 226:6 279:4 286:8 336:15 353:3 394:10
outstanding 93:13
outyears 190:7 213:6
overall 17:9 74:22 86:20 95:12 106:19,22 112:22 113:14 125:22 372:5 460:2
overarching 34:22 141:10
overbudgeted 40:22
overdue 416:19,20
overfly 90:6,7
overhauled 257:3
overlap 260:7 345:7
overlay 111:9 135:20
overnight 172:5 173:16
overseas 298:21
oversee 175:15 200:22
overseeing 353:11
overseen 204:11
Oversees 255:19
oversight 162:18 170:15 174:13 175:11,19 176:1,2 179:12 202:7 204:1 211:21 253:4 255:4 270:1 270:3 271:1 274:2 274:4 297:19 312:4 320:7 351:20 367:17
oversight's 175:13
overwatching 182:7
overwhelming 422:5
owe 143:10 164:3 170:14 171:3
OWF 346:13
owner 129:8,15
owners 129:10
owns 129:19 266:5 266:5 267:5,5,6 271:8 272:15
OWR 68:3
O6 364:3

P

package 375:5
packets 309:8
page 45:8 55:15 68:20,22 114:17 207:8 265:18 373:10,10 463:16
pages 38:20 207:7 324:18,19
paid 14:6
pain 117:14 199:4 234:11 302:20
palm 213:6
Palms 10:18 40:2 45:13 192:20 193:9
panel 27:14 306:10
paper 8:14 9:22 11:14,19,21 26:15 203:6 270:22 323:12 325:11 326:2 354:11 411:13 454:1
paperwork 203:18 354:22
paradox 24:6
paralegal 32:22 33:1
parallel 352:3
parameter 340:3
pardon 105:9 426:11
Park 162:5
parochial 48:17
part 9:11 14:2 28:15 29:3,16 40:12 46:4 59:1 80:1,12 82:6 94:9 97:21 101:8 163:1 165:21 167:7 169:16 184:11 188:20 192:18 195:6,9 196:21 231:1 233:18 269:3 280:21 281:15 290:4 307:6 308:17 310:9 312:6 317:18 319:3 330:20 331:2 332:18 349:7 359:1,2 369:10 371:14 390:21 392:12 393:4 399:7,9 400:19 401:20 413:12 416:6 450:5 457:19
participant 445:20
participants 11:7 14:7
participate 71:17 99:12 265:3 333:11,15 338:2,5 338:8,11,13,13,18 340:14 341:8 382:20 402:20
participated 92:21
participating 31:12 50:20 254:16,21 342:22
participation 56:19 58:18,19 59:1,5 59:22 61:9 64:14 67:19
particular 28:1 74:9 76:9 93:21 105:15 106:11 119:19 178:12 179:3 241:8 248:15 270:18 273:20 274:3,6 276:3,10 290:22 318:10,17 322:19 323:10 329:17

346:4 391:16 393:15 418:8 421:21 464:14
particularly 90:18 329:11
parties 309:6
partner 437:19
partnered 381:17
partnering 374:12 380:11,12 405:18
partners 320:21 399:2 441:8
partnership 287:20
parts 458:7
pass 24:9 51:3 319:8
passed 152:15 345:16
passive 57:9
paternalistic 219:7
path 237:1 240:13 241:7 318:22 320:12
pathways 237:4
patient 198:17 216:2,14 240:12 242:19 243:9 245:4,13 249:3 285:14,14,14 357:21 358:21,22 403:6,12 463:18 464:4 466:12
patients 148:16 196:14 198:2 242:9 357:16 458:4 459:6,7
patient's 358:3
pay 147:1 153:8,14 157:1,10 159:7 194:21 299:4 392:7,8 393:21,22 394:4,5,6,9,13
paying 29:14 158:8
payment 159:5
pays 129:19 130:1 152:4,4 153:22 156:17 159:6
PCC 266:9,10 268:13
PCM 238:17
PCS 193:10
PD 88:4
PDF 60:1
PDH 88:2
PDHA 86:2 87:2
PDHAs 78:15 87:6 87:19 88:9 102:22 104:6
PDHRA 86:2 87:1 141:5
PDHRAs 87:6 88:9 103:1
peak 110:19
PEB 15:2 110:11 114:1 122:13 125:8,10 133:2 301:3 305:12 369:16,21 410:20 416:7
PEBLO 142:7,14 151:15 152:2 189:15 197:20 214:8 370:19 407:2,4 408:2,15 415:10 418:17 423:4
PEBLOs 142:7 159:22 189:11,11 197:21 198:5 199:8 214:7 384:5 408:1 415:7 417:1 418:12,14 422:7
peers 305:18
pending 33:1
Pendleton 174:21
penny 201:15,18 208:6,7
Pensacola 407:7
Pentagon 132:10 222:3
Pentagon's 170:13
people 8:18 11:18 11:21 12:12,17 13:12 14:9 15:20 16:6 17:2,12 18:11,15 20:9 23:14,21,22 24:11 25:1 26:17 27:3 31:16 33:2,21 35:8 36:1,12,14 36:17,18 37:7,9 47:3 49:2 57:11 57:12,17 58:16 59:6 60:4,6,21 61:19 62:7 63:3,5 63:20 65:8,9,13 65:16 66:12 81:5 81:17,20 82:18 87:3,10 89:5 93:21 104:18 113:4 117:17 119:15 120:20 122:17,18 125:10 133:5 140:18,22 141:5,8,21,22 142:5,9 143:22 145:19 147:12 150:2 156:5 157:17 158:17 163:3,3 167:3,4,5 169:21 170:6 182:20 183:4,11 185:18 189:22 190:1 191:10,12 197:11,18 198:7 198:22 199:1 202:1 203:12 204:14 205:14,16 205:20,20,22 209:12 211:19 212:17 221:9 222:12,15 223:19 225:1,21 226:6 240:8 243:3 245:19 254:22 259:15 296:10 309:12 310:20 321:8,14,17 325:14 327:8,16 328:19 329:1 331:18 332:1 361:22 371:17,22 375:10 377:7 387:4 398:16,21 400:15 406:19,21 409:19 423:19 424:3 426:17 433:8 434:3 440:20 452:4 453:10 454:16 460:2 466:20 467:1
perceived 14:18
percent 28:1 74:19 74:21,22,22 78:1 80:7,12,17 81:2 82:7,8 85:2 87:6,7 87:16 91:18 94:1 94:3 95:6 96:18 97:6,7 98:5 107:16 108:8,11 108:11 109:16 111:5 114:20,21 115:4 122:20,21 133:21 135:2,2,22 137:13 140:22 141:4,11 144:3 147:7 202:4 225:9 240:5 300:5 302:8 307:17,18,20 308:1,6 312:14 338:10 351:20 406:19 415:16 417:7 418:6,7 420:8 421:2 422:14 454:14,17 455:4
percentage 84:9,10 86:9,11 95:7 107:21 108:3,4 113:4 124:2 132:18 140:15 158:17 300:8 312:14 340:6,13
percentages 28:8 29:17 85:4 94:4 115:15 419:17,21 420:16
perception 336:17
perceptions 128:19
perfect 120:17 122:19 263:18 281:3 282:13,20 283:21
perfectly 120:22
perform 374:22 425:16
performance 70:8 137:19 141:16 420:4 453:6
performed 445:8
performing 414:19 426:1
period 40:5 47:9 103:21 105:7 112:18 160:9 175:21 329:22 337:17 417:14 447:13
periods 129:7
perks 336:18
permanent 427:22 429:19
permission 307:2 311:1,15 465:4
person 25:7 109:3 121:5,6 122:22,22 134:21 146:15,15 146:21 150:10,12 150:15 155:17 157:13 160:21,22 166:5 182:7 185:22 200:13 202:13 206:13 208:9,11 215:14 220:10 228:10 258:8 259:4 262:4 275:9,19 276:8 283:2 298:12 311:14 317:4,7 321:8 322:10 326:20 329:6 370:4,13 372:6,6 372:14 377:3 423:15 434:13

461:17 462:6 463:1 466:10,11
personal 12:19 62:20 118:8 246:13 332:19 333:1 338:19 341:18 342:4 347:16
personalities 63:3
personality 169:11
personally 133:8 332:15,20
personnel 71:11 73:11 75:18 99:21 99:21 102:16 152:16 256:8 348:12 360:17 364:3 366:12 375:21 396:5 399:8
personnelist 375:11
person's 195:20 340:12
perspective 75:19 136:9 218:4 240:16 338:5 381:7 392:14 427:7 440:9 460:22
phase 133:2,3 136:8 138:16 164:5 192:8 330:8 331:14 415:10 432:6,7,7 458:17
phases 148:11 190:3 432:5
phase-by-phase 138:15
phenomenal 156:20 183:14 184:7
Phil 176:19 187:13
PHILIP 2:1
Phillip 39:10 130:19
Phillips 1:18 6:16 6:16 18:2 19:18 19:19 22:21 24:5 24:16 25:11 27:19 29:19 49:10 50:21 51:6 63:8 65:11 97:4 98:4 106:12 114:11 115:2,18 121:21 156:8 157:21 169:2 183:6 192:17 206:16 207:2,11 209:21 287:6 308:11 343:19 344:5,18 345:3 418:4 419:3 447:7 455:14,16,21 456:12
phone 54:3 81:12 82:17,17 83:6,18 83:21,21 84:3,5 90:2 292:15 304:15 381:21 432:15,16
phonebook 137:22
phonebooks 138:2 138:2
phones 83:9,10
photocopy 220:14
photographed 200:16
phrase 97:9 395:17
physical 96:11 110:6 149:12 156:14,15,16,17 156:20,21 157:10 157:19 158:15 159:3 194:17 231:18 246:12 407:22
physically 60:2 111:20 266:3 320:18 378:8
physician 7:11 19:5 19:6 194:18
physicians 216:9 375:6
pick 276:17 389:21
picked 185:14 346:10
picking 109:3
pictorial 92:16
picture 145:10 416:5 422:6,22 441:18
pictures 162:2,7 296:20
piece 37:16 135:11 153:16 175:19 203:6 291:14 312:7 318:15 331:22 351:8 386:20 436:8 440:11
pieces 102:22 371:4
pilot 403:13 404:5 406:1,5
piloted 286:6
Pinellas 162:5
pink 109:1
pinpoint 27:7 235:20
pipeline 190:6 191:12
pitching 282:15 283:18
pivot 420:18
pizza 309:6
place 13:14 23:21 33:20 49:13 73:19 149:1 162:16 175:11 182:14 185:22 186:7 205:3 216:18 233:14 234:5 235:5 252:10 253:9 258:19 265:20 267:3 274:5,8 276:13 280:12 284:11 287:7 299:12 311:12 315:15 316:10 329:21 352:10 353:19 360:20 408:9 414:10 417:8 427:18 428:21 430:16 438:5
placed 290:5
places 12:17 32:13 109:12 162:4 183:7 193:3 200:8 215:18 271:19 278:7 279:11 294:8 316:6
plainly 253:21
plan 9:5 20:4 28:14 52:16 65:1 118:21 164:4 168:21 170:11 192:1,7,14 200:6,10 205:6,10 209:16,18 231:3 233:7 236:3,7 253:2,11,16 255:3 255:13 258:6 269:6 276:21 307:2,7 317:22 354:6,6 358:19,20 359:3 371:14 383:3,6,12 396:3 399:15 417:10,12 439:13,14 442:7 443:21 444:15 453:19 466:3
plane 223:2
planned 40:21
planning 52:9 63:17 170:3 205:8 385:3 452:6
plans 9:13 34:2,17 40:19 203:22 212:10 235:11 236:12 287:7 347:16 391:7
plate 156:7
platforms 38:8
platinum 167:8
platoon 25:2,6,12 25:13,21 204:12
play 271:7 396:17
played 16:7
playing 24:11 54:11
plays 145:8
Plaza 1:10
please 5:11 34:5 69:8 78:10 79:17 122:3 163:14 164:17 181:15 195:13 200:4 214:22 228:19 233:11 245:10 252:22 260:14 273:3 274:12 294:1 324:20 343:19 346:3 357:11 394:21 407:19 409:13 422:2,19 423:8 430:13 438:17 447:22
pleased 15:22 163:5 195:5
pleasure 229:13 319:10
plot 98:10
plus 359:3
PNR 218:2
pocket 5:13
pockets 109:15 184:5
Poindexter 2:8 358:4,6,7 371:2 372:8 395:11,12 425:7
point 12:14 21:14 27:20 44:9,9 50:4 72:21 79:13 81:3 88:12 93:11 103:18 118:20 130:7 143:1,8 150:20 154:14 157:11 158:1 177:11 180:21 183:13 185:6,13 188:11 193:16 198:19 204:6 221:7 222:5 224:8 239:21 247:14

248:12 271:22 276:7 283:3 302:19 306:17 311:3 314:16 327:16 335:2,16 335:18,18,20,22 338:14 339:9 363:13 365:15,18 369:7,9 370:6 371:22 372:4,13 372:13 373:5,20 377:19 378:10 380:10 381:18 382:4,13 385:17 392:20,21 395:21 403:4 420:15 434:6 445:12 446:19 447:16 451:10,16 452:7 459:5
pointed 145:17 158:5,7
points 7:12 62:2 66:22 98:2,7,8,11 100:22 106:9,10 106:11 111:7 124:9 132:18 175:2 222:6 233:16 253:22 300:8 315:19 359:11 360:2 395:13 434:7 447:3
poised 34:15
policies 44:11 276:5 360:17,20 361:1 363:8 364:20,21 365:4 367:15,18 414:9
policy 2:2,9 16:15 16:16 17:3 100:1 130:22 132:22 139:10 171:4 173:22 174:1,4,8 174:13 175:11,15 176:2 177:1 184:19 185:10 193:17 204:18 205:14 212:6 213:16 245:20 267:3 269:22 270:2,22 297:19 312:4 330:12 336:22 346:1 358:8 362:20 363:6 364:6 389:2 391:18,20 393:10 393:16,16 398:9
polite 218:19
politick 312:8
polytrauma 190:12
POM 252:15,16
POMS 366:6,8
POM'd 252:18
POM4 366:12
poor 93:12 109:18
popular 57:20
population 10:21 22:1 29:4,13,14 35:21 36:9 48:14 141:11 189:5,20 198:9,15 199:7 234:10 237:9 238:20 249:4 260:10 273:20 274:11,15,20 275:4 276:3 289:19 302:7 306:21 307:17,18 328:14 351:21 392:4 440:13 442:21 455:5 466:17
population-based 191:5
portal 292:9,18
portfolio 177:15
portfolios 219:7
portion 50:7 171:16 330:22 359:22 434:21
position 15:4 181:18 231:22 256:18 259:2,18 269:9 333:8
positions 33:3
positive 15:20 29:21 88:19 98:12 106:7 107:13 110:16,16 113:13 113:15,22 141:5 208:17 229:22 293:18 311:13,22 396:13
positively 416:3
positiveness 179:5
possibilities 120:2 216:5
possibility 65:19 254:11
possible 19:11 52:4 61:8 64:12 115:3 234:3 236:11 341:21 344:11 349:6 362:17 400:7 427:13
possibly 34:7 59:2 326:8
post 36:16 57:13 60:2 62:15 71:5 85:9 143:4 160:20 186:3 234:10 270:18 272:18 341:15
postings 59:15 62:15 67:2
posts 24:19 59:4 141:16 188:15
post-deployment 77:8,20 78:1,15 78:16 80:17,18 85:9
post-military 30:7
Post-Operational 3:9
post-separation 344:16
potential 27:7 287:3 344:21 357:22 371:9 397:11 407:14 426:10,13 433:15
potentially 260:1 419:20
power 463:13,19 464:3 465:21
practice 17:19 18:17 27:17 233:22 238:5,6,14 238:16 240:16 241:22 242:5 248:9 285:21 291:20 358:18 395:8
practices 18:9 140:3 237:8 265:15 288:14 348:11,15 418:9
practitioner 197:5
practitioners 133:1 156:3,4,5 196:21 198:21 199:9
pragmatic 173:7
precise 27:20
precisely 235:20
preclude 313:10
precluding 177:10
predict 235:17
predicted 197:1
predicting 215:12
predictive 198:16
predominantly 84:22
preemptive 34:4
preferred 67:9 107:20
preliminary 5:1 305:2
premature 351:10
premise 319:20,21
prep 206:3
preparation 318:8 333:14 343:7 347:13
preparations 370:16
prepare 318:21
prepared 18:7,8 154:7 320:19 354:12 370:3 440:16
preparing 77:10
prescribe 393:10
presence 66:19
present 1:13,21 2:1 52:11 70:16 72:22 448:14
presentation 230:13 231:11,20 438:15
presented 74:10,12 100:19 101:6 118:14 242:9 400:21
presently 231:13
presents 108:20
President 195:5 225:11,12
Presidential 221:4
presiding 1:12
pretend 393:8
pretty 9:1 10:2 42:2 45:19 46:9 47:7 64:13 66:3 67:18 69:15 95:4 148:5 182:9 258:18 263:17 278:12 279:6,6 282:14 283:20,21 288:13 303:18 360:4 369:2,17 404:14 431:22
prevent 416:18 423:7
preventing 280:22
previous 19:6 122:14 131:2
previously 144:15
pre-command 265:2 266:11
price 153:7 193:7
pride 242:22
primarily 48:15 66:20 139:2,3 260:9

primary 19:5,5 25:2,8,9 56:12 59:21 67:9,22 222:11 240:22 322:13 425:16
Prime 187:22 192:5
principal 2:1 77:6 130:20
print 225:15
printed 10:1
prior 59:17 72:10 83:11 325:22 330:7 343:16 362:8
priorities 264:21
priority 134:15 136:2 329:1 361:11
Priscilla 1:24 228:9 230:15 233:2 243:14 256:12,22 266:12 267:7 294:22
privacy 115:14 465:5
private 342:20 345:12 348:6 439:9 441:21
privately 82:1
proactive 194:7 414:21
probable 239:11
probably 8:7 12:15 15:19 31:22 55:3 64:17 68:11 69:20 84:22 85:7 148:17 157:9 193:13 196:11 210:1,3 217:16 220:4 221:21 278:4,8 280:1 281:4 284:15 315:4 316:12 320:1 321:6 334:7 347:21 360:4 405:3 406:5 407:15 413:21 433:8 436:15 459:2
problem 12:16 24:8 28:5 118:9 123:13 159:15 208:19 209:3,8 298:8 314:2 325:21,22 380:6 386:11 388:20 412:10
problematic 96:7 171:11 312:12,22
problems 29:18 78:6 95:22 96:1 120:8 298:12
procedures 270:10
proceed 14:1 236:16
process 8:14 11:3 11:14 12:18 13:17 14:22 15:6,9 19:17 26:12,13 27:8,13 28:15 48:22 49:5,7 50:15 51:21 53:20 64:12 70:2 110:4 110:6 111:20 113:11 114:11 116:14 129:16 139:2 146:12,14 146:17 147:13 151:20 152:1 155:22 156:9 157:17 158:10 161:18,21 196:22 198:4 213:5 235:3 239:18 240:15 247:15 249:16 260:18 273:7 274:8 288:12 299:9 302:21 308:19 315:18,22 316:1,22 318:14 325:9 330:7,7 335:10 351:9,21 352:4 354:17 365:19 366:5,13 368:4 370:8 372:3 374:12,20 375:22 376:5,11 380:5,18 380:22 381:2 385:22 389:1 401:2,20 402:9 409:20 410:1,7 411:9 417:4 418:16,18 420:1 423:15 424:1,8 425:1,2 441:17 453:1 456:14
processed 203:12 404:4
processes 120:21 195:17 198:10 298:22
processing 12:19 309:9 327:17 424:17
process-oriented 114:6,12
produce 357:19
produced 86:15
product 42:7 45:18 46:2 51:11 129:2 203:15 205:11 209:8
productive 360:15
products 40:9,9 45:22 46:4 47:2 47:12
professional 242:7 396:11
professionally 104:4
professionals 216:8
profile 26:14 28:21 29:7 30:17 331:3 331:3,14 428:3
profiles 27:1,11 29:1 325:22 326:1 329:17 427:21,22 428:1
program 1:23 2:16 13:10,13,14 15:11 15:15,19 16:4 30:14,17 31:7,13 31:16 36:10,11 37:2 42:4 45:2 73:13 89:5 91:11 91:17 102:18 104:22 154:20 164:21 169:19 172:1,17 176:22 178:10,17 180:21 183:16 185:9 206:18 229:17 230:1 232:2,3,5 232:15 243:20 254:6 255:19 266:7,8 267:6,17 268:4 269:1,1 271:2 273:16 285:2 290:12 300:16,17,21 301:4,6,9 305:7 307:15 311:15 313:10 316:19 325:1 329:8,12 334:8 336:19 341:13 342:2 343:13 346:21 348:17 361:19 362:3,21 365:8 369:1,11 370:22 373:11 381:4 383:7 394:16 396:14 397:1,5 398:7,19 401:14 401:17 402:16 403:3,13 404:19 405:13 406:2 412:18 413:2,4,13 413:14 416:9 425:18 426:17 428:20 431:10 432:1 436:2,5 437:2,4,12,15,22 438:9,16,20 439:5 439:11 440:10,18 441:3 442:13,16 442:17 443:15 445:7,19 446:15 447:8,12 450:11 452:12,17,21 453:7,15 454:7,18 457:2,15 460:22 466:9 467:10,10 467:12,15,16 468:2
programmatic 312:4
programmatics 285:2
programs 3:17 8:22 9:2 14:7 16:14 35:3 44:12 89:4 91:10 119:7 234:18 238:10 292:20 299:12 310:17 333:11 347:1,15 356:10 362:1 365:2,3,5,5 365:7 366:3 369:19 397:15 398:18 402:11 413:14 425:10 431:9 439:6 441:5 441:13 442:18 445:17 446:14 448:4,17,22 449:5 449:8,19 450:2,13 450:19 463:20
progress 178:14 197:15 221:11 382:21
progressed 385:17 418:22
progressing 383:9
prohibit 312:5
project 251:12,14 251:16
projects 260:21
proliferate 56:22
promise 162:11 163:17
promised 248:18
promoted 414:2
promotion 361:3,6

promulgating 237:3
pronunciation 322:5
proof 140:15
proof-of-concept 248:3
properly 22:19 214:7 347:13
proponents 238:13
proportion 93:20
proposed 39:8,13
proposing 42:11
prosthesis 199:3 219:3
prosthetic 247:11
prosthetics 199:16
protected 73:6
protection 322:6
protocol 64:18 444:9
protocols 233:14 233:21 235:8 357:13,20 358:1
proud 221:16
provable 137:6
proven 422:12
provide 16:18,19 83:20 95:18,18 99:3,14 100:12 101:17 102:1 113:16,18 115:12 115:15 119:12 120:7 122:11 123:5 125:12,16 126:5 192:20 209:7 229:15 232:15 233:15 235:22 241:21 242:1 246:10 257:20 261:16 265:8,20 269:19 287:18 292:14 303:3 318:19 333:19 338:2 342:15 346:16 356:15,16 357:8 359:14 381:6 384:1 395:2 405:21 408:3 409:19 416:13 419:9 422:18 423:12 426:14 432:22 438:21 439:18 440:9 444:16 446:12 450:17 454:7 455:12
provided 46:20 74:13 131:5 216:11 231:1 235:9,16 261:16 334:9 357:6 380:8
provider 77:16 88:14 243:7 418:17 463:17
providers 216:12 326:11 417:16 418:12,14 421:12 423:6
provides 243:22 253:19 257:19 265:15 271:21 286:3
providing 32:11 139:3 299:8 318:6 341:7 343:14 358:16 370:1,4,13 382:13 396:10 427:11,12 442:19 449:20 457:6 461:9 462:10
prudent 56:21
PTS 144:22 215:14 232:12 312:17
PTSD 238:15 306:4 378:2,17 392:17 395:1,5,9,22
public 57:20 58:20 59:19 62:10,21 64:20 129:1 396:13,16 456:11 468:9
publication 366:22
publications 28:11
publicly 28:7
publish 39:5 137:22 175:20 261:2,4 352:2,13
published 57:13 176:10 183:15 261:10 290:16 329:19 352:9
publishing 185:8
pull 247:22 248:5 251:20 263:13 398:18
pulled 75:3
pulling 247:16 314:11
pulse 23:2
punitive 21:14
purchase 142:5
purpose 23:3 37:9 37:10 103:15 203:3,5,17
purposes 160:1 170:3 456:2
pursue 333:17
pursuing 68:8 155:14 310:18
purview 219:10,11 345:21
push 21:3 57:11 58:11 61:8 169:9
pushed 302:22
pushes 60:15
pushing 56:18 57:5
put 20:9 23:16 24:7 39:19 55:12 62:5 65:16 67:2 72:18 136:5,19 139:10 141:19 144:9 150:19 163:21 165:16 175:16 188:3 189:17 207:20,21 208:10 212:17 223:9 225:16 247:18 248:19 261:2 268:1 277:18 288:16 291:2 292:5,6 318:11 319:20 327:12 332:2 337:1 346:4 348:17 352:9 360:20 391:7 393:19 403:21 417:3,5,8,22 424:16 462:9
puts 120:22 211:10 265:14 330:3
putting 58:15 179:12 194:15 321:7,21 323:8 414:9
P-R-O-C-E-E-D-... 4:1
P.K 1:17
p.m 227:19,21 228:2 355:13,14 438:1,3 468:10

Q

qualification 406:17 412:8
qualified 79:11 381:3 454:15,19
qualifies 372:14,16 381:14 452:21 461:8,17
qualify 371:22 372:1 379:15,19 379:21 381:8,12 382:7 394:1 406:21 407:13
qualifying 30:9
quality 143:16 202:10 208:13 384:2 395:6
quantified 462:6
quantify 286:13
quardsman 146:10
quarter 101:4 106:1 110:14,19 110:19 111:7 125:6 267:2,3
quarterly 73:10 94:16 99:12,14,16 106:1,9 107:10 127:10,12 130:8 130:10,10 246:2 265:13
question 22:15 32:6 35:5 47:17 66:9 67:12 72:5 76:9 82:5,20 89:2 93:10,21 95:17 100:17 106:5 107:12,15 110:3 112:21 115:1,19 116:2 117:6 119:12 120:16 121:8,14,15 125:14 126:13 129:5,7 136:17 140:17 147:9 156:8 157:20 159:2,12 160:15 190:11 191:17 207:1 214:17 224:7 239:1,10 242:21 247:3 250:5 278:11 280:14,19 287:6 289:5 294:10 295:9 300:4 319:12 327:15 331:16 337:11,19 370:3,12 374:1,2 375:9,19 377:16 392:12 393:5,21 403:20 404:9 405:11 423:9 425:10 429:13,16 430:13 433:17 445:4 448:7 456:22 460:19 464:20
questioned 273:8
questions 20:7 73:2 73:3 76:21 77:7 86:18 92:6,12,17 92:19,19,21 93:1 93:4,6 95:20 96:9

96:13 102:9 106:17 109:22 114:5 117:14,18 118:3,4,9,12,12 125:4 126:15 131:7 132:7 140:13 186:1 200:9 228:20 241:9 265:9 274:6 276:20 332:10 347:17,22 356:14 356:16 357:4,8,10 358:12 374:14 421:21 464:18
quick 146:3 156:8 193:22 236:17 294:2 306:15 356:19 466:16
quicker 50:14 425:3
quickly 71:12,21 77:12 83:2 109:20 116:1 146:11 148:18 162:11 210:3 244:4 284:19 287:12
quite 39:9 60:12 68:10 165:15 172:19 186:15 187:12 244:5 328:8 334:14 388:16 406:17
quote 141:4
quoting 147:6

R

R 375:21
radius 292:11
raise 34:6 215:7 396:13,21
raised 66:6 358:12
raises 401:15
raising 6:2
ramped 148:15
ran 54:14,15 184:14
RAND 91:11 367:21 368:1
range 98:18 125:4 127:2 167:12 390:16
ranger 252:5
ranging 36:4
ranking 434:13
ranks 165:8
rapidly 16:11 227:3
rarely 90:5,6
RAs 87:19
rate 75:1,13 81:16 82:8,9 91:18 93:19,22 94:2 96:15,17 101:14 105:12 107:17 111:1 118:7
rated 96:20,22 107:15 110:10 158:1
rates 85:12
rating 13:12,18 15:2 107:21 108:3 108:4,9 110:16 113:7 140:21 141:1 144:9 156:9 158:1 406:18 427:3,14 454:14 454:17
ratings 14:12 82:6 93:11,17,18 95:12 97:5 103:16 105:11,14 106:3 107:16,19 108:14 109:14 110:13,14 110:18,22,22 112:22 113:2,18 122:7,13,21 125:8 127:17 135:19 144:5 151:10,11 152:20 153:7 426:19,22 427:21
ratio 213:3,13 276:22 280:9 408:14 456:19 457:14 458:4
ratios 211:10,11 271:16,16 278:4 409:17 430:15 459:13
raw 50:12 74:19 114:13 115:3 420:19
RCC 176:14 178:18 180:3,13 180:17 182:4,7,8 182:13 183:7 185:2 200:9 255:8 256:10 258:1 361:19 365:8 366:3 371:12,13 371:17 373:4,22 375:20 378:11,18 379:15 380:1,12 381:8,12,14,16 383:1,5,11 467:10 467:12,15
RCCPs 9:6
RCCs 178:15 184:10 360:7 364:1 371:7 372:1 374:3 375:16 380:16 383:2 425:19 430:7,16 436:7 450:1 451:7
RCP 179:22
RCPSS 201:18 383:7
reach 17:1 60:3 64:20 65:8 142:21 279:4 309:17 335:17 362:16 406:21 420:8
reached 181:15 196:8 307:16 308:2
reaches 335:18,20
reaching 64:3 280:22 310:8 367:19 380:4
reactive 194:5 414:21
read 18:21 94:8 104:19 105:1 125:5 174:12 209:18 467:5
readable 161:12
readily 316:7
readiness 1:22 2:11 28:14,19 37:12 41:8 71:11 73:11 75:18 99:21,22 230:22 231:2,10 322:8,15,21,22 323:11,21,22 327:13 332:7 427:20 428:2
reading 53:7 86:21 335:8
ready 28:9 29:5 33:21 42:10 52:10 316:10 319:5 325:6 349:18 357:7 427:5,5
real 9:1 10:17 116:1 140:17 142:22 143:2 148:19 155:9 167:22 178:14 181:1 193:22 199:22 208:11 222:7 247:3 266:15 281:9 283:18 284:19 294:2 306:14 312:8 356:19 420:3 466:16 467:7
realistic 35:2 168:20 171:6 173:7
realities 43:12
reality 15:14 34:11 44:15 52:12 54:13 267:12 291:9 307:22 341:5 405:3
realize 63:4 242:17 305:5 311:20
really 9:13 10:20 11:8,9,16,18,22 12:13 13:15 19:22 20:1 23:14 24:13 25:3,6,7,14 29:3 29:13 30:14 33:12 36:21 37:18,20 44:11,14 46:15 48:10 56:18 60:3 60:5 62:16 63:6 75:14 82:19 99:2 102:10 120:7,20 123:2,21 127:2 128:16 132:16 135:8,9 136:6 143:17 145:2 146:5 151:16 157:7 161:15,17 163:5 169:10 172:22 181:13,18 182:6 185:3 186:15 188:4 189:9 190:10 194:13,14 196:2,6 198:8,9 199:6,18 201:7 210:18 211:5 220:19 222:18 233:22 242:6 246:7 248:20 249:4,10 253:20 262:7 263:11 264:12 266:14 270:5 275:4 282:8 288:21 294:16 297:2,2,4 311:9 318:18 320:2,9 322:3 323:12 327:11,14 328:16 337:10,19 339:2,3 367:14 373:5 377:22 388:9 391:13 394:10 400:16 405:11 418:13,15 422:12 435:8 446:22 447:4 448:6 450:11,21 452:5

460:20 461:4
realm 308:3
realms 428:10
Realpolitik 336:5
real-time 322:19
rearranged 100:20 101:5 345:15
reason 36:20 41:12 75:1 89:3 91:21 128:22 129:2 157:18 188:2 209:21 239:19 327:14 328:21 339:6 388:19 439:11 452:16
reasonable 218:13 243:18
reasons 31:2 111:14 311:10
reassessment 78:2 78:2 85:10
reassessments 78:16 80:19
recall 466:8
receive 57:14 79:8 79:9 87:17 116:11 116:12 231:6 235:15 254:4,12 255:11,20 256:8 263:15 330:16 358:22 369:4 383:20 393:3 430:22 441:19 442:3 461:17
received 32:21 77:4 79:6,19,22 81:6 85:3 400:13
receives 219:18 255:12 463:22
receiving 235:1,12 275:1 276:8 289:12 349:8 390:16 392:5 400:15,18
recognize 60:19 168:18 172:15 181:12 184:10 234:2 320:4
recognized 285:13 306:19
recognizes 322:13
recognizing 324:15
recollections 46:1
recommend 77:19 120:9 395:6
recommendation 20:18 46:9 78:18 128:15 163:21 165:22 168:16 169:8 172:14 186:20 192:18 199:6 210:22 217:14,22 218:9 218:14 219:15 233:12 253:1 264:6 273:4 274:13 281:16 289:9 302:5 306:16 352:20 357:12,15 360:9 382:16 383:14,22 394:20,22 396:2 402:14 407:20 409:15 440:7
recommendational 88:15
recommendations 3:12 40:11 42:16 51:19 54:3 55:2 95:19 121:22 122:2 128:13 131:3 162:14 164:6 187:9 230:19 233:8 290:18 467:4
recommendation... 40:16
recommended 78:21
reconcile 154:6,8
reconvene 468:8
record 69:12 159:14,21 160:3,4 161:12 190:16 210:6 227:20 325:13,15 355:13 438:2 463:15 464:6,13 468:11
recorded 121:22
records 11:20 77:5 78:14,20 79:3,3 83:17 85:10 114:19 115:5 142:11 159:17 160:1,9 463:13
recover 252:13 320:11
recovering 1:4 10:3 70:9 104:18 165:4 165:13 168:5,8,9 169:14 172:2 176:13 189:1 198:2 209:7 219:17 224:2 239:13,15 261:7 281:17 282:10 299:4 306:20 319:4 350:19 368:22 369:9 370:2 383:9 391:11 393:12 396:5 402:17 431:19 433:12
recovery 2:15 9:5 9:13 27:5 169:21 170:1 172:1 173:2 199:2 200:6,10 219:18 220:7,9 236:8 253:2,11 255:3,7 256:4,21 258:21 261:7 290:3 319:14 320:20 322:14,17 357:14 358:1 365:19 370:7 371:6,14 373:11 373:18 381:3 382:18 383:3,6,12 384:8 396:12 398:6 400:1 401:17 405:19 412:22 426:5 434:15 437:11,14 437:21 438:8,16 438:20 439:2,10 439:13,20 440:3 440:10,15,21 441:10,14 442:7 442:13 443:16,21 445:9,19 447:5 449:15,17 452:22 453:19 454:4 462:18 463:4 466:3 467:9 468:2
recreate 282:22
recruiters 343:4
recurring 18:13 219:19
red 423:3,7
redefine 435:14 436:11
redefinition 435:20
reds 109:1 423:2
reduce 33:18 94:16
reduced 435:12
reducing 429:14
reduction 32:8,16
reductions 32:12 429:17
Reed 5:8 7:4 74:8 90:3 159:16 247:9 308:20 404:13 449:2 452:7
Reeds 123:12
reemphasize 19:20
reevaluate 156:11
refer 13:12 236:4 242:22
reference 55:19 67:8 69:6 79:13 273:10 332:10 363:9,10 364:7
referenced 28:11
referral 88:10,15 316:3 380:17,19 415:9 416:1,4 417:9 421:7,9 422:9 441:19 442:3
referrals 101:14 378:6
referred 76:20 78:21 287:14 315:22
referring 399:14 434:2
refine 117:2 235:17
reflect 50:8
reflection 62:20
refrad 301:12 305:1
refreshing 29:10
regard 117:16 118:3 313:8
regarding 147:11 220:11 313:6 348:5,7 377:18 385:12 421:7
regardless 150:3 372:4 379:19
regards 159:3 227:3 357:9
Regiment 11:11 16:17 17:4 68:6
region 14:3,5 268:6 271:20 272:5 274:4 277:6 288:4 343:3
regional 273:22 279:1 345:4 384:9
Register 67:6
registered 439:3 440:16
regression 98:3,9
regular 219:19 260:22 265:7 273:12 362:5 381:21
regulations 456:7
rehabilitation 315:12 318:12,19 361:7 402:15 440:3
rehauled 257:2
Rehbein 1:19 5:19

5:20,21 11:5 48:16 51:5 61:10 64:22 84:7 172:6 172:9 260:13 262:7,11,15 263:7 281:14 290:20 291:21 368:17 397:18,20 399:4 399:11 419:10,14 423:17 445:22 446:3,7,17
reintegration 440:3
reinvent 422:11
reiterate 15:18
rejecting 311:1
related 21:17 25:15 49:17 93:3 114:11 125:7 207:3 210:4 253:2 347:4,12
relation 112:22 120:4 214:17
relationship 32:4
relative 37:22 123:8 125:21 151:12
relatively 94:13 290:16 465:11
release 58:13 59:14
released 328:19
relevant 453:9
reliable 322:20
reliance 260:17
reliant 9:10
relied 84:4
relief 179:9
rely 43:22 452:21
relying 433:13,22
remain 218:2 231:3 299:17 301:15,16 425:14 430:14
remarkable 354:22
remember 6:2 8:9 22:18 51:12 54:2 54:16 102:5 138:2 138:6 157:2 307:14 312:15 314:13 459:9
remembering 368:20
remind 395:16
reminds 176:20
remodel 133:13
remodeled 139:16
remote 192:19 290:11 292:14 293:7 383:21
rendered 79:4
reorganization 363:21 367:3 373:9,14 430:1,19
reorganized 6:10
reorganizing 363:17
rep 282:19 283:10 283:10 402:22
repeat 109:21
repetitive 20:3
repetitively 66:6
replacing 395:6
replicated 26:9
report 17:18 39:4 41:22 42:19 43:20 47:14,22 49:12 51:2 54:4 73:9 74:15 76:8 100:19 130:10 131:4,6 133:22 202:2 221:10 229:21 230:1,8 233:9 307:16 325:8 378:21 419:21 452:1
reported 73:5 75:16
reporting 83:6 94:11 129:14 324:2 379:5
reports 43:11 99:16 111:15 127:20 271:5,5 272:17,19
repository 83:4 92:3
represent 188:3
representative 4:19 92:11
representatives 72:4 73:7 92:8 99:11 117:7 441:4 457:21
represented 163:4
representing 230:16
represents 155:9 162:21 168:1 190:14 199:22 208:15
reps 100:7,10,12 126:7
request 218:20
requested 9:22
require 57:15 58:22 231:7 232:17 275:7,10 276:6 358:19 391:8 417:9 443:9 447:14
required 16:18 27:3 86:2 88:20 254:5,8 446:16
requirement 278:17 306:22 315:21 349:16 443:15
requirements 216:17 276:22
requires 178:19 180:16 217:22 218:10
requiring 232:9,11
research 5:10,22 40:6 47:4 139:3 199:8 235:17 236:22
Reserve 22:3 24:21 30:12 43:17,18 48:1,13,15 145:11 190:1 230:17 272:16 279:10 283:10,15,17 284:1 289:7,10,15 289:17,22 291:2,6 291:10,17 295:3,7 295:21 296:4 298:18,20 299:4 299:20 300:13 301:1 302:8 303:21 305:4,20 337:15 383:16 384:2,18 385:21 387:10,11 389:18 390:12 391:3 392:9,13 393:11 393:19 399:3
Reserves 385:16
reservist 72:13
reservists 25:10 294:5 385:8,13 389:22 390:12
resident 205:3
resides 165:1
resilience 362:17
resolve 91:16 330:17
resolving 160:6
resource 190:4 191:1 199:21 216:20 219:21 220:6,12 222:2 223:4,10,13,18,21 292:13 348:11 391:14 403:1 406:1 407:7
resourced 199:20 251:7
resources 91:3 133:4 193:18 222:12 223:14,14 226:9,17 251:11 254:20 271:21 287:19,22 288:3 289:2 290:2 292:10 297:1 324:11 330:10 348:16 362:11 391:8 405:22 407:1 408:16 434:8 439:17
resourcing 41:8 211:21 212:9,10 214:18 365:3,5
respect 90:18 107:14 210:14 269:12
respectfully 181:11 186:22
respective 102:9
respond 20:11 26:3 86:10 95:8,10 111:8 183:11 287:7 335:12
responded 20:8 95:21 96:19 99:8 103:17 455:8
responding 63:22 96:19 122:17
responds 23:15
response 15:20 17:8 21:14 22:20 24:2,7 38:14 74:22 75:13 80:7 80:8 81:16 82:8,9 101:14 120:17 187:9 200:2 207:19 255:6 417:19 421:22 423:10 460:7
responses 20:7 23:19,22 79:20,22 82:11 85:3 95:15 112:12 113:17 123:10,14 125:4 233:10 356:14 410:8
responsibilities 131:22 261:22 263:22 323:20 448:17 449:4
responsibility 211:6 253:8 260:19 282:3,7 302:12,16 320:7 322:14 393:10
responsible 310:8 321:15 382:18

443:7
responsive 25:13 81:21 121:9
rest 107:7 152:10 162:12 228:11 267:3 287:22
restrictions 348:4
restrictive 65:12
restructuring 290:13
result 142:22 143:2 173:2 204:18 221:18 358:1
results 70:20,22 73:1 74:10,13,13 100:8 106:1 107:11 108:21 112:1,9 133:5 143:7 178:5 215:17 237:13 376:21 453:14,16
resume 206:3,6,7 333:15 343:9
resumed 69:13 227:21 355:14 438:3
resumes 343:11,15
retention 361:3 365:21
retire 362:10
retired 4:20 397:7
retirees 152:17,22
retirement 138:4 362:15
retrain 361:12
retraining 361:4 375:10 376:21 377:1,19
retrieve 33:10
retrieved 115:7
retrospective 114:14
return 27:4,16 49:17 86:3 91:18 233:19 360:15 369:4,14 371:9 467:22
returned 48:20 68:7 75:2,4,14 81:7 369:2,17
returning 69:22 78:4 104:17 360:11
returns 378:3
revamped 185:12
reverse 19:11
revert 300:18
review 7:14 9:12 53:2 198:9 207:9 230:7 273:12 329:17 382:14 421:10 448:20
reviewed 26:22
reviews 3:4 142:15
revised 360:16
revising 184:3
revision 206:12
rewarding 332:20
re-establish 66:13
re-integration 396:12
re-offer 446:19
re-offered 446:20
re-rated 158:2,17
re-rating 158:10,13
re-scheduled 41:11 41:12
re-tell 283:6
Rich 1:23 6:18 30:19 38:11 43:8 104:15 118:13 120:16,21 130:16
Richard 1:19 69:9 70:7
RIDES 152:7
Rifles 336:6
right 7:13 12:15 13:2,3 35:4 43:16 53:8 54:2,11 57:22 58:11 59:14 62:8 64:10 68:19 73:9 77:20 84:17 86:14,21 87:22 88:2,21 91:5,16 97:16 105:16 109:7 123:21 130:6 136:7 143:11 144:4,6,16 145:9 147:4 148:20,21 149:13 150:1,8 151:1,2,4 151:4 154:17,22 155:20 158:12 168:6 169:14 171:22 174:19,21 178:6 183:1 184:13,16 186:1 189:20 193:15 198:12 200:14 207:10,16 209:12 212:3 217:13 224:17 226:17,18 237:1 243:13 250:3,22 252:21 254:22 255:9 256:3 257:13 258:7,19 259:18 260:10 264:13 267:18 270:16,17 275:18,18 276:2 277:9 278:3 279:6 279:18 280:2,3 284:9 287:13 289:6 293:22 294:12 297:16 300:7 304:20,22 306:17 314:11,16 323:6 328:13 334:13 338:9 340:15,16,20,22 342:8 345:16 352:21,22 353:18 354:3 360:9 363:1 364:9 367:1,20 369:8 370:17 374:6 376:4 377:15 380:21 382:3,15 387:6 389:8 391:15 394:16 398:10 399:7,21 400:15 402:2,14,22 406:4 406:10 408:6,8,9 409:1,5 412:2,12 413:19 414:22 425:9 427:1 428:13 429:8 430:3,21 432:2 434:10 436:14 448:21 452:2 457:8 458:19 460:18 461:12
rightfully 249:1
rights 313:6
rigor 288:19 300:2
risk 48:17
risks 213:7
risky 149:10
RMC 278:22 279:2 279:3,5
RN 2:14
road 47:4 320:20 442:1 447:1 448:9 457:9
roadmap 234:22 243:22 246:16 444:16 451:12,13
Robb 194:13
robbed 182:18
robust 251:17 412:7
Rock 41:16
Roger 296:21
role 16:7 261:22 263:16 396:17 449:14,17
roles 323:19 373:17 448:16 449:4 451:10
roll 38:19 298:13
rolled 39:16 314:1 386:6
room 150:6 170:19 170:21 202:22 221:13 246:11 297:14 422:15 451:22 461:11
Rose 225:12
rotated 31:15
rotations 87:11
ROTC 252:7
rote 245:11
rough 247:17
roughly 87:10
round 68:10 407:16
route 139:21
routine 395:1,7,17 395:18
routinely 267:8
RPA 387:10 389:22 390:3 393:2
RRC 377:17,17
RRCs 25:6
RSFAC 19:21
RSS 65:19
rule 21:22 52:15
rules 188:16 195:18 312:5 456:7
run 15:15 31:22 33:15 175:7 292:18 297:20 303:9 328:17,18 351:11 466:2
runners 221:21
running 8:10 306:2 344:11 347:19 367:2 368:11 456:19
runs 139:11 156:1 183:19 255:18
Russ 7:10
RUSSELL 1:20
Ruth 318:4
RW 60:11 309:14 382:19
RWs 360:10 383:16,17,19 408:4

S

s 147:17
sacrifices 396:9
Safe 91:17

SAF/MR 391:18,20 393:7,13
SAF/MR's 393:16
sailor 146:10 293:9
SAMC 90:3 404:14
sample 84:9 86:20 87:4,7 91:3 102:21,22 103:3 444:21
sampled 79:18,21
San 4:14 7:11 34:13,20 90:4 146:1 162:6 185:12 257:4 266:2 272:2,4 286:17 303:8 306:7 365:11 368:19 373:12 398:16 408:11 411:22
SAS 106:16
sat 138:14 142:18 223:6
satisfaction 91:8 98:21 104:21 111:12 113:2,8,14 116:4,4 119:2 132:19 133:21 134:7 135:3,11,16 137:2,14 143:20 144:5 147:7 148:9 151:7,12 453:11 454:14
satisfaction's 151:5
satisfied 81:21 140:18
Saturday 138:7
save 161:21
saved 149:14,15
saving 150:2
saw 8:7 13:6 15:19 26:8 36:5 51:11 83:12 132:12 142:18 144:21 257:6 294:13,14 299:2 301:20,21
saying 84:12 109:16,17 113:21 113:22 119:15,18 122:21 136:12 141:2 167:22 175:10 177:3,8,10 181:7 182:19 211:2,8 225:20 303:12 313:17 314:12 374:19 379:11,12 404:2 458:15
says 39:9 53:5 93:5 155:5 157:13 168:4,8 169:18 170:10 171:4 200:13,17 203:7 212:7 218:9 241:7 247:16 260:21 269:19 271:15 304:6 306:18 307:4,10 309:14 310:13 321:11 329:3 335:17 383:14 391:11 393:7 423:21 461:16,19,20 467:5
scalable 194:22
scale 93:11,15,20 96:16 105:13 107:22 108:2 110:8 111:2
scan 145:16
scenes 51:9,14
schedule 43:14 55:5 69:16
scheduled 44:1 46:13
schematic 149:1
scheme 223:7
school 30:12
schools 22:5
science 164:22 169:5
scientific 137:11 195:17 260:20
scientifically 225:18
Scientists 5:22
scope 43:9 132:5 346:2
Scott 237:22 238:1 239:5,8 240:11 241:20 247:21 285:12 287:13
scream 160:16
screw 282:20
scrimmage 246:2
scripts 4:8
scrub 103:9
scrutiny 132:11
se 388:12
Sean 1:17 7:6 18:2 25:18
searchable 161:12
searched 21:19
seat 131:16 132:14
Sec 120:17
second 4:13 37:16 150:5 172:13 217:7 243:12 247:1 277:16 281:21 282:1 325:21 327:4 336:3 337:20 343:5 393:4 400:9 416:12 437:10
secondary 188:19
seconds 162:11 291:11
secret 191:3
Secretaries 213:21
Secretary 71:6 99:17 101:19 133:8,10 139:11 156:6 162:8 163:22 167:1 174:20 178:3 180:15 190:10 212:6 217:19,20 230:17 233:3 264:15 336:22
section 55:14,17 65:3 206:6,7,8 468:9
sector 248:10 439:9 441:22 458:7
securing 251:10
security 396:18
see 17:20 35:13 49:9 51:15,17 52:16 53:4,15 76:14,17 79:3 82:10 84:10 92:13 93:16 94:20 95:20 95:22 96:1 99:7 101:4 105:2,16,21 108:1 110:11 112:10 113:19 114:14 115:20 117:15,16 118:20 119:8,16,17 120:12 122:10,14 123:7 124:19 125:2,17 126:3,7 127:11 128:1 135:20 138:12 143:7 144:2 150:8 151:3 153:2,10 155:2 157:16 158:21 161:1 164:21 169:17 174:4 178:5 180:5 182:9 203:11,13 206:5 229:22 234:9 237:20 239:22 243:10 244:6,19 251:10 259:8 261:12 265:8 267:21 268:3 269:13 280:12 283:14,18 286:7 287:9 307:8 310:7 316:21 319:5 332:13 343:16 352:12 372:9 379:2,10,14 405:9,13 416:2 420:20 423:1 428:14 433:20 435:15 448:8 452:14
seeing 9:17 36:22 71:1 100:8,17 107:11 109:13 134:9 170:15 178:22 190:5 199:15 248:9,11 303:11 424:20 425:4 449:6
seek 79:6 348:5 410:6
seeking 179:8
seen 8:8 9:19 11:16 13:14 16:1 33:6 111:15 132:10 135:4 157:12 161:1 178:14 185:15 201:11 237:5 245:14 257:12 294:8 304:3 354:21 415:17 416:3 423:22 424:6
sees 282:10 427:10
segue 131:18 277:15 289:8 391:10,11
self-assessments 246:21
self-identified 104:3
self-reported 77:17
self-reporting 77:16
semi-annual 432:15
Senate 345:14
send 194:16,18 217:9 260:2 267:19 296:20 297:13 352:14 447:19
sending 56:12 60:1 197:22 283:1
sends 87:10
senior 2:3 99:15 100:19 162:18

163:2,3 234:19 244:11 263:2 266:4,6 267:4,8 267:13 268:15,22 271:1,11 272:18 272:19 288:2 298:7 319:13 320:6 329:16 337:9 342:12 346:20 361:17 401:12,12 415:3
senior-level 31:3
sense 35:17 105:3
sensible 324:14
sent 190:15 305:1 375:5 391:5
separate 14:12 161:6 319:1 362:10 412:5
separation 362:15 402:18
September 39:6 130:3,12 134:3,4
sequential 111:11
sequentially 214:20
sergeant 6:3 7:7 25:2,7 165:7 166:21 171:8 172:20,21 202:5 244:18 252:6 256:19,21 258:19 258:20 259:3,16 259:18,22 260:12 266:15 303:7 309:3 313:2 402:4
sergeants 25:12,13 25:21
Sergeant's 193:16 204:6
series 363:18
serious 351:6
seriously 360:21 361:20 371:11 374:8 376:2 378:8 378:9 398:19 413:7,8 424:13
seriousness 378:22
serve 23:3 31:20 53:9 155:20 233:22 309:18
served 167:12 227:14 238:13
service 3:8 15:3,4 16:17 17:1 18:11 30:7 31:19 44:13 45:4 47:1 60:14 64:6 71:16 72:6 73:7,16,22 75:20 77:1 82:22 85:12 87:20 91:4,8 93:13 94:19 95:9 95:17 103:11,16 104:2 111:18 112:13 113:21 114:18 117:20 119:18 125:20 126:6,8 134:8 139:17 140:9 141:2 143:12 146:20 148:10 149:9 151:6,10 153:22 154:10 155:1,21 156:4 158:6 161:3 168:5 168:9,12 169:14 169:21 171:9 172:2 173:3 176:13 177:7 181:9 182:4,5 183:18 184:21 186:10,14 189:1 193:19 201:11 205:4 209:7,14,15 211:5,15 219:17 220:8 221:19 222:1 224:2 236:13 239:13,15 239:19 274:22 292:7,20 293:1 307:1,4,10 309:13 310:13,13,18 313:20 314:8 342:10,17 343:12 357:18 367:11,19 368:16 369:9 370:2,10,15 378:3 379:6 381:11 383:9 395:2 396:16 397:9 402:18,19 410:5 419:21 422:18 423:13 431:3 433:12,13,22 434:4,5 439:1,15 439:21 441:15 442:22 443:8 444:13 445:18 452:18 460:7,9 461:9,16 462:7,10 462:22 463:22 464:22 467:6,14
serviced 185:7
services 2:11 32:11 33:11,12 34:20 35:13 57:5 71:22 72:3,18 74:1,15 81:6 89:4 90:8,15 92:7 94:5 95:14 95:16 99:2,3,5,11 99:19 100:14 101:11 113:19 116:6,8,17 117:7 117:16 119:16,21 120:10 121:7,8,13 121:18 123:4,6,7 123:8,19 125:15 126:9,12,22 127:5 129:10 130:14 132:22 137:18 138:3 139:8,9,14 139:15 142:19,22 159:3,6,8 160:19 167:15 169:20 172:4 173:8,14 174:17 175:1,6 176:7 177:2,9 178:2 181:8 192:21 193:4 194:4 196:17 198:14 201:10 202:3 204:3 208:21 209:10 211:6,18 214:5 237:10,15 238:8 249:3 275:1 287:1 287:5 291:5 292:4 292:20 318:20 328:22 347:15 359:7,12 360:13 361:18 362:11 384:1 403:18 420:13 421:4 438:22 439:6,19 442:20 443:1 444:1,4 446:11 447:14,21 449:20 457:6,13
service-specific 177:21
service-wide 204:20
serving 84:17 166:6 327:10 429:19
session 187:12,17
sessions 264:2 308:8
set 40:3 93:1 117:17 126:15 197:16 205:15 211:13 251:22 264:22 265:4 273:10,21 312:20 318:17 389:17 445:7 466:17,18
sets 72:5 247:19
setting 54:18 85:18 102:8
settings 341:16
seven 93:4 262:2 388:8
Seventeenth 88:6
seventh 352:7 432:6
Seventy 409:9
severe 318:9,20
severely 438:22 466:19,22 467:21
severity 379:20
SFAC 18:18 32:6,9 32:17 33:5 246:8 309:6 333:16 347:9
SFACs 291:1,2
SFAC-like 292:4
SFAC-type 291:5
SG 356:21,21 399:2
shake 228:7
shaky 61:22
shape 150:20 383:15
shaped 294:19
shapes 294:17
share 8:4 29:6 62:22 102:16 168:19 173:6 222:9 346:5 427:12
shared 260:18 282:3,7 313:8
sharing 237:8,9,10 237:13 276:13 310:14 436:22
shattering 163:20
sheet 152:21
sheets 19:16
shelf 194:15
she'd 307:16
shift 130:8,10 279:22 306:9
shine 213:17
Shinseki 133:10
shiny 201:15,18 208:6,6
ship 133:17 435:17
shooting 280:17
shop 33:6 251:17 251:18 260:11
short 131:20 167:18 268:1 295:9 296:6
shortages 408:17
shorthanded 433:7
shortly 77:11 112:1 118:6

short-term 251:9
shot 243:12 309:1 337:21
show 82:4 97:2,14 103:14 104:12 105:10 113:13 118:6 124:10 125:3 127:19 132:17 138:10 222:13,13 251:3 259:10 263:20 277:22 313:22 386:16 416:15,20 417:1 420:3 423:14 452:1
showed 268:19 286:22
showing 86:5 96:8 105:18 106:1 107:4 108:18 140:15 418:16
shown 79:21 137:2 214:6
shows 128:14 258:20 392:18 420:19
shut 311:11,18
SI 379:4 381:16
sick 405:14
sickest 405:13
side 24:21,21 35:17 151:15 197:5 207:12 223:14 269:15,16 303:1 303:21 304:9 392:3
sidebar 420:12
sides 207:5 216:9 223:13
Sigma 251:19 451:20
sign 65:14,17 304:21
signature 199:15
signed 205:17 315:14 330:11 417:10 434:12
significant 31:15 32:4 50:6 70:21 97:8,10,22 105:5 106:7 108:13 137:6 145:12 183:2 212:18 215:16 225:13 226:1 241:11 331:2,8 361:1 419:4,5
significantly 16:22 31:17 35:20,22 36:7 98:14 144:18 147:11 408:21 458:16
signify 415:14
Silver 384:15,17,18 386:9 387:6,14,20 388:1,6,15 389:9 389:12 390:5 391:1,16 392:11 393:15,22 394:8
similar 31:2 36:16 47:7 122:15 176:22 317:8
simple 286:11
simplicity 210:4
simply 24:14
single 66:11 144:21 152:7 159:3 196:6 198:17 201:17 221:6 234:3 235:21 242:16 266:1,4 284:15 451:15
sir 10:14 13:7 14:2 14:14 18:4 26:7 35:19 38:16 46:16 48:3 84:7 86:8 87:15 89:12 97:3 98:15 106:5 111:4 113:9 116:1 127:6 165:20 171:13 173:19 185:13 187:4 193:22 202:15 222:20 229:2,6 239:2 243:10 248:12 249:17,19 250:22 251:16,21 252:14 252:17,18,21 261:10 262:6,10 262:13,18,20 263:12 267:22 268:17 269:17 270:1,4,8,22 271:12,17 272:9 272:15 273:1 280:7 281:13 283:7 284:8,18 288:7 289:4 291:8 291:13 293:21 296:21 297:6 298:16 302:21 303:11 306:12,15 307:9 308:11,13 310:5 313:12 314:22 315:2,10 317:2 327:21 328:7,12 329:5 331:20 335:16 336:17 337:6 339:8,12 345:22 348:20,21 349:13 350:5,9,16 351:4 351:15 353:4 354:10,13,19 355:1,4,5 356:7 359:16 362:19 364:14,18 365:6 366:7,8 367:1,11 369:6,13 375:14 376:19 377:11,14 377:20 385:14 386:2,9 387:14 388:1,15 389:9 390:19 391:17 392:3 394:17 395:10 397:19 399:13,19 402:12 404:5,16 406:12 409:12 410:2 411:1,10,11 421:11 428:5 435:13 436:13 437:5 438:11
sister 161:18 359:6 421:4 464:8
sit 16:19 89:18 138:21 141:21 142:21 156:3 213:15 251:2 262:22 267:2 314:9 316:6 358:11
site 3:4 17:21 22:18 38:2 43:3 66:11 73:6 137:19 138:4 138:12 213:12 223:15 225:8 258:4 265:6 303:9 367:2 404:6
sited 71:19
sites 8:13,22 17:16 21:19,20,21 31:18 47:17 134:3 137:22 141:19 180:6 203:10 223:9 328:18 405:5,10,15 406:8 417:6
site-by 138:3
site-by-site 137:21 138:8
sitting 155:18 213:22 339:5
situation 76:2 96:14 183:1 328:5 410:9
situations 282:8 460:4
six 9:10 42:21 78:3 91:18 106:17 112:12 147:18 173:9 249:7,8 251:19 252:12 267:14 284:16 296:19 300:8 337:14 367:4 390:15 415:11 424:19 425:3 429:18 451:20
sixth 283:5 284:9
six-minute 31:21
six-month 87:11 196:7
skew 314:4
skewed 340:7
skill 318:17
skills 31:1 456:18
skillset 142:8
skip 319:3
sleep 153:12 247:10
sleeves 298:14
slide 78:10 79:17 92:15 94:6 96:5,8 97:2,14 100:17,20 103:14 105:18,20 108:15,20 109:19 118:6 122:3,14 123:22 163:13 233:11 252:22 253:14 259:7 264:5 273:2 274:12 289:8 294:1,17 315:11 323:4 324:20 346:3,4 357:11 360:8 374:14,15 383:13 391:10 401:10 407:19 409:4,13 412:13 416:2 421:21 422:1,19,21 423:8 429:13 430:13 438:17 440:5 445:21 448:2,2 453:4
slides 94:21 96:3 101:1,4 105:11 127:4 163:18,20 306:5 332:1 334:15 348:8 349:3,12 357:4 425:6
slight 395:20
slightly 81:19

slip 19:16
slope 98:1,13 106:7 108:13
slow 64:12 140:20 145:20
slowing 239:18
small 62:11 67:4 94:13 123:19,21 124:8,11 126:2 127:3 344:12 405:7,10 411:22 420:2,20,21
smaller 359:9
smart 197:21 226:7 363:19
smartest 161:2
smells 298:3
smirked 23:14
smooth 107:10
sneakers 223:1
soapbox 132:6
SOC 162:18 167:19 168:3 213:18,20 215:6 217:2,8,11 217:18 227:4 452:12
soccer 222:21
social 12:7 55:16 55:19 56:1,8,22 66:22 246:13 265:18 291:7 317:19 397:12 439:4 440:17 451:8 458:1 459:17
society 224:18 285:20
SOC's 166:12
soft 134:11
solder 185:20 304:20
solders 321:15
soldier 23:2 28:14 33:15 146:9 231:2 235:21 236:2,5,9 246:3,8,12 250:17 254:2 257:20 259:17 275:7 276:10 282:21 284:8 291:3,17,18 293:9 298:12 299:5,14 301:10 301:11 302:12,17 304:5 305:5 324:2 325:5 326:7 331:9 331:12 332:16,21 334:18 335:18,20 338:1,15 341:1 342:1 343:21 353:3 392:10
soldiers 21:5 27:22 33:7 89:15 95:10 207:12 230:4 231:1,3 232:9,16 233:15,19 234:4 234:22 235:11 241:5 244:3,7 256:14 259:2 263:4 266:17 269:10 276:3 277:19 278:3,13 278:18,19 283:16 296:5,14,16 298:20 300:13 301:7 302:2,22 303:12 304:17,22 305:10,16,19 311:8 316:8 318:13,20 319:5 320:8,17 322:15 323:17 324:3 325:4,17,19 326:2 329:17 330:4,6,13 333:20 334:7 335:1 338:7,9 343:2,17 345:20 346:13 347:14 352:11
soldier's 312:10 322:21 339:21 341:17
sole 458:15
solicited 343:11
solid 365:7 389:18
solider 257:10
solidified 374:4
solidify 399:21
solidifying 405:21
solo 136:20
solution 157:12 161:9
solutions 120:9 294:18,18 383:15
solved 12:22 32:19 166:8
somebody 160:12 210:8,18 271:22 328:5 372:12 375:21 388:4 407:11 461:2 462:20 466:8
someone's 19:1 183:3 185:7
somewhat 49:16 52:20 87:22 314:4
soon 308:18 349:6 363:15 367:6 368:10 373:3 400:7
sophomore 252:7
sorry 4:15 172:7,8 228:12 306:14 314:18,19 345:1 364:17 368:7 406:14 409:9
sort 21:22 24:6,10 61:10 84:19 115:16 132:5 134:18 157:21 161:13 167:19 174:15 186:9 188:17 190:14,16 193:6 204:13 221:11 243:15 297:17 311:19 351:19 353:10 426:21 444:17
sorting 250:9
sorts 145:12 216:16 420:10 426:19 427:3,17
sounding 48:17
sounds 37:3 177:8 203:14 444:8
source 67:14 168:1
sources 78:11 235:8
south 249:22 260:12 389:1
space 348:12
Spangdahlem 123:15
speak 34:11,19 36:4 49:14 58:12 61:14 130:20 208:5 219:1 266:8 284:7 310:12 318:2 329:6 438:13 443:16 462:22 463:16 464:4 465:4,9 466:13
speaking 61:19 62:12 219:1 392:13
special 167:10,13 188:4 227:1,6
specialized 317:17
specially 317:13
specialties 19:4,7
specialty 340:12 361:10,12 425:21 427:20
specific 32:15 96:3 115:9,11 131:7 211:6 228:20 233:17 237:16,18 251:14 313:8 347:22 348:4
specifically 70:17 96:10 114:9 117:15 131:3 203:22 234:16 235:20 238:18 304:20 310:12 311:5 318:6 383:11,18 466:1
specifics 245:22 348:13
spectrum 48:1 175:8
spend 131:17 135:10 284:2 338:16 440:17
spending 225:5 351:3
spent 29:11 61:5 92:9 151:21,21 260:19 418:15 457:1
spinal 458:17
spinning 402:7
spirit 180:16
spiritual 77:19
split 459:19
spoke 283:12
spoken 220:4,9
spot 261:10 436:18
spotlight 213:17
spots 74:8
spot-on 250:2
spouse 16:18 309:11 460:12,15
spouses 19:10,13 19:15 20:12 22:11 307:19 335:13 460:1
spread 65:17
spreadsheet 286:12 415:12 420:18 423:1
spring 2:9 36:2 37:17 39:5 230:20 319:8,9 327:5 328:11 330:18 347:1 352:5
SPSS 106:15
spur 214:1
squad 180:3,14,18 182:3,15 183:7 185:1,14 200:22 201:4 204:9,11 208:10 243:17 244:9 246:5 255:4 255:12 257:22

258:2 271:10,14 271:17 272:7 277:18 278:5 283:5 287:21 347:10
squadron 401:21 401:22 427:6
squandered 241:15
squawking 314:1
St 44:3
stability 362:18
stable 35:10 95:4 105:3 129:5 435:7
staff 23:1 32:12,15 40:6 51:4 56:6 63:9 123:17 147:22 190:13 194:14 207:6 227:15 234:16 242:7 264:16,17 270:7 275:5 295:22 296:1 299:8 316:13 318:4 324:9,10 333:16 337:1 341:10,22 346:12 347:8 349:21 366:19 398:6 399:10 400:2 404:7 429:15 434:17 435:3,12 445:13
staffing 20:21 32:8 284:21 287:10 407:21 408:2 412:18 419:4
stage 415:9 416:1 417:9
stages 147:18 415:21 416:4 422:10 458:12
stance 307:3
stand 95:1 123:7 344:18
standard 83:4 176:5 180:5 184:4 185:19 201:21 211:13 213:13 220:19 239:18 242:15 256:11 257:14 277:7 280:12,15,18,21 281:1,7 335:17 384:2 391:22 392:1 425:4 458:3
standardization 208:20 288:16 352:17,19 353:1 353:21 429:6
standardize 201:9
standardized 164:19 170:14 231:17 357:13
standards 2:12 116:20 136:5 161:10 189:20 191:5 211:4,7 230:22 247:4,6 253:3 261:3,5 264:9 265:4 266:17 269:13,16 273:10,20 276:5 285:21 289:13 304:9 335:15 383:17 391:12
standards-based 352:19,21,22
standing 121:6 128:5 240:12 243:11 398:13 402:22
standpoint 152:13 156:2 170:13 181:6 364:11
stands 62:8 130:3 304:5 404:14
star 222:21 267:4,5
stares 200:11
start 4:7 5:17,18 8:2 18:4 40:10 88:3,4 90:10 126:3 224:4 243:3 288:17 355:10 365:20 389:3 403:4 421:17 442:4,6 459:12 461:14 466:9
started 14:21 80:16 83:1 84:21 89:7 90:16 102:2 107:3 134:4 138:7 147:4 196:16 232:19 298:11 346:20 416:2 421:6 467:10
starting 83:13 102:12 105:22 112:5 329:14 398:6
starts 146:17 212:20 322:4 388:22 402:5 406:18
state 21:21 114:18 187:20 190:20 292:17 295:17 298:6 305:4 342:21 344:1,13 345:4,11 390:7,9 466:10
stated 103:22 233:1 373:3 382:22
statement 35:15 40:22 111:5 141:10 155:16 159:21 171:14 219:16 308:3 393:13 462:2,5
statements 90:13 141:15 323:8
states 1:1 74:3 153:19 154:4 378:3,13,21 381:11,13 383:1 434:13
static 105:19 220:14
station 143:4 160:20 186:3 272:18 316:11
stations 141:17 188:15
statistical 98:10 106:6
statistically 80:3 97:7,10,12,22 98:13 105:4 106:4 106:7,13 108:13 132:17 137:5
statistics 56:14 97:5 293:3
status 59:12 64:19 84:19 93:8 276:15 283:17 284:1 291:17 299:21 300:18 301:1,2,8 323:16 325:5,19 326:3,13 369:19 393:2 426:16,22 441:16 442:2 455:1 461:14
stay 35:14 146:20 148:10 163:17 164:13 175:5 187:16 195:19,20 236:10 243:4 263:4 301:1 375:7 375:8 376:10 439:22
staying 35:10 216:5
stays 261:6
steady 419:8
step 12:1 65:21,21 179:12 181:12,17 184:7,13 208:15 217:7,7 221:3 243:4 245:3 249:21 365:12 416:11 437:13
Stephen 373:10,10
steps 185:8 367:16 381:15
Steve 6:4,16 68:12 377:4
Steven 1:15,18 55:20,20 56:5 61:10 63:8
stewards 191:9
Stewart 7:17 18:1 26:8 31:8 35:5,18 36:16 45:11 258:4 258:8 345:5
stipend 463:22
Stoltz 283:11 284:5
Stone 1:19 6:18,18 28:3 30:2 33:14 36:10,21 37:8 42:17 44:2 48:19 98:16 99:5 100:9 102:15 103:12 111:9 117:2,8 120:15 121:15 136:11,22 137:7 137:15 138:19 151:8 153:5,18,21 155:15 158:7 179:7,18 180:4 181:4 186:22 187:3,5 198:8 248:17 249:20 250:2 252:19
Stone's 250:5
stood 452:12 467:11,12
stop 92:3 144:4 436:10
stops 195:7
stories 281:20
story 252:3 283:6
straight 115:22 284:6 301:19 337:10 358:14
straightforward 324:15 406:5
strata 226:2
strategic 155:9 226:15 250:14 251:9,11 270:14 284:4 294:17,18 294:19 383:15 396:12
strategically 243:15
strategies 44:18 177:17

streamlined 8:15 221:19
street 1:10 363:15
strengthen 454:3
stress 234:11 400:22
stressed 400:19
strict 435:2
strictly 446:14
strides 364:10
strike 34:4 207:15
strong 199:6 362:4 425:2
structure 252:11
struggle 244:5,8
struggling 44:11 49:16 120:14 138:11 177:1 210:6
stuck 155:6 408:21
studies 152:1 285:22
study 199:7 290:15 430:2,9,18
studying 153:1,9
stuff 12:9 51:14 177:12 185:3 194:15 197:22 294:14 297:1 353:12 354:9 359:18 412:4 426:22
stumbling 183:4
stunning 192:9
subcontractor 103:5
subject 356:15 357:6 441:5
subjective 284:21 289:2
submission 228:15 355:22
subordinate 250:13 324:10
subsections 92:20
subsequently 79:1
subset 29:15
subsets 28:22
subsidiary 51:10
substantial 44:5 199:18
substantiate 128:18
substitute 284:22
success 136:14 147:6 148:2 422:13
successful 147:8 224:21 245:7 250:11 307:21
sudden 435:16
suddenly 287:9
suffer 154:10
suffered 360:22
suffering 154:13,15
suffers 154:1
suffice 394:15
sufficient 72:6 123:16 274:14
suggest 169:2 312:6
suggestion 19:14 354:15
suggests 303:15
suiter 333:9
summary 126:6
summer 139:15 195:6 215:6 296:11 346:9,19
super 363:21 385:20 387:8 390:21 398:12 430:1,5
superintendent 7:8 402:4
superintendents 401:21
supersede 285:3
superstars 209:4
supervisor 287:15
supervisors 286:4
support 17:3 25:17 30:6 31:4 44:12 77:4 93:7 170:8 229:16 230:3 231:1,6 232:16 264:14 266:22 290:3,6,10 292:7 292:21 293:1 296:13 316:13 319:4 358:9 360:14 363:10 364:8 396:5,11,20 397:4 408:1 409:19 410:20 411:9 412:4,6 423:12 424:21 431:1 462:10
supported 106:21 139:1 320:18
supporting 74:12 293:5 365:8 396:15
supports 103:2
suppose 61:22 420:6
supposed 87:2 182:11 264:1 280:13 310:9 335:10 392:14 442:21 443:2,5 461:1
sure 11:9 30:14 43:13 44:8 70:4 72:4 78:19 83:15 89:17,21 90:1 100:21 104:17 108:6 119:11 139:12 143:12 148:12 150:9,15 152:14,22 163:4,8 168:20 170:15 184:18 186:8 187:13 188:13 190:4 191:10,11 192:15 193:14 194:19 197:5 198:2 204:10,21 205:10,13,14,16 205:19 206:12,22 210:22 211:1 214:2 226:15 235:11 253:4 255:3 258:7 261:6 264:8 266:20 275:17 283:4 284:5,12 288:18 296:7,17 305:13 308:20 347:11 350:5 352:15 364:22 365:17 370:19 373:18 374:13 380:19 383:8 384:9 386:21 390:7 393:8 395:13 400:21 401:2 402:2,3,10 405:20 406:1,2 411:2 413:17 419:13,15 422:17 431:6,18 434:10 442:22 443:6 444:1 449:15 453:7,17 453:21 454:4,8 456:6 464:11
surface 78:7
surgeon 2:19 6:19 6:21 26:11 28:20 66:7 92:10 116:20 194:13 229:11 230:21 238:3 250:7,10 251:21 258:15 264:17 270:9,12 304:14 330:11 351:15,16 352:9,18 353:22
surgeons 73:10 99:19 101:3 130:4
Surgeon's 270:7
surgery 21:7,9
surgical 49:19
surprised 84:9 308:16
surveillance 78:14 87:18
survey 3:8 69:21 70:18 71:12 72:2 72:3,18 73:15 75:5 76:3,16 80:6 81:9,12,14 82:10 82:15 84:21 86:6 86:10 89:4,17,21 89:22 90:4,10 91:8,15 92:2,6,7 92:11 94:10 95:6 95:11 98:17 99:10 99:12,13 100:7 103:11 104:1,16 107:4 108:17 111:17,22 114:2,7 114:8,12 116:21 116:22 117:3,7 120:19,22 122:1 123:13 125:20 126:6 129:18,19 130:2,9,9,10,11 205:8 367:21 453:12 454:21 455:9,19,21 456:2
surveyed 74:20 80:12 82:8 85:3 125:11 455:5,6 456:2,4
surveying 70:9 74:4,17 81:3
surveyors 449:1
surveys 80:21 81:11 98:20 102:9 102:11 117:1 138:11 368:1
survivor 2:22 355:20 356:9,12 356:22 357:2 360:19 364:1 385:18 398:17 412:21 413:1,4,12 430:4
survivors 413:5
Susan 284:5 285:11 291:10,14 292:2 300:11
Susie 237:22
suspect 87:22
sustainable 153:3

sustaining 405:16
sustainment 432:7 432:11,11
Suzanne 1:12,14 6:22
Swanson 2:13 231:12 329:5 352:5
swelled 57:6
swimming 157:17
switch 312:21
switched 85:1 137:3
switching 83:10 136:22
swoop 270:11
sword 140:20
sworn 4:5 6:1
syndrome 208:6
synergies 430:7,9
synergy 244:14
synthesize 40:7 42:9
synthesized 46:22 51:13
system 8:10 12:20 12:22 16:5,10,12 27:4,8,15 28:17 28:19,21 29:7 30:1 36:13,16,18 37:6 66:14 72:17 75:21 76:1 78:20 79:2,10,11,14 81:7 83:6,16 84:4 89:10,17 90:2,19 90:21 91:15,20 94:17,18 104:8,10 111:10,11 112:6 113:1 114:6 120:5 121:3 133:6 134:2 136:4,18 137:1,3 137:10 138:18 139:18 140:17 141:8 142:6 143:11 144:3 146:5,22 148:13 148:16 156:9,15 157:1 158:18 159:18 161:14 196:14 205:21 207:5,16,17 215:15 231:5,14 248:16 275:22 286:19 300:7 322:6 331:1 333:13 353:10 354:8 368:7,10,11 375:13 380:21 386:11 387:2 404:3,12 427:17 428:3
systematic 51:8,21
systems 2:5 37:19 37:20 95:12 96:10 139:11 158:1 161:4 206:20 383:19 384:7
systemwide 141:15
system-wide 136:4
S-E-S-S-I-O-N 228:1

T

t 99:8
Tab 7:22 38:18,19 68:20 70:10 131:9 228:21,22 356:3 437:15
table 13:9 46:3 68:10 155:18 201:15 217:3,3 262:22 391:6 407:16 420:18 453:8
tackle 29:17
tactical 243:16 248:13 270:14,18
tactics 270:10
tag 43:4 153:7 159:11 298:6
TAGs 295:15
tailor 358:2 396:3
take 17:11 30:13 34:18 53:13 57:15 65:20 70:13 73:2 98:2 100:13 114:14 132:7 149:9 150:10,15 150:17 156:13 174:7 177:22 181:12,17 206:11 214:1 215:13 231:21 240:4,14 241:7,19 242:22 244:17 245:11 248:12,15 252:12 261:8 267:1 274:15 282:2 297:20 301:20 308:22 311:21 312:2 313:2 315:8 319:5 326:20 335:7 337:20 353:2 354:2 355:9 357:1 388:10 392:11 405:1 411:17 424:15 428:22 437:9 440:13 451:14 452:18 453:16 467:6
takeaway 10:12 266:15
taken 11:22 98:19 101:1 116:19 146:22 304:19 398:9 409:19 425:2 437:18
takes 47:2,3 147:2 150:10 207:7 277:10 356:21 383:12 386:12 424:7,18
talk 7:19 13:16 25:1 33:22 37:19 38:8 39:3 48:1 53:13 54:12 55:2 56:7 63:5,12 68:10 93:6,17 95:3 100:6 131:19 138:22 140:9 160:9 161:7 162:13 163:15 164:15 198:1 203:10 209:13 227:11 231:22 256:13,14 257:18 260:14 266:1,3,9 267:8 268:9,9 269:6,9,11 282:17 283:12 284:7 291:10,15 296:8 304:6 306:22 310:5 314:3,6,9 319:11,16,21 323:4,10 326:14 339:10 348:9,18 350:2,4 353:8 354:12 362:2 367:13,21 370:5 401:9 414:17 440:6 460:6,9,10 461:18 465:2
talked 8:17 10:9 12:11,12 15:21 17:12,13 34:13 55:16 85:10 172:11,12 196:18 197:8,9 216:13 220:9 266:13 267:8 281:17 304:16 305:4 307:19 333:4
talking 37:6 82:18 87:1,8 91:13 92:22 97:21 111:6 119:1 121:4 123:20 129:17 142:6,7 144:19,20 153:11 176:21 181:13 198:11 212:15 216:1 243:3 255:21 256:6,12 257:1 282:15,16 283:15 289:16 305:17,18 307:3,11 309:3 314:2 317:8 321:14,16 334:16 350:21 353:21 367:11 371:8,15 375:16,17 399:16 399:16,18 405:4 427:9,16 429:7 437:20 438:7 449:21 457:1 459:12
talks 261:18,21 307:11 382:7 393:9
tall 167:20
tangible 173:17 179:2
TAP 177:5,6 206:9 206:10 209:12,13
tape 31:21,21
tapping 58:2 354:3
target 240:2 241:13 349:20 456:20
targets 235:1 239:14
Task 1:3,9 2:13 3:11 4:17 7:16 30:4 41:10 48:21 49:20 55:21 56:11 58:16 60:11 61:20 66:20 129:17 131:12 168:11 195:4 228:14 229:7,14,19 230:18 231:14,16 282:4 306:10 347:21 355:21 413:20 431:19 445:14,20
tasked 426:18
tasking 139:7 316:5 411:17
tasks 217:9
tattoo 340:2 341:2
taught 234:15
Tavera 258:20
taxpayer 183:19 191:10
TBI 144:22 215:14

TBIs 199:16
TDA 278:7,7
TDRLs 409:16
TDY 14:3,6
teach 240:19
teaches 204:9
teaching 286:16
team 5:10 26:11 30:6 42:20 43:5 44:20 48:20 148:8 221:14 228:12 236:6 245:2 246:6 246:9 253:7,8 254:2,12,16 261:1 261:4,5,21,22 262:1,8,21 263:9 275:9 278:9 285:17 294:11 296:2,11 312:10 312:20 326:15 331:11 350:10,21 351:17 355:8 358:21 364:1 381:9 382:18 411:22 426:4 441:1 444:15 451:20 463:6
teaming 374:3
teams 28:8,17 139:22 140:1 141:20 142:14 195:11 221:13 267:19 385:1 442:5
tech 252:5 402:4
technical 22:17 208:5 347:3
technically 20:6 23:8 186:19 207:12,16
techniques 270:10
technology 60:4 106:12
telephone 3:6 40:18 76:3 81:11 81:14,18,22 103:6
tell 43:8,22 59:11 79:7 84:20 85:13 86:4 97:20 100:6 109:10 110:1,7 119:20 131:15 137:8 158:21 164:7,8 171:18 177:5 181:16 188:11,18 190:16 190:22 206:20 213:1 225:6 230:8 240:3,5 252:4 255:11 259:6 281:3,8 282:19 283:8 284:15 285:5 310:16 314:13 316:18 327:20 366:14,18 367:15 370:21 392:3,8 401:19 427:19 435:19 447:20 459:15 460:21 462:15,19
telling 21:6 180:15 200:7 215:12 216:14 232:20 312:13 385:11 390:2 461:15
tells 96:3 262:21 424:2 446:4
temporary 331:14 428:1
ten 28:1 122:5 124:7 139:22 145:4 152:8 163:16 164:14 194:3 250:17 268:13 295:4 355:9
tend 81:17,20 126:22 159:6
tends 94:16 213:22
Teresa 2:3 408:10 412:15 414:16
term 166:1,9,10 167:18 168:7 169:13,14 189:10 218:21 251:8 324:14 382:8 460:3
termination 231:6 325:5
terminology 72:15 176:6,8 459:21 462:8
terms 10:6 12:18 13:1 16:7 34:18 43:17 52:4 64:19 65:22 82:16 113:3 113:6,7,13 116:15 129:6 140:19 159:4 164:19,22 164:22 166:3,4,6 167:9 169:1 170:3 172:13,15 173:1 176:12 189:4 196:6 239:17 243:2 254:3 258:19 280:2 326:22 348:2,12 352:10 385:7 406:7 409:21 428:2 440:10,21 450:16 454:8
terrible 167:7
terrific 183:20 188:1
terrified 165:6
terrifies 161:5
territory 61:22
tertiary 90:9
tested 275:14
testify 204:4
testing 318:7
Texas 271:14
text 94:7
thank 4:3,10 29:19 38:16,17 43:6 53:10 68:17 70:12 70:14 88:16 92:4 100:16 102:13 103:12 115:18 128:10 130:17 131:10,13 159:10 162:15 181:19 227:7,11,12,13 229:2 233:4 239:3 298:15 300:15 338:21 339:8 347:18 348:2 349:2,10 350:18 355:4,6 356:5,8 364:15 399:11 402:12 406:12 407:18 409:11 414:11 419:3 428:4 436:22 437:6,8 438:10,11 438:12 444:22 445:4 468:3
thanks 38:11 130:15 131:12 188:7 227:1 229:6 239:5 249:17 272:22 293:20 304:18 351:2,4,5 355:11 394:19 406:11 411:15 452:9
that'd 87:12
theater 70:1 74:2,3 74:5 75:3,3,4,15 76:11 77:11,12,13 77:21 78:4,8 81:1 83:1,2,3,11,12 84:18 90:1
theirs 101:12 200:20 416:7
theme 18:13 195:22
themes 51:10,10 250:14
therapists 194:18 347:8
therapy 18:16 149:12 245:12
thing 14:20 31:6 50:4 61:17 63:16 65:11 72:16,16 105:21 129:11 149:9 150:5 151:7 152:5 163:10 164:7 169:11 178:1,6 182:2,21 184:16 188:4,14 191:14 196:10 200:18 201:14 202:17 204:2 206:15 216:7 251:9 268:5 282:3 284:9 304:12 306:15 321:11 326:18 329:4 339:16 352:8 353:15 368:2 371:3 381:6 389:13 400:8 419:16 433:11,21 435:20 445:11 448:10 459:1,21 463:8,11
things 8:7,12,21 9:4 14:15 15:5,13 17:10,15,18 18:6 19:20 24:9 26:8 43:9 63:13 66:8 71:14 82:15 101:14 118:16 119:21 120:2,10 129:12 131:19 132:1,13 133:12 133:15,16 135:17 140:4 144:14 145:12,21 149:20 152:6 153:4,11,13 158:3 160:2,17 162:3 163:11 166:15 175:22 178:13 186:10 191:19 194:20 197:2 202:14 212:2 215:22 216:16 222:16 226:6 227:2,7 241:12 242:11 243:21 247:13 251:20 257:17 258:22 263:10 265:10,16,19,20

290:21 292:11 298:17 300:13 303:1 304:16 305:15 316:9 321:7 322:9,22 323:8,19 325:2 334:14 340:5 348:6,10 351:7,13 351:18 352:11,12 353:9 367:11 382:1 384:19 398:7,12 401:13 406:13 416:18,20 418:21 419:19,22 420:10 435:4 440:20 449:16 452:3 464:13 466:12
think 8:16 9:6 10:4 10:20 11:1,5,15 11:22 12:3,14,22 13:20 15:10,13 16:7 17:9,10,19 18:20 20:16 22:5 22:10 25:11 27:19 30:3 31:10 32:22 34:10 35:1,15 37:16 41:9 42:20 43:16,19 44:8,17 44:21 47:10,13 48:20 49:5,8,21 50:18,22 52:8,17 54:6,12 58:3 60:3 62:6 68:14 76:7 84:11 90:9 102:5 102:10 103:7 112:13,14 117:5 120:6,15 125:14 134:8 141:13 143:8,9 145:4,8 145:10 146:8,13 148:1 149:1,7 151:1,13 154:21 155:8,9 158:15,16 161:14 162:21 163:5 164:3 165:11,14 166:20 167:22 171:1,2 172:5,22 173:5,15 175:7 176:15 177:17 178:5,11 179:1,4,22 180:19 181:20 183:3,14 185:8,10,11,21 186:7,15 188:11 189:7,19 190:13 191:8,8 193:6,18 194:11 195:1,12 195:14,16 196:2 196:20 197:3,20 198:4,22 199:13 199:19,21 200:7 200:19,20,21 201:1,3,5,20 205:14,22 206:7 208:3,11,14 209:11 210:10 212:14,20,21 214:9,10,20 215:9 216:19 217:6,7,13 219:4 221:20 222:2,7 226:4,11 226:21 237:2,7,11 240:16 242:3 243:13,14 244:9 245:12 248:1 249:1,19,21 251:5 252:3,19 257:5 258:18 263:7,17 266:19 268:21 277:4,8,21 278:5 278:6,9 279:7,22 280:4 281:9,11 282:4,13 285:7 288:10,11 289:14 289:18 295:8 296:6 297:2,4 305:9,21 306:6 308:4 312:13 313:5 316:16 317:1 321:5,12 328:9 331:16 336:7,21 339:1 347:19 359:5 371:2 375:15 378:15 380:14 381:1 394:14 403:19 405:5,17 413:20 414:20 419:2,19 422:12 425:5 429:10 431:20 435:14,21 436:9,14,19 440:19 447:1,4,16 450:10 451:3,19 451:22 452:7 458:22 459:2,14 463:11 464:17 466:10
thinking 41:1 68:13 124:16 155:10 164:8 194:14 196:9 210:7 219:22 291:21 317:18 406:20 458:9
third 4:12 84:2 96:18 100:20 268:21 283:5 325:21
thirdly 81:19
thirds 316:12
Thomas 233:3
thorough 441:17
thought 13:8 91:15 110:7 139:17 150:5,7 192:18 218:5 389:10
thoughts 25:19 59:10 61:16 132:1 211:20
three 26:22 48:10 73:8 76:19 78:3 83:20 93:14 108:6 109:2,9 112:1 125:7,19 126:22 133:10,11 140:1 145:5 148:14 187:2 212:1 222:11 234:12 238:17 246:17 249:11 250:12,20 259:13,19,19 262:3 267:5 351:22 352:14 385:1 414:3,6,7 417:16 425:7 426:16 457:9
threes 98:8
three-day 24:9 39:18 45:15
three-star 268:10
throw 168:7 259:1 263:14 276:19 339:15
throwing 167:21
thrust 243:19
thumbs 53:7 349:18
Thursday 55:4 132:21 139:13 140:8 156:3
tied 169:13
Tim 44:20 366:17
time 6:13 7:19 8:18 11:15 15:1,2,19 17:14 26:21 29:11 32:20 36:1 39:3 49:3,22 50:1 54:8 54:15 55:3 61:5 65:20 67:4,8 69:7 72:8,9 73:20 74:4 74:9,12,17 75:17 84:16 85:4 92:10 94:4 95:14 96:21 103:14,21 104:5 105:5,7 107:10 108:10,21 109:14 111:21 112:18 114:20 117:19 118:7,20 119:3 120:3 122:4 123:10 127:13,18 127:22 128:6 129:7 130:8 134:17,20 135:10 135:20 145:13 150:18 151:20 152:1 157:1 160:8 160:16 176:21 178:2 179:18 187:6,12,14 188:6 189:14 190:14,21 191:1 202:16 203:18 210:15 217:4,11 229:5 251:2 261:19 262:4,4 263:6 268:12 277:10 279:13 282:17 283:14 284:2,22 285:9 293:11 297:9 298:13 301:5 306:2 312:14 321:9 326:14 327:16 329:17,22 335:16 351:3 353:7 354:2 354:11 363:16 365:9 368:21 369:1 392:15 410:6 417:14 418:20 420:6 423:22 424:7,17 426:8 430:6 433:8 434:16 437:13 440:18 441:18 446:18 447:14 450:10 454:22 455:6 457:1,5 459:5 462:17 467:12,18 468:6
timeframe 72:2
timeline 15:7 39:8 39:14 45:9,10
timelines 7:20 135:13
timeliness 134:10 156:18 415:18 416:4,11 417:8 418:3
timely 16:12 142:20 174:5 322:16 360:11 395:1,4

times 23:10 87:12 87:13 129:9 133:11 146:8 190:17 222:14 236:4 243:1 244:22 268:13 281:19
timetables 243:2
time-in-motion 285:22
timing 43:21,21 135:16 140:19 226:22
tired 266:19 267:1
Title 283:16,22 291:16 298:21 299:5,10,10 300:18 301:2,8 304:21 386:12,14 387:9,11,13,16 389:11,12,13,15 389:20,22 390:3,6 390:15,16 391:19 392:5,6,10 393:17 394:6,7,9
TMA 121:16,20
TMA/HA 130:12
today 7:14 56:7 70:16 71:2 72:22 134:12 148:17 164:21 223:13 230:7,13 233:2,5 296:22 348:9,18 349:19 350:2 351:12 356:8 357:4 386:5,8 404:11 414:17
today's 396:17
Todd 2:8 358:7
told 20:8 24:22 99:1 180:6 182:6 182:11 212:12 258:16 343:20 353:16 410:18 424:10 433:1
toll 277:10
tomorrow 41:7 49:12 52:11,17 53:14 55:4 468:8
ton 184:8,9
tool 9:7,15 10:2 24:14,15 29:12 63:10 121:9,13 208:19,22 209:1,2 209:2 240:18 241:21 253:5 275:15 285:18 286:4,7,10 287:8 287:15 289:1 293:14 324:12 353:18 368:13 385:6 415:8 427:13
tools 29:9 37:21 63:12 235:14 240:21 242:1 249:13 250:6,22 260:1 289:3 319:17 323:6,10 324:2 327:7 426:14
top 93:18 94:1 105:13 110:10 122:12 156:7 171:4 192:11 195:18 272:2 424:16
topic 133:9 289:16
topics 40:14 70:17 347:3
total 76:5 86:22 102:18 103:7 159:6 292:6 390:9 391:1 396:22 397:7 409:7 454:15 465:10
totally 132:15 257:2 402:7 428:10
toting 307:21
touch 62:17 79:10 118:16 172:6,9 256:17 449:18 450:1
touched 79:1 81:6 83:15
touchpoints 42:13
tough 224:11 339:17
towel 167:21 177:20
town 19:4 298:10
Towns 366:18
track 37:4 38:2 89:16 130:6 145:22 199:2 249:9,12 275:16 283:9 368:5 383:8 387:5,8 389:14,18 390:6 442:22 449:15 451:21
tracked 28:6 347:14 387:15,18 387:19 388:2,3 390:4,5
tracking 37:4 249:20 415:1
tracks 89:14 178:21 278:15 373:7 387:7 390:8
traction 244:16 414:8
trade 22:9 30:12
traditional 61:7 111:11 387:10 389:22 390:11
TRADOC 38:7 321:1
traffic 225:8,14,17
tragic 167:6
trail 284:13
train 30:22 175:17 201:22
trained 178:18 183:9,11 256:10 317:13 318:11 377:3
training 22:19 24:1 30:10 38:7 178:19 183:17 184:2 185:9,13,15,18 194:2 200:21 201:3 204:9,16 208:14 246:20 254:3,4,5,9,13,17 254:19 255:1,10 255:11,13,16 256:5,7,22 257:2 257:3,3 258:1,1 258:10 259:20 260:2,4,4,5,6,7 286:10 296:9 304:2,9 306:6 319:13,22 321:1 324:4 327:7 333:11 346:16,18 347:2 370:19 400:20 418:13 422:7 427:11 439:5 441:3 450:16 454:8
trainings 335:6
transcript 50:5,12
transfer 159:14 160:18 161:16,20 383:20
transferred 182:18 415:11
transition 1:4,25 2:2,20 9:8 20:4 21:2,10,22 36:14 37:1 41:16,21 42:2 48:6,12 49:1 52:21 53:3 70:2 72:9 73:13 77:1 89:12 90:11 91:9 93:3 100:1 130:22 136:8 170:2 176:21 209:16,17 228:8 229:11,12 229:17 230:11 231:9 232:1,15 233:20 236:2,12 238:2,19,21 240:14 250:7 252:1,10 257:16 259:20 272:11 274:1,16 276:4,7 292:16 295:4 299:22 300:6,17 307:7 318:15,17 318:22 332:7,18 332:22 334:10 336:1 341:11,13 343:13 345:19 346:6,7,11 347:6 349:5 362:12 365:22 384:6 425:17 426:8 434:9 437:10
transitioned 431:4 434:3 442:2
transitioning 281:16 360:12 403:1 450:4
transitions 440:2 442:10 447:2
translate 31:2
translating 30:8
transmitted 101:18
transparency 266:18
transparent 336:9 336:9
traumatic 219:2 232:13 234:11,14 378:16
traumatically 146:6
travel 295:14
traveling 69:5 320:20
travesties 299:2
treated 75:4 76:21 172:21 294:5 441:21
treatment 71:8 75:10 115:9 138:9 232:11 236:7 271:3 358:19 361:6
tremendous 63:10 63:18 157:6 161:10 194:12 195:1 199:20

trend 97:13,19 105:3 107:12 113:13 126:3 132:19 135:6 144:3 298:9
trended 82:5
trending 127:6,9 144:5 226:18
trends 127:13 128:14
triad 244:11 246:4 254:7 256:20 263:1 269:5 276:2 287:22
triads 244:15
Trials 174:22 175:4
TRICARE 3:6 130:1 384:4,8 403:5
trickle 222:17
tried 72:4 84:2 145:21 159:14
trigger 369:8,9 373:5 434:6,7
triggers 199:1,5
triple 196:11 451:16
tripping 448:5
trolling 224:4
troop 170:17
troops 49:17 272:3 275:19
trouble 13:21 20:11 26:5
true 25:3,4 29:16 128:16 254:18 373:1
truly 8:6 95:9
truncate 52:20
trust 336:21
truth 336:8
try 43:14 50:1 57:1 59:19 66:13 71:13 75:19 98:10 109:8 112:12 168:19 190:2 215:6 221:8 222:4 309:8,17 339:2 353:11 368:2 402:8 422:6 433:8 450:21
trying 8:8 13:19 17:14 30:21 54:4 61:7 64:11,19 65:8,20 72:15 73:16 82:10 126:2 149:4,4 165:12 166:17 176:5 188:11,18 195:16 196:3 210:12 226:9 245:11 302:2 307:14 320:5,11 325:16 326:5 328:8 341:19,22 353:20 364:6 367:8 368:5 373:21 431:4 435:9 448:7 457:10 459:1 462:4
Ts 24:17 184:18
TTP 295:14
Tuesday 1:6 55:9 55:10 296:22
tuition 22:3
turn 55:14 231:20 415:14
turnaround 50:13
turned 23:20 25:3 47:5 163:22
Turner 1:20 7:10 7:10 32:14 33:5 59:11 60:8 116:1 116:10 121:11 203:20 210:21 211:12,15,20 212:3 236:14,16 237:16 239:3 251:4 252:15 284:19 288:21 359:16,21 364:12 364:15,19 366:1,6 384:12 391:9 409:5,11 435:8,12 435:15,19 444:8 444:18,22
turning 99:6 133:17 446:5
tweet 222:14
tweeting 63:16
tweets 59:12,14 60:9
Twitter 57:7,18 67:1 265:19 397:13
two 4:16 7:18 11:7 18:10 22:11 26:5 30:20 31:11 32:21 33:2 39:20 46:18 47:6 50:22 56:3 63:20 75:12 77:6 80:19,20 90:12 93:14,17,18,18,19 93:22,22 94:1 105:10,11,12,13 107:19,22 108:4 108:21 109:22 110:10 111:1,1,13 114:4 122:12,14 133:12 134:11 138:13 139:22 145:17,18 149:5 160:17 166:15 185:8 200:9 207:7 221:20 223:13 238:17 244:13,14 249:11 250:19 255:15 259:9,13 262:2,11 266:10 267:4 268:10 280:16 297:9 316:12 317:5 323:6,9 338:18 342:12 343:9 348:8 351:17 354:5 385:15 391:4 398:15 418:15 420:7,22 426:16 457:9 463:20
twos 98:8 109:2
two-day 53:2
two-edged 140:19
two-star 279:1
two-week 185:13
type 65:22 86:1 119:9 128:18 146:14 194:21 200:18 201:14 205:21 206:15 254:13 292:8 293:10 319:13 324:16 328:21 385:5 387:2
types 15:5 33:10 105:10 108:22 145:17,18 188:21 194:20 197:2 386:22
typical 84:4 93:10
typically 79:15 81:14 84:5 93:12 101:2 105:10 153:12,14 332:16 333:9 334:9

U

ultimate 129:15 341:18 342:4
unable 71:16 154:6 465:8
unclassified 191:7
unclear 10:18
uncomfortable 187:7
unconnected 120:19
undergo 231:4 273:11
undergoing 330:13 361:6
underlying 95:9
underscore 324:13 330:18
understand 26:5 49:4 72:7 73:2 84:12 85:18 87:21 100:10 112:18 115:19 116:3 117:19,22 119:12 148:19 149:4 158:3 166:8 187:8 196:3 197:10,13 198:3,22 204:14 211:1 220:16 237:17 245:1,9 263:8 291:1 305:21 306:4 309:2 310:5,15 319:12,18 321:12 323:14 324:1 325:16 327:2 335:7 341:22 345:2 352:16 357:5 365:3 368:15 374:20 379:16 391:19 400:5 402:8 413:17
understandable 197:6
understanding 25:16 166:19 179:17 186:11,14 197:12 235:19 258:5 299:11 315:14 317:21 325:18 326:21
understands 232:5 264:19 289:15 357:16
understood 11:2 73:17 370:1 412:19
underutilized 129:2
underway 155:8
unenforceable 179:8,11,16
unfair 108:18
unfavorable 108:14 113:18 116:15 119:17 125:8
unfavorables 107:6
unfavorably 96:17

96:21 108:10
unfortunately 336:16 406:16
unfunded 213:5
unhappy 135:9 144:1
uniform 163:3 172:18,20 180:4,7 360:12 407:21 408:6
uniformed 190:1
uniformity 331:5
unique 43:1 273:19 275:7 289:10 358:3 367:12 383:16
unit 10:7,11 21:2,3 21:4 36:14 37:5,7 37:9 41:16,21 42:2 44:7 48:12 49:1,19 52:22 53:3 78:4 89:13 169:22 170:2 182:17 310:21 323:22 324:4 325:20 326:7 328:6 329:2 330:4 332:18 333:3,12 333:22 334:10 338:3 347:5 365:13 379:8 382:10 390:12 392:20 425:22 426:4,14 427:4,13 427:19 428:2,16
United 1:1 153:19 154:3
units 27:18 34:5 36:1,3 41:13 72:9 77:12 89:22 90:11 91:9 170:7 231:4 238:21 244:1,4 250:13 257:16 269:13 279:11 310:20 318:18 323:15 327:19 328:1,2,18,19 332:12 333:18 338:10 341:10 343:13 346:7,10 387:11 390:6 425:12,15,18,20
universally 24:18
universe 19:21
unnamed 267:20
unquestionably 125:7
unresolved 300:20
unresponsive 25:14
untold 149:15
unused 10:2
upcoming 7:19,21 39:4
update 3:20 44:14 60:22 228:14 229:15 275:21 355:21 437:11
updated 253:17
updates 59:12,14 265:15
upfront 266:16
upper 110:21
upset 136:21
upstream 157:10 157:17
uptick 225:13
upward 97:12
upwards 110:13
urge 401:1
usable 208:8 321:18,22
USAF 2:8
use 20:6 22:17,19 37:22 65:9 66:21 102:20 116:8,15 121:9 128:11 129:1,18 143:19 146:4 166:1,3,6 178:16 193:17 201:18,19 208:21 218:14 234:21 235:5,10 242:13 242:14 245:2 253:12,12 274:19 286:8 289:1 309:18,19 321:8 323:9,22 324:7 327:8 332:1 348:3 382:1 383:7 404:2 411:3 414:22 415:5,6,8,20 419:17 444:11,12 444:16 447:4
useful 12:13 20:5 52:11 293:13 427:13 464:14
useless 207:5
user 205:10 208:18
USSOCOM 7:8
usually 81:16 90:8 100:6 151:17
utilization 38:4,10 99:8 148:14
utilize 58:7
utilized 191:11 192:15 458:6
utilizing 410:19
U.S 57:21 60:16 154:8 155:2 180:2

V

VA 6:10 11:17 12:2 13:16 21:9 22:12 22:13 49:19 60:16 76:20 77:1,2 93:7 93:7 101:10,11,12 101:13,13 102:1,3 102:11 118:17 133:13 138:18 147:19 148:3 149:13,18,19 151:10,15 152:4 153:6 154:9 155:5 155:18,21 156:1,4 156:16 157:4 158:2 159:5,20 161:8,9,16 163:4 190:9,12,15,18,22 191:5 197:9,10 216:10,12 217:3 217:19 234:6 236:19 238:8 276:12,17 303:1 315:15 316:10,16 316:16 317:4,7,11 317:17 318:19 333:16 354:18 357:19 373:22 394:22 402:15 403:3,16 404:7 405:9,20 416:7 437:20 441:7 442:16 445:12,15 445:17 448:22 457:20 459:6 463:12 464:2 465:1
vague 196:5
validate 91:14 128:12
validity 44:22
valuable 12:21 117:10 123:11 321:18 332:3 359:18
valuation 109:22
value 51:18 117:3 121:12,13 203:11 232:5 237:3,8 241:12
values 269:12
Vance 420:21
variants 353:14
variation 94:14,16 94:20,21 137:19
varied 311:7
varies 285:14,16 459:2
variety 165:19 186:2 341:15 346:17 347:2 358:1
various 92:22 230:12 274:17 371:15 434:7
varying 141:17 335:3 338:22
vast 302:8
VA's 155:10 156:14,19
VA-DoD 404:1
VA/DoD 147:18 395:8
VBA 317:9,10 318:6
vehicle 213:18
venue 244:21 295:19
venues 346:17
verb 154:16
verbiage 96:2 395:20
verified 34:15,21
verify 26:1
version 286:20
versions 205:2
versus 10:7,11 12:20 24:21 74:20 81:22 145:11 169:19 239:18 367:14 374:10 427:22 429:1 457:8
Vertically 414:13
vested 238:11
veteran 223:8 257:20 260:10 343:13 439:22 444:14
veterans 4:18,22 136:19 149:10 154:5 221:20,22 255:19 276:15 342:17 343:2 397:8 415:1 439:1 439:7,15 441:15 442:2 443:1 445:18 452:19 455:17 467:6,14
VHA 317:9
vice 21:7 138:20 147:22 264:16 354:5
victory 226:5
videoteleconfere...

138:6
view 181:9
views 232:3
Virginia 1:10 252:4
virtual 291:13
virtually 180:6
vis 173:10,10
visibility 27:9 28:16,21 29:7 37:10 43:17 205:5 378:5 428:2
vision 47:20 219:3 431:6
visit 3:4 7:16 8:4,13 17:10 34:13 42:18 43:3,15 44:17 45:13,21 47:19 49:4 50:18 52:4 141:20 170:16 183:8 186:12 187:20,22 215:17 258:4 354:16 368:19,20
visited 47:18 141:19 200:8 431:19
visits 7:15,19 17:21 38:13 40:20 45:17 50:7 55:6 58:7,20 59:17 61:16 62:3 62:11 63:7 65:4 140:7 213:12 220:2 265:6 319:19 327:11
vital 56:14 396:17
vocational 12:9,10 13:22 22:5 315:12 318:7,11,19 402:15
voice 58:4 62:6
voices 296:7,14
voicing 410:11
volume 199:20 245:14 410:17
voluntarily 49:18
voluntary 446:15
volunteer 50:22 301:6 344:8
volunteers 55:7
voted 53:17
voting 53:17,21
VR&E 13:10,13,14 14:13,22 15:9 16:8 315:16 316:3 317:13 318:4 333:16 402:22 403:13,21 404:11 404:19 406:6,17 407:5
VSI 379:4 381:16
VSOs 57:5 61:6 64:9
VTA 415:20
VTC 266:3
VTCs 148:1

W

wait 49:11 152:3 372:21 373:2
waiting 345:17 424:8
walk 28:3 50:19 73:1 228:7 233:9 245:16 291:11 401:4
walked 138:15 315:2,4
walking 247:12 308:15
walks 302:1
walk-run 134:2 175:10
wall 150:19 162:2 180:10 261:13
Walter 5:8 7:4 74:8 90:3 123:12 159:16 247:9 308:20 404:13 449:2 452:7
want 11:13 18:2,3 21:3 22:9 43:3 44:19 50:21 53:16 55:5,21 58:12,13 63:3,8,21 68:11 68:21 75:10 80:4 80:5 102:4 109:4 109:10 114:20 128:15 145:3 146:2,11 164:19 166:1 168:6,22 171:6 172:6,9 177:21,22 178:6 187:16 189:14 191:9 199:17 200:12 207:2 208:6 214:13 215:11 219:16 233:4 239:8 241:18 245:2 259:10,11,15 260:16 284:12 288:18 296:17 300:11,22 304:6 305:1,3 307:10 309:14 311:8,11 313:8 319:20 323:10 324:13 338:13,20 341:2 342:14 344:16 352:9 353:17 389:17,21 400:9 400:22 413:16 422:10 431:16 447:8 459:8 461:3 462:14,19 464:12 465:20
wanted 8:3 12:14 39:21 56:7 60:8 75:18 117:16 135:6,7 141:6 177:2 201:14 344:8 395:15 422:21 445:12 459:11
wanting 22:8 295:5
wants 130:12 146:10 161:1 180:3 210:18 252:5,6 461:21
war 333:6 334:6 341:14 361:1
warm 161:4 276:6 276:7 416:22
warrant 266:20,21 337:13
warrior 1:25 2:2,20 2:22 5:7 7:3 11:11 16:17 17:4 21:2 29:3 31:10 31:18 32:2 36:14 41:16,21 42:2,3 48:6,11 49:1 52:21 53:3 68:6 72:9 73:12,18 89:12 91:9 93:2 100:1 130:21 159:16 160:3 165:5,13,13 166:5 166:13,14 167:2 167:18 168:8,14 170:1 174:22 178:10 187:21 192:10 203:17 205:9 209:15 228:8 229:10,12 229:17 230:11 231:9 232:1,14 238:1,19,21 250:6 252:1,10 255:18 257:16 259:20 272:11 274:1 282:10 295:3 299:22 300:5,16 306:21 315:3 316:20 318:17 326:7 332:7,17 334:9 341:13 342:11 343:12 345:18 346:7,11 349:4 355:20 356:9,12,22 357:2 360:19 362:21 363:22 364:2 365:14 369:11 373:17 385:18 396:6,14 397:1,4 401:14 412:21 425:17 429:15 430:4 431:19 450:2,19 451:12 451:17
warriors 10:3 31:9 70:9 73:17 104:17 104:18 116:21 159:13 175:3,4 176:12 183:22 184:12 188:5 198:2 202:4 209:6 219:6 225:20 226:16 237:2 256:13,17 260:12 264:21 266:19 272:7,15 280:8 281:18 300:5 319:4,15 320:11 330:15 336:18 350:19 359:9 360:15 362:14 368:22 375:18 391:12 393:12 396:8,21 397:6 402:17 407:3 430:21 432:20 433:3 452:4
warrior's 261:7
Washington 1:10 71:5
wasn't 10:1 21:18 29:20 47:13 303:10
watch 129:12 134:6 221:15
watching 35:13
wave 26:13 80:16
way 11:2,4,19 12:15 15:8,22 33:19 57:10,14 58:8,16 59:22 60:6 61:2,3,8 62:7 62:13 63:2 65:7 65:17 83:16 98:11 105:2,17 106:8 116:7 120:10,19 139:18 146:8 150:20 153:16

155:3 165:2,2 167:17 168:1 170:7 171:13 173:7 175:22 186:9 187:6 190:8 190:21,22 194:19 201:21 208:18 209:5 224:11 225:3,19 242:4 263:20 264:15 268:11 278:20,21 279:19 280:6,10 288:8 294:4 295:18 311:13 321:12 322:1,12 329:15 334:2 335:9,10,12 336:14 342:15 354:21 363:17 365:12 367:22 377:2 380:13 382:22 383:10 391:13 433:21 434:7 451:9,19 452:17 466:1
ways 242:8 268:7 311:20 320:15 361:16 373:21 397:2 447:6
wayside 369:3
wears 223:1
weather 41:2
web 56:6 223:8
webinars 291:6
website 56:11 57:10,16 65:10 66:12,21 67:5,9 67:14,15,18,21 68:1 81:13 82:2 125:17 222:10 225:13,21 292:7,9 293:16 296:9 343:21,22 345:5,7
websites 66:8 221:6 221:16,18 222:4 226:3 344:1
Wednesday 55:3
week 45:13 140:1 207:9 256:6 266:11 267:10,21 294:12 297:10 301:22 309:9 314:17 329:19 339:10 342:9 349:22 350:8 351:13 352:3,9 353:7 398:14
weekend 296:19
weekly 415:5 416:14,17
weeks 40:11 55:10 138:13 139:22 249:7 250:12 256:15 258:16 262:11 351:17 352:1,14 391:5 400:3
Weese 2:14 437:13 437:20 438:6,11 443:14 444:5,7,12 444:20 445:1 446:2,6,9,20 447:10 448:11 449:12 450:10 452:9 454:21 455:10,15,19 456:1,15,21 458:13,21 459:18 460:18 461:12,20 462:3,12 463:3 464:17,21 465:3 465:11,14,19 467:3 468:5
weigh 338:17
weight 80:10 278:6
weightings 104:12
welcome 4:9,12 228:4 399:12 402:13
welcomed 230:2
Wennergran 160:11
went 44:3,6 67:20 69:12 83:4 85:8 110:3 137:1 138:6 138:8 139:21 157:2,3 167:1 183:21 213:12 214:9 225:17 227:20 268:2 280:7 295:15 311:12 338:6 345:13 346:9 352:3,8,18 355:13 398:15 410:1 418:6 438:2 466:14 468:11
weren't 19:13 20:10 115:6 149:12 214:6 280:9 297:8 339:19 410:16
West 271:22
we'll 17:20 28:12 39:5 52:16 53:13 53:13 55:2,12 65:5 66:3 69:17 93:17 105:21 112:1,9 148:8,9 157:9 163:12 181:3 185:5 201:20,21 202:15 213:3,4,6,6,7 251:2 262:20 267:1 288:11 303:17 315:8 336:13,15 337:7,8 337:9 354:10 355:9 362:2 363:14 367:21 368:2,12 401:9 402:8 404:22 416:8 432:15,16 432:19 437:12
we're 4:7 5:4 7:14 15:12 23:10 29:14 33:3,21 34:2,6 37:3 38:19 45:11 45:12 46:11 47:21 48:8 54:22 55:22 59:8 60:22 61:1,3 61:7,17 63:14 64:11 65:8,20 73:4,15 75:13 81:3 84:15 92:22 97:21 102:11 103:8 107:11 110:20 121:4 128:7 130:6,8 132:18 133:14,14 133:17 134:7,20 134:22 135:1 136:3,6,7,9 140:2 142:4,5,6,7 143:16 146:13,20 147:21 148:12,22 150:1,22 152:8,21 153:9,11 155:14 156:17 159:22 164:5,9 165:14 166:17 168:4,9 169:12 171:3,18 172:22 173:13,13 173:14 174:16 175:22 177:19 178:3 180:6 181:13 184:13,20 186:20 190:2,5,6 191:6 194:2,6,8 196:2 199:12,15 201:16 204:19 205:19 208:12 210:11,15 214:18 221:7,16 224:10 226:4,4,6,8,11 227:8 230:6 242:7 243:6 246:17 248:4,9,10,11 249:22 250:3 258:18 260:8,9 261:14 268:16,20 276:11 277:14 278:12 279:5,18 279:19 280:13,17 281:11 284:17 286:10 288:13 301:21 306:2 320:5 321:21 328:21 331:5 334:16 335:19 340:20 341:7 343:1 345:16 347:1,19,20 348:8 349:21 352:16 353:20 354:4,4,11 355:17 363:16,17 363:22 364:9 365:7 366:5 367:2 367:5,7 368:3 373:8,21 374:5,12 375:16 384:21 385:3 389:1 395:19 398:20 400:6,16 401:2 402:2 406:2 407:2 412:14 414:5,6,18 422:14,17 424:10 424:19 425:1,4 427:8 429:7 430:6 430:10,21 431:13 431:21 432:12,14 434:14 435:7 436:12 437:9,10 442:21 447:22 451:8 452:7 457:10 466:5 468:7
we've 4:5 7:15 10:15 12:22 13:1 18:20 21:13 34:8 36:3 38:1 50:9 57:6 65:18 69:4 73:4 85:7 92:11 101:13 103:22 109:20 111:22 112:5 114:4 117:13,17 118:2,4 118:11 135:3,12 141:19 142:10,13 142:16 143:11,13 144:22 145:21 146:7 148:10,11 149:1,15 160:7 161:2,8 162:6,15 163:6,12 164:11

171:10 172:11,12 174:17 175:5 178:8,14 180:19 180:22 184:22 186:21 187:1 189:7,17 190:9,14 193:14 195:9 201:8,11 204:15 207:4 210:6,15,19 219:5 223:3 226:14 232:18 234:6 237:9 244:22 245:14 249:21 252:19 253:10 260:3 263:17 270:11 276:1 277:12 281:10,17,18 302:21 304:2 323:7 324:12 327:10 328:18 329:7 339:16 343:7,10 346:19 350:22 351:1 352:21 353:14 355:8 359:1 363:7 363:8,9 373:9 388:20 391:6 400:10 411:12,13 411:18 416:3 417:8,21,22 436:19 447:5 450:14 451:6,9,19 452:1 464:8,9
WFW2 360:7
whatever's 180:10 239:20
whatsoever 9:15 116:14 203:17
wheel 422:11
wheels 402:7
wherewithal 120:11
whiskey 257:9
white 30:18 261:12
who've 14:9 167:12
wide 109:9 209:3
widely 226:12
widespread 171:2 179:15
wife 307:11 314:9 314:10,20 335:5 462:8
wilco 348:20 355:4
Williams 2:17 178:12 183:14 184:7 186:4 200:19 204:8 228:6,18 229:1,2 229:10 233:1 243:10 249:17 250:16 251:13 252:17 255:15 256:2,4 258:14,20 261:8 262:10,13 262:18 263:12 264:18 265:14,22 269:22 270:4,8 271:11 272:9 273:1 277:4 279:18 281:2 282:12 287:14 288:7 289:4,20 291:8 292:3 294:10 297:12 299:19 301:18 303:6 305:18 307:5 308:4,13,22 312:2 313:12,16 313:21 314:15,22 315:2 327:21 328:2,7,12 331:20 336:3,12 339:9,14 342:13 345:22 346:21 348:20 349:11,14,17 350:1,7,14,16 351:4 354:19 355:1,4
willing 49:11 224:10 279:16 301:20 339:16 340:8
wing 192:7 402:1
wingman 259:4
wise 178:22
wiser 43:13
wish 165:8
wishful 219:22
withheld 14:17
wives 339:4
women 314:11
wonder 30:2 102:15 160:6 282:6
wondered 37:5
wonderful 219:22 327:7
wondering 48:18 59:9 97:4 144:14 157:22 172:17 214:19 216:20 261:2 306:18 369:3 419:18
wonders 282:11
woods 168:17
Woodson 99:18
word 39:15 59:7,20 136:17 147:17 193:8 244:17,17 305:17 320:1 352:17 397:14 411:3
worded 72:5 311:5 311:13,17
words 79:12 124:6 129:8 141:6 159:5 190:20 287:8 321:7
work 5:1 34:9 38:21 40:22 51:8 52:8 54:3,3,6,19 71:21 134:15 136:2,3,14,15 143:10,16 154:17 155:8,22 156:1,5 161:10 163:7 171:10 173:12,13 174:15 176:18 178:3 179:16 180:19 183:15,20 184:22 187:6,11 189:8,18,18 190:9 195:12 197:3 209:22 212:22 214:11 215:9 221:17 227:5 229:16,20 231:11 236:19 239:11 257:9,11 268:5 270:8 272:7 279:16 284:14 285:13,19 286:13 286:13,18 288:5 290:12 295:18 303:2,17 318:3 320:19,22 321:3 322:16 326:9,17 332:10,14 333:5,7 333:9,15 334:1,3 334:19,20 335:21 336:13 340:4,11 340:21 342:3,14 343:8 344:8 346:14 347:15 358:15 359:6 360:18 361:16 384:4 385:9 386:20 398:5 400:5 408:11 416:6,7 417:2 422:4 425:12 428:16 433:6 441:14 443:4 444:13 447:18 448:13 451:4,18 458:10,18 461:3 461:21 462:13,14 462:17 465:5,20 466:1
worked 13:22 72:3 72:17 92:7 119:8 212:22 234:6 238:20 245:8 451:6,13 453:6,20 454:3
workers 317:19 439:4 440:17 451:8 458:1 459:17
working 19:8 30:20 32:18 55:18 89:3 99:12 143:3 145:19,20 163:17 173:14 177:19 191:2 218:16 222:8 236:9 260:20 275:6 276:12 277:3 279:15 316:8 324:7 331:5 335:10 339:19 341:11,12 342:6 344:12 347:10 371:6 374:5 375:10 385:1 398:21 399:2,9 400:6 403:2 406:16 411:12 412:3,11 422:17 436:1 440:18 442:4 453:10 454:6 461:1 466:5
workload 34:19 275:13,22 285:15 285:18 286:2,5,19 409:16 457:5
works 208:7 212:21 231:8 260:22 284:15 317:10 320:14 345:18 361:18
worksheet 246:2
workshops 343:10
world 121:16 123:12 174:15 375:22
worldwide 76:3 81:10 83:3 103:10 114:3
worn 172:18
worried 46:12,12 110:21 136:7
worry 80:5 152:10
worse 129:12

worth 138:2 158:20
worthless 203:13
worthwhile 18:21
worthy 31:8
wouldn't 16:11 37:8 43:13 52:15 105:1 147:14 331:17 465:1
wounded 1:4,25 2:2 3:17 11:10 16:16 17:3 29:3 31:9,9,17 32:2 42:3 68:6 73:17 73:18 84:19 100:1 116:21 130:21 163:6,9 165:13 166:5,13,14 167:2 167:18 168:13 171:15 175:3 176:12 178:10 183:21 184:12 187:21 188:4 192:10 194:6 202:4 209:15 219:6 225:20 226:16 230:4 233:15 234:9 237:1 238:10,12 249:22 250:16 255:18 264:20 272:7 274:20 278:18 295:3 298:20 299:6 330:15 337:16 341:13 342:11,16 343:1,11 345:18 359:9 360:15,21 361:4 362:4,14,21 364:2 365:14 369:11 372:6,7,15 372:17,20,21 373:17 374:10,11 375:17 376:2 377:11 379:20 381:8 382:6 386:14 396:8,14 396:15,21 397:1,4 397:5 401:14 407:3 425:11 428:7 429:15 430:21 432:20 433:3 438:22 445:14 450:2,19 451:11,17 460:3 466:19 467:21
wounds 232:10 361:1 379:15
wow 95:2
wrapped 288:11
wreck 374:9
wrestled 132:2
writable 161:11
write 51:1 139:9 152:9 173:19,21 174:3,12 175:10 175:14,16 211:9 211:11 213:16 223:7 295:22 337:5
writer 245:20
writes 212:6
writing 59:4 161:10 343:10 348:14 397:20 398:2 399:4,7
written 253:15 324:14 452:16
wrong 22:2 42:22 121:5 171:13 261:13 299:15 343:20 366:10 368:20
wrote 174:8,8 223:7
WT 302:3
WTB 269:4 271:4 451:13
WTC 1:22 2:17 3:14 237:20 269:19 283:9 288:5 297:18 302:14 318:3 332:5 346:2,19
WTU 26:18 36:9 36:17 45:2 89:14 89:20 93:2 185:9 193:1 257:19 284:10 327:18 328:3 332:2 333:19 334:21,22 335:22 336:15 343:22 353:3,3
WTUs 35:22 191:17 250:1 261:3 269:20 276:22 332:11 334:2,17
WWCTP 3:11 131:1 222:10 237:12 256:10
WWR 10:7,10 89:17,20 170:2 191:17
WW2 89:4,13 377:8 405:13
Wyatt 2:21 355:16 355:18 356:5,11 359:20 360:6 363:1 364:13,14 364:18 365:6 366:2,7,17,20 367:1,20 369:6 372:15,18 373:1 375:14 376:1,5,12 377:10,14,22 379:10,16,22 380:9 382:3,15 384:15 385:4,14 394:17,20 396:2 397:18,19,22 399:6,12,18 401:8 402:13 403:10 404:22 405:17 406:12 407:18 409:3,13 411:10 411:18 412:12,16 412:20 413:6,11 413:18 414:1,4,11 425:9 426:11,19 427:1 428:13 429:3,7,12 432:2 434:2 435:13 436:13,19 437:5,8
W2 141:7

X

X 80:6 165:17 168:3,4 171:5 175:16,16 198:19 212:7,7 225:9 241:19 243:20 247:11,12 304:21 340:10 457:14

Y

Y 190:20 340:10
year 4:13 7:21 28:13 40:17 45:14 46:20 47:8 51:11 53:17 54:1,14 56:9,10,17,19 59:21 76:15,17 94:10 103:8,9 104:6,7,8 110:18 111:3 112:8,18 121:22 125:19 130:4 132:9 133:11 142:3 177:16 201:21 220:10 224:7 232:19 248:1,18 254:15 255:18 263:5 266:10 268:14 283:13 316:5 345:10 350:6 363:4 389:4 409:21 410:19 415:19 418:13 421:17 428:12 429:1 451:6 453:13 457:9
years 30:21 31:15 70:19 87:13 142:4 167:18 172:19 189:16 194:3 212:19 223:1 241:16 249:6 260:19 363:7 413:22 414:3,6,7 427:19 428:8 429:2 457:9,9
yelling 26:3
yellow 415:14 423:4
yield 74:19 239:7
yielded 212:16
young 82:22 151:22 161:3 303:9 361:16
younger 177:15
YouTube 397:12

Z

Z 340:10
zero 98:1 148:16
zip 292:9,11 293:11

$

$1 103:10
$1.4 103:7
$100K 225:5
$400,000 103:9
$963 152:15

#

#14 306:16
#18 306:9,11,13
#19 319:3
#3 233:13
#4 253:1
#7 274:13
#8 289:9

0

03 145:5
04 145:5
05 144:21
06 144:21
07 87:1 134:4 148:16 150:7 164:21 184:14
08 150:7
09 170:20 360:17

1

1 186:20 213:3 253:17 271:16,16

277:7,20,20 278:5 278:5,7 298:9 315:13 353:17 408:14,15,20,20 408:21 456:19 457:14 458:15
1st 42:9
1,000 42:22
1.2 58:1
10 85:2 108:11 110:14,19 271:16 271:17 277:7 278:7 283:16 284:1 291:16 298:21 299:5,10 299:10 386:12,14 387:11,13,16 389:11,12,13,15 389:20 390:15,16 391:19 392:5,6,10 393:17 394:6,9,20 394:22
10th 278:2,3
10,000 29:2 249:22 260:11,12
10:30 138:7
100 77:22 80:12,17 81:2 82:6 87:5,7 87:16 93:20 122:20,20 140:22 202:4 307:17 308:6 415:16 420:8 422:14
100s 127:2
101 139:7
101st 278:2
11 85:2 87:12 148:11 149:22 440:7
1100 296:10
12 42:5 75:16 125:6 132:18 133:20 135:21 137:12 140:15 141:4,10 144:2 147:6 215:20 424:19 425:3 429:2,17
12th 45:21 55:8,11
12:05 227:19
12:47 227:21 228:2
120 57:8 148:3 329:18 389:5
1200 184:11
13 42:5 142:4 219:15 396:2
13th 45:21 55:8,11 188:1
13,000 223:14
1300.24 430:15
131 3:12
139 134:3 137:21 161:6
14 40:21 75:16 210:16
140 148:4
15 21:15 31:14 40:21 45:16 132:18 133:21 135:21 141:4 147:7 186:19 267:13 347:20 388:17 408:18,22
15th 40:14,15,16 42:10,15 46:5 53:18
16 45:16
16th 40:15
17 45:16 72:2 76:12 80:16 142:4 429:18
17th 40:15 90:17 94:15 162:21
1700 36:15
18 76:12 109:15 137:13 140:15 141:10 144:3 296:16 298:1 315:11 402:14
18th 90:17
180 329:18
19 76:12 296:16 407:20 409:15
19th 90:17
19-delta 257:7

2

2 110:19 188:9
2:44 355:13
2:59 355:14
20 31:14 93:21 94:1 97:6,15 108:8 111:5 126:22 135:1 220:4 240:4 291:11 302:7 307:20 308:1 312:14 388:17 406:19 408:14,15 408:22
20th 94:15
200 94:13 255:20 256:9 315:17
200,000 79:19
200-some 335:9
2004 144:21
2007 70:9 71:5 72:19 98:16 104:21 454:22
2008 149:21 152:14 452:13 467:11
2009 174:9 176:10 179:20 211:17
2010 453:12
2011 57:4 131:4 134:5 229:20 233:8 253:18 393:9
2012 1:7 453:13
2017 192:13
205,000 86:21
21 1:7 161:21 162:14,20 217:22 218:9 384:22 391:2 421:14
21114 293:13
22 31:9 408:20
22,000 148:17
220,000 225:1
228,000 223:19 225:21
229 3:14
23 223:1 408:20
24 24:4 234:7 261:20
24/7 257:10
240,000 87:14
25 74:19 97:6,15 111:5 351:2 456:18 459:16
26th 53:19
265 36:17
27 161:21
27th 53:19
270 36:4 329:18 418:14
28 163:1
28th 53:19
29 10:18 40:2 45:13 192:19 193:9 250:1
295 142:21 150:7 150:13 151:3 416:9
295-day 143:14

3

3 110:14,19 131:6 218:14 228:15 304:8 355:22 467:20
3A 357:12
3B 360:9
3rd 164:3 278:4
30 74:4 76:10 96:18 97:7,17 135:2 146:7 207:8 220:4 262:2,15 302:7 315:5 443:17 445:9 447:18 449:22 454:6
30th 85:8
30,000 87:10
30-day 26:14,14 448:1
300 36:13
32 221:13 300:18 301:2,8 387:9 389:22 390:3,7 394:7
320 36:5
33 88:7
34 92:18
34-1101 366:19
35 456:18
35,000 87:10
350 146:8,16
356 3:18 125:6
39 418:6
396 134:13
397 134:13

4

4 210:15 382:16
4As 408:16
4:22 438:1
4:28 438:3
4:59 468:10
40 56:20,20 57:6 67:3 207:9 213:3 298:10 315:5 458:15
400 74:18 94:13
42 74:22,22 82:8
420 401:11
438 3:20
45 74:5,21 76:10 156:18
47 156:19

5

5 264:6
50 74:21 124:8 127:20 156:18 292:10 293:13 421:1
50th 72:22 73:4
50,000 79:20 98:7
50/50 459:18
500 36:1 74:18 387:7,12 388:18 389:9
501(c)(3)s 342:21
51 300:5
52,000 79:20
53,000 79:20
540 134:12
55 277:8
56 73:5 277:9

338:10

6

6 39:9 273:4 277:20 278:5
6:00 23:12 138:8
60 107:16 261:12 329:18 352:6
60,000 87:12,13
600 36:1 74:18
62 192:6 315:4
650 57:7
660 57:7
68 257:8
69 418:7

7

7 3:4 210:21,22 277:20 278:5
70 3:9
700 142:5,14 159:22 212:17
72 114:20,21 115:4

8

8A 383:14
8B 391:9
8:00 1:11 468:9
8:14 4:2
8:15 4:7
80 95:5 417:7 454:13,17 455:4
800 36:18
82nds 278:1
865 456:18

9

9 393:9
9,000 184:11 255:19
9:29 69:11
9:30 69:8
9:45 69:9
9:49 69:13
90 162:10 316:11 342:19 389:4
90-second 132:6
901 1:10
96-room 192:10

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Task Force on the Care, Management, and Transition of Recovering Wounded

Before: US DOD

Date: 02-21-12

Place: Alexandria, VA

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Court Reporter