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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THURSDAY,
FEBRUARY 23, 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:
LT GEN CHARLES GREEN, Co-Chair
SUZANNE CROCKETT-JONES, Co-Chair
JUSTIN CONSTANTINE
CSM STEVEN D. DeJONG

CAPT CONSTANCE EVANS
LT COL 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:

LT COL DAVID H. DICKEY, Chief of Mental Health at the Air Force Medical Support Agency attached to the Pentagon

CAPT PAUL HAMMER, Director of Psychological Health and Traumatic Brain Injury Defense Centers of Excellence

CHARLES HOGE, MD, Senior Scientist and Neuropsychiatry Consultant at the Office of the Army Surgeon General and WRAIR

CDR JEAN LORD, Director of Clinical Support Service Deployment Health, Wounded Ill and Injured

CDR ROSEMARY CARR MALONE, MD, Director, Deployment Health, Wounded Ill and Injured

DAVID M. WENNERGREN, Assistant Deputy Chief Management Officer, Department of Defense

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

Page
WELCOME:
Suzanne Crockett-Jones, Co-Chair. 4

ADMINISTRATIVE ITEMS:
Getting to Iowa:
Denise Dailey, Exec. Dir. 4
DCoE, PH & TBI UPDATE:
Paul Hammer 47
Questions:. 110

EVIDENCE-BASED TREATMENT - PTSD PANEL:
United States Army:
Charles Hoge, WRAIR 129
United States Navy:
Rosemary Malone, BUMED: 175
United States Air Force:
David Dickey. 223
Questions:. 249

INTERAGENCY PROGRAM OFFICE:
David Wennergren, DoD 273
Questions:. 305

MARINE CORPS WWR UPDATE:

Task Force Recommendations:
John Mayer. 366
Questions:. 390
Paul Williamson 392
Support for Marines:
John Mayer. 392
Questions:. 401

Meaningful Work:
John Mayer. 451
Questions:. 454
IDES:
Paul Williamson 475
Questions:. 480
John Mayer. 481

ADJOURN:
Charles Green, Co-Chair 493

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

8:01 a.m.

MS. CROCKETT-JONES: Good morning, everybody. I believe we have about a half hour for some administrative things and office things. Are we going to come to some conclusion on the visit to Iowa?

MS. DAILEY: Yes. And I'm missing Dr. Stone and General Stone and Dr. Phillips. I got an email from Dr. Phillips just a moment ago and said that he was in the parking lot, along GW Parkway.

DR. TURNER: I would like to introduce Mr. Drach, who is here today.

MR. DRACH: Glad to be here.

MS. DAILEY: But, yes, we have half an hour here. It is administrative time for us to utilize. And what was put on the table yesterday was that we talk about Iowa and getting to Iowa.

The person who seemed particularly interested in it was Major General Stone and

we don't quite have him yet. So I'm not sure of the value of proceeding without him.

LT GEN GREEN: Do we know a rough timing? Did you talk with him at all yesterday about timing?

MS. DAILEY: Yes. I mean, we would be talking March or April, that's rough timing. I don't have any dates for you, so March or April, yes.

LT GEN GREEN: I think we clearly need to visit and I think that General Stone needs to go. And so the big question is what will work for him and then let others who can work their schedules around his.

But I think there is consensus we need to go, so we will definitely plan the visit. Ideally in March, okay, so that we would have at least the discussion items by the time we got back together.

MS. DAILEY: Yes. And I will contact the unit. I have chatted with them afterwards and said we are probably going to

reschedule.

One of the things I was hoping to achieve is these community-based -- and I assume we are talking community-based Warrior Transition Unit. These community-based Warrior Transition Units, in fact, hold a muster, a quarterly muster where they bring everyone in.

One of my goals is to try and link up our visits with the quarterly muster. You get family member participation. You get all of the dispersed individuals coming to the table at the same time, but I haven't been successful yet in doing once a quarter. We have got a limited time frame, but I want to check with the unit on when their next muster is and see if we can align our visit with the next muster.

Good morning, sir. Good morning, Major General Stone.

LT GEN GREEN: We were all caught in traffic. One of the questions is we are

1 looking at the Iowa visit and we all feel we
2 need to visit after the discussion yesterday
3 and would like for you to be kind of the
4 person who is going on that one.
5 So do you know your schedule well
6 enough to project a date?
7 MG STONE: Yes. And I spoke last
8 night to the lead medical officer for the
9 National Guard, General Wilmont, and asked him
10 to engage the National Guard Surgeon last
11 night. He is to get a report to me in 24
12 hours of his intention of when he will go out.
13 He asked that he accompany us.
14 I'm not sure that is completely appropriate,
15 but he needs to go out there.
16 And so we will take a look at the
17 schedule today and see where we are at. He
18 gave me six days that he was available and
19 would change his schedule to free up for that.
20 He had been engaged previously and
21 had been assured that things were going well.
22 I assured him that that was incorrect

1 statement, based on what you all told me
2 yesterday, unless anybody feels differently
3 today.
4 It's a -- and I apologize for not
5 being part of the briefing, but we had had
6 substantial problems in the demobilization
7 station with a sense of urgency to go home.
8 And, therefore, the transition of many, many
9 hundreds of referrals to the Civilian Delivery
10 System that just, frankly, fell apart.
11 And is that your impression of
12 what is going on out there, that this
13 continued emergence of disease processes as
14 well as the anxiousness to get out of the
15 demob station?
16 MSGT MacKENZIE: Yes, sir, that's
17 what I felt, you know, looking at the
18 demobilization to -- with a facility that
19 doesn't have an MTF was really, really
20 surprising.
21 MS. DAILEY: Yeah, I would like to
22 comment on that. We have got -- as part of a

1 process as our holistic look, we heard the
2 same things at demob from Fort Stewart and
3 demob from Fort Lewis. So they couldn't get
4 people into the WTUs. They couldn't get a lot
5 of diagnostic activity at Fort Stewart or Fort
6 Lewis and so I have to say with this piece
7 from Iowa coming in, I'm not sure that we
8 didn't -- we haven't fixed it, if they are
9 going to an MTF.
10 There are some things done at the
11 MTF, but no one stays at the MTF. They have
12 to go to a WTU or back to the community for
13 these things to be treated. But there is some
14 diagnostic capability at the MTF, but --
15 MS. CROCKETT-JONES: I think it
16 was the sheer number comparison to what we
17 have seen other places. I think it is the
18 very smallest of referrals, the dental, the
19 numbers, I think, was what was surprising
20 about what they told us, not so much the
21 problems, but the volume associated with not
22 having the MTF.

1 There seemed to be even the
2 smallest of things were totally untracked and
3 out in the ether.
4 LT GEN GREEN: Yeah, one of the
5 questions I had for the folks who had visited
6 the other two sites is are we seeing the same
7 numbers? Is it two-thirds of the people that
8 need some type of medical follow-up when they
9 return?
10 CSM DeJONG: But traditionally,
11 sir, the dental shouldn't so much be involved
12 into it, because every National Guard soldier
13 that demobilizes gets a VA dental appointment
14 given to them and a schedule set up prior to
15 them walking away to handle any dental issues.
16 I think what furthers the problem
17 is the contract physicians and the contract
18 and how it is written and the pressure from
19 these contract physician groups to push them
20 into the VA system versus a WTU and then on
21 the flipside, the WTUs pushing them into the
22 VA system and not accepting them as readily as

1 they would an active duty soldier.

2 MS. DAILEY: And I think that has

3 been consistent across the MTFs. These aren't

4 all contract docs when they are demobing at --

5 I mean, they aren't all military doctors at

6 Lewis and Fort Stewart. There are still --

7 the same contract is still being utilized at

8 MTF. So it is the same theme from the MTF to

9 a place like Fort McCoy, which is they are

10 getting pushed into the community. They are

11 getting pushed to the VA versus what the

12 alternative is, which is the WTUs, which has

13 an equal amount of push back.

14 MSGT MacKENZIE: One of the things

15 I saw, too, was the -- I can't think of the

16 right word here, but, the comments we hear a

17 lot is what you can do is just go get that at

18 home. You can just go get that at the VA. I

19 think one of the things that the surgeon

20 brought up yesterday that I felt valuable was

21 the inability of or the documentation not

22 coming to him so he could take care of his

1 soldiers.
2 You know, his inability to take
3 care of these folks because he didn't have
4 this documentation that helped him to track
5 and follow these guys to make sure they are
6 getting their care. And I think that's
7 another thing to really look at is what is
8 that paperwork trail? How is that missing in
9 this situation? And what are the faults there
10 that lead to this?
11 MS. DAILEY: And we asked him --
12 MSGT MacKENZIE: I guess my
13 question is --
14 MS. DAILEY: -- to get back to us.
15 LT GEN GREEN: Right. But before
16 we jump in this situation, I still don't have
17 a sense of how significant is this for all of
18 the returning Reserve units? So is it as much
19 as two-thirds? Can they actually get this
20 stuff done that they need to get done within
21 the 45 day, you know, period that they are
22 talking about or is there a need for us to,

1 basically, make recommendation with regards to
2 the length of time they have, full TRICARE
3 benefits for instance, after return from a six
4 month to one year deployment?
5 So I mean, we have some leeway
6 here. I mean, we can tweak the system or we
7 can recommend that we, basically, give them a
8 longer period of time to get settled and for
9 things that actually need further follow-up,
10 that also buys the Reserve or Guard system
11 time to do the line of duties, if they had
12 medical coverage for, you know, three months,
13 six months after they returned as an active
14 duty member having TRICARE benefits to get the
15 appointments.
16 Then it's -- one of the things I
17 was trying to bring up yesterday with the
18 Guard and the Reserves, the normal way of them
19 getting care is to use their private health
20 care insurance or to get whatever their
21 private system is and it has always been their
22 responsibility to bring that back for the

1 system to deal with, if it's something that
2 affects their readiness.
3 And so one of the problems right
4 now, and we heard it a couple of times from
5 the nurse, is that because they are coming
6 back from deployment and, you know, "we're
7 responsible" now for their whatever it is,
8 their ailment, they are not using the same
9 system.
10 And so the question then becomes
11 is that simply because we haven't insured them
12 to use the same system that they always used?
13 And I don't think we can rebuild the medical
14 system at every Guard and Reserve station. So
15 the question I have is are we not giving them
16 enough medical benefits to, basically, discern
17 whether they have a longer term problem that
18 we could then do the line of duty for?
19 DR. TURNER: I would just agree
20 with General Green. If we feel, as a group,
21 that this is a very significant problem with
22 the Guard and possibly Reserve, then I think

1 we should quantify the problem across the
2 Guard.
3 You know, is this just a one-off
4 with these numbers or does this exist across
5 the Guard? And maybe if -- I don't know
6 what's the best way to look at that without
7 going to each individual state.
8 CSM DeJONG: Well, we could
9 probably get that information from TRICARE,
10 because one of the issues with TRICARE and the
11 Guard and Reserve soldiers, in defense of the
12 system, is a lot of the service members are
13 set with their home docs, their home health
14 care and when you start getting away from MTFs
15 and whatever else, TRICARE is not always that
16 accepted in some areas.
17 And they don't want to take the
18 time to change doctors and change providers
19 and change everything that they are
20 comfortable with to get the TRICARE accepted.
21 So then they choose, and I have seen this in
22 my own state, to go down their own path that

1 they are comfortable with.
2 TRICARE is not accepted there or
3 they don't go through the referral steps that
4 TRICARE requires to get to some specialty care
5 and then they are sitting with large medical
6 bills that TRICARE is not willing to accept,
7 because they didn't go through the referral
8 process. And that is when they raise their
9 hand and say I need help, because I have
10 several thousand dollars of medical bills and
11 then they say the system is not helping me.
12 MS. CROCKETT-JONES: And I would
13 say it is less than basic TRICARE coverage.
14 I mean, TRICARE -- even -- in this economy
15 right now, co-pays are serious. That is a
16 detriment. And a lot of these folks, you
17 know, going to someone local, even if they can
18 get them to accept TRICARE, they have -- the
19 co-pays can be a chunk, especially if it's
20 something that is going to require them to be
21 going back several times a week for say
22 physical therapy.

1 But on top of that, it didn't seem
2 to be the coverage necessarily, but that they
3 can't walk back into their jobs until they
4 have gotten this tackled. So we have got --
5 it's so multi-layered, I'm not exactly sure
6 that recommending more insurance is hitting
7 the spot.
8 MG STONE: Okay. So a year and a
9 half ago we ran into trouble with the Oregon
10 Guard in a demobilization process that became
11 very high profile, based on some briefings
12 that were done that were trying to push
13 through the Oregon Guards members.
14 In response to that, the Army
15 wrote a DAXORD that it's a requirement-based
16 demobilization order. The first thing we need
17 is a copy of that DAXORD. That DAXORD
18 identifies all the requirements of
19 demobilization of a COMPO-2 or COMPO-3 member
20 prior to leaving the demobilization station.
21 You may not be released from the
22 demobilization station until your commander

1 certifies the unit and the individuals as
2 going through all the requirements necessary.
3 Part of that -- so we need to copy the DAXORD.
4 The second thing we need to do is
5 to cross-reference what happened with the Iowa
6 Guard and whether they met the DAXORD. Then
7 we will know whether the DAXORD is appropriate
8 or inappropriate or has gaps in it or whether
9 -- and I'm not interested in assigning fault
10 of how we got to this, but when you read that
11 DAXORD it will say:
12 (1) All LODs are completed prior
13 to leaving theater and failing to do that all
14 LODs are completed prior to leaving the
15 demobilization station, so it is not a burden
16 upon the individual state headquarters.
17 You can see clearly that didn't
18 happen, because this is a state that is really
19 struggling through the recognition of
20 additional disease processes or somebody
21 didn't report something just trying to get out
22 of the demobilization station and getting

1 home.

2 The second piece is in that

3 DAXORD, it will say all identified health care

4 problems have to have a valid referral either

5 to the co-located MTF, which is not present at

6 Fort McCoy, they use a civilian health care

7 system, and if failing that, may go back to

8 the state in order to get health care.

9 But a case manager must be

10 involved and there has to be a valid delivery

11 system that accepts TRICARE in order to

12 accomplish that and that must be agreed upon

13 by the white cell from the state that is in

14 the demobilization station and there must be

15 a warm handoff between the demobilization

16 processors and the gaining state, that they

17 have complete visibility of all of those

18 disease processes. Clearly, there was

19 problems in that.

20 So the next thing we need to do is

21 we need to bring in the health policy and the

22 services people responsible for this from the

1 Office of the Surgeon General and the MEDCOM
2 for the Army. I have already given them a
3 heads-up that I was quite sure you would want
4 to talk to them about how they worked this.
5 We need to bring in the Guard
6 Surgeon, Anne Naclerio, who will want to do
7 this. And this is not an investigation. We
8 don't do investigations. We do reviews of
9 policies.
10 I think the next piece is the TAMP
11 benefits, the transitional benefit when a
12 Guardsman or a Reservist leaves active duty,
13 it covers 180 days of TRICARE standard without
14 deductible. Okay. It is just like you are on
15 active duty.
16 So from the day you come off of
17 active duty, for the next 180 days, you have
18 complete coverage. After that, if something
19 arises, then you deal with deductibles, co-
20 pays.
21 Now, if somebody goes outside of
22 the TRICARE-approved case managed system, then

1 we get in trouble. And so there is going to
2 be lots of pieces that you feed into this as
3 you look at it.
4 I think what you have to define,
5 as a Committee, or we have to define as a
6 Committee is what do we want to gain as we go
7 out there without having the other pieces in
8 place, the DAXORD and a review, hearing from
9 the Guard Surgeon, hearing from the Office of
10 the Surgeon General Health Policy and Services
11 and you have already heard from the state.
12 And as you look at all of those
13 things, then the next piece is to go into the
14 state and really take a look at what is going
15 on.
16 LT GEN GREEN: So just yesterday,
17 they brief us, said it was an 80-20 with a 20
18 percent co-pay. So if you are saying that
19 TAMP is 100 percent coverage for 180 days,
20 then why is it that the people that are
21 executing this don't know it? I mean, that's
22 a huge problem.

1 So I do think we need to get the
2 guidance on TAMP to make sure that we
3 understand it right and then how do they
4 exclude the co-pays if they are under TRICARE
5 standard? Do you know how they do it?
6 CSM DeJONG: Sir, they are getting
7 close to being out of their 180 days. So then
8 a lot of them may have elected for TRICARE
9 Reserve Select, which is an 80-20.
10 LT GEN GREEN: So you are saying
11 that they are not able to get their problems
12 resolved even within 180 days? I mean, it's
13 hard to fathom.
14 CSM DeJONG: It's either that or
15 the disease -- it's either that or they --
16 it's exacerbated after the 180 days and they
17 still want help, but they still want free
18 help, but they are on TRICARE Reserve Select,
19 which may or may not be elected.
20 LT GEN GREEN: So are we saying
21 that the Guard or Reserve unit that is
22 overseeing this can't get them a line of duty

1 within 180 days, if something like this
2 occurs?
3 CSM DeJONG: I believe that all
4 the line of duties, from being briefed on
5 Iowa, sir, all the LODs were done in theater
6 prior to coming home. I think it's the
7 exorbitant number that they have and I think
8 it's some of the extended care and extended
9 time it's taken to care for some of these that
10 they are getting out of their 180 days, which
11 then puts them on either their civilian
12 insurance or puts them on TRICARE Reserve
13 Select, which is an 80-20.
14 DR. TURNER: How difficult would
15 it be to get the Guard Surgeon in here to hear
16 him talk?
17 MG STONE: It shouldn't be hard at
18 all. I'm not sure Anne Naclerio would agree
19 with me that it shouldn't be hard at all, but,
20 you know, we can put a call out this morning.
21 MS. CROCKETT-JONES: We also
22 should look at since he was saying a lot of

1 those were orthopedic, and orthopedic
2 referrals can be very -- can be hard to get.
3 I mean, if there is specialty enough, so there
4 might be an access issue. And I guess we need
5 to know if people are having a provider
6 problem.
7 CSM DeJONG: So it would be
8 helpful to hear from focus groups in Iowa of
9 who is having difficulty with this, because
10 the TRICARE system, even for someone that
11 understands it on the civilian side, is very
12 difficult to get through.
13 And there are multiple -- I have
14 had multiple soldiers within our state that
15 have gone to and made physical therapy
16 appointments or ophthalmology appointments or
17 other specialty appointments without the
18 proper referral through TRICARE and then that
19 bill comes to them.
20 And then that right away goes to
21 Congress and Congressionals and comes back
22 down, because the system was not either

1 thoroughly explained or thoroughly understood
2 by the individuals using it.
3 MR. CONSTANTINE: The line of
4 duties are only good for six months, so you
5 can get another one, but maybe it's a
6 timeliness issue whether, you know, it takes
7 you three months to get an appointment and
8 then they start doing their therapy, the line
9 of duty expires and then they are incurring
10 more costs and then they are stuck with the
11 80-20, because they haven't gotten another
12 line of duty.
13 DR. PHILLIPS: I absolutely agree.
14 MSGT MacKENZIE: Yes. Go ahead.
15 DR. PHILLIPS: I absolutely agree.
16 General Stone really outlined a good process
17 that we should go through. Having said that,
18 what pushed my button was the fact that the
19 Iowa Cadre were actually telling us that they
20 have a significant problem. And in all of our
21 base visits, I don't remember ever hearing the
22 cadre and the staff expounding as much related

to issues.

And even though there is a logical process to go through and we need to see all the things that you mentioned, I really would like to hear from the focus groups. And I don't know, you know, time-wise we're in a little bit of a crunch, but I don't know if that would really affect our final recommendations, because we often hear a very different story from the focus groups as compared to the staff.

MSGT MacKENZIE: Sir, the other thing, too, that struck me on this was if there is an actual problem with the timeline, people keep dabbling into in the visits that we have gone on, you know, is this time enough or they don't think this time is enough. I think we need to get the facts, which is what is it about this timeline that is not sufficient to meet the needs of our Guard and Reserve personnel?

You know, what is this timeline in

1 comparison to access that is causing this
2 problem? Because I think that, you know,
3 that's where some of that comes in as well is,
4 you know, is there something wrong with the
5 time? And what is it that is wrong? So then
6 we can look at that as well, because that is -
7 - it has been brought up at several other
8 Guard locations.
9 It is we're running out of time or
10 I can't get an appointment in time or it keeps
11 going back to this timeline. And I think we
12 need more clarity on what it is about this
13 timeline and what is making it challenging for
14 these soldiers to get it done.
15 MG STONE: I think from a process
16 basis, the post-deployment health reassessment
17 is done between 91 days and 180 days. So if
18 your TAMP benefit runs out at 180 days and you
19 are at 120 or 150 days when you do your PDHRA,
20 and we have seen dramatic increases in the
21 amount of post-traumatic stress disorder
22 arising during that time frame.

1 When you are artificially tied
2 into an insurance benefit that runs out at 180
3 days, it just doesn't match the recognition of
4 the disease process. When it takes -- and you
5 heard yesterday about the creation of orders
6 and how many days it took and the Navy is
7 saying we've got it down to 20 days, that's a
8 best practice.
9 I will tell you the Army,
10 especially in the Guard and Reserve, are not
11 generating orders that quickly to bring people
12 back on active duty to care for disease
13 processes. It can take a long period of time
14 to get the LOD done. Once the LOD is done, it
15 can take up to 180 days to get the orders
16 recut in order to get people back on active
17 duty.
18 Now, we do, you know, presumptive
19 LODs for emergency problems. So if it's an
20 emergency psychiatric problem, there is a
21 presumptive LOD and any MTF you get somebody
22 to will take and stabilize the emergency

1 problem. But it is that -- especially at an
2 orthopedic basis, these are very often sort of
3 subacute problems that cause difficulty in
4 civilian employment and have placed these
5 service members at tremendous risk.
6 I mean, I think it is worth --
7 this is exactly why I wanted Iowa to come,
8 because it highlights so many difficulties
9 that we have in this population and the fact
10 that I don't think we have it right yet.
11 CSM DeJONG: And I know we were
12 briefed on the 180 day orders to get a simple
13 orthopedic fix. I have got two of my
14 companies right now that have just come back
15 and that order system is broke. I've got a
16 couple individuals that were briefed, hey,
17 these 180 day orders are out there. We can
18 get you fixed in a hurry.
19 We are going on 45 days of these
20 guys not working, because the orders have not
21 been cut and the process is not fully
22 understood at the state level to execute what

1 we thought was going to be a great system.
2 DR. TURNER: I think just the way
3 I'm looking at it is the choice we have to
4 look at is how much of the problem is the
5 process and the plan and how much of it is how
6 that plan is executed or resourced, because as
7 we heard before, usually the plan is not a bad
8 plan. It's just is the plan resourced
9 correctly?
10 And I have a suspicion that the
11 plan is probably good, like the EXORD, it's
12 probably pretty close. But the resources
13 don't exist to turn that good plan into a
14 reality.
15 MSGT MacKENZIE: One of the other
16 things, because I'm not certain I'll be able
17 to go, but the other question that may be
18 worth looking into is any time you are at a
19 military installation, there is a relationship
20 between the MTF medical and the civilian
21 medical within that area.
22 You know, do they have a -- do

1 these Guard units have a contingency plan with
2 some of their civilian medical folks where you
3 have that? I mean, if I walk into an MTF and
4 I need care and they can't handle it, it's
5 like boom I get a referral and I'm going
6 downtown and these guys are making room for me
7 to come in, because that relationship is built
8 locally.
9 I wonder is there that
10 relationship? Do they have a contingency plan
11 where they have these civilian doctors that
12 are willing to make that extra effort to
13 provide services without a three or four month
14 wait type thing? It's just something I was
15 wondering.
16 LT GEN GREEN: Let me try and add
17 just a little structure here. So we all want
18 to see the Iowa visit and so Rich is just
19 suggesting that possibly the 14th and 15th may
20 be the dates that could work. Will that work
21 for you of March?
22 MS. DAILEY: Of March?

LT GEN GREEN: Is that too soon? That's when you are doing Portsmouth?

MS. DAILEY: Yes. Well, we are doing Portsmouth the 12th and 13th, so that week, no.

LT GEN GREEN: Okay. So, Rich, back to you to look again.

MG STONE: All right. 21 and 22?

MS. DAILEY: I mean, generally, if we are going to go to a community-based Warrior Transition Unit, in less than a month that -- we're not going to get there.

MG STONE: Okay.

MS. DAILEY: It's going to be tough.

MG STONE: We could also go into the first week of April, other than running into Easter week, which is going to make it more difficult for people traveling to the site. Do you want me to resay that?

LT GEN GREEN: If you would use your mike in the future.

MG STONE: Okay.

MS. DAILEY: Yes, you're right. That -- I'm not going to get anyone to a focus group in Easter week either.

LT GEN GREEN: So why don't we shoot -- because of the difficulties they are having, why don't we do it sooner rather than later and try to go the 21st? So, Denise, we will let you work that and we will see if others can get their schedule to where they could go during that time frame.

The other thing that bothers me a little bit is what we are talking about here are redundant systems and yet the redundant systems are still not enough to take care of the problem.

So if we truly have a TRICARE TAMP Program that waives the deductible, in other words, they have 100 percent coverage, but they can't get care, okay, that's a problem. And so the question is is TAMP too much of a one-off?

1 And so should we talk with the
2 TRICARE people about how they actually execute
3 TAMP and why it would be so difficult for
4 Guardsmen and Reservists working with local
5 providers to use their TRICARE benefit. I
6 think we need to hear a little bit about TAMP.
7 MG STONE: Number one, I agree
8 with you completely. And I go back to the
9 fact that this is an artificially -- I mean,
10 it's an artificial date at 180 days. It
11 doesn't match disease process recognition from
12 this war.
13 I think you are going to come back
14 to another basic process concept and that is
15 the Army using demobilization stations that
16 have no MTF associated with it. It is clearly
17 easier if you can walk down the street to the
18 MTF and take care of these, otherwise there is
19 this tendency to want to go home.
20 You know, I can do it just the
21 same at home with my civilian provider. And
22 I really believe that's what happened here.

1 And that the basic decision to use Fort McCoy
2 as a demobilization station was probably the
3 key "error" in this one.
4 And I put error in quotes because
5 I'm getting ahead of myself in this process.
6 LT GEN GREEN: Perhaps, but going
7 one step further, so let's talk TAMP for a
8 second and then I'll talk about the line of
9 duty. So if you are keeping them at a demob
10 station until they have everything supposedly
11 outlined in terms of line of duty, etcetera,
12 then their TAMP should not start until you
13 release them from the demob station, correct?
14 MG STONE: That's correct.
15 LT GEN GREEN: Which means that
16 they really have like eight months, okay,
17 because if you keep them for 45 days or
18 whatever you are keeping them at the demob
19 station --
20 MS. DAILEY: Five days. Five days
21 at demob, sir.
22 LT GEN GREEN: So five days at

1 demob station, so --

2 MG STONE: That is not right. We

3 are now under -- it used to be five days. We

4 are under a requirements-based demob. That

5 unit may have stayed five days, but it was

6 because the commander said we have completed

7 all of the certifying requirements and I

8 accept the fact that I'll take my unit out of

9 the demobilization station.

10 That's a decision made between the

11 demobilizing unit as well as the people

12 running the demob station, but it's

13 requirements-based not time-based. And it

14 says that in the EXORD. This is not a time-

15 based process. Usually, it is completed

16 within five to 14 days.

17 Now, in NDAA 2011, I believe,

18 there was Senator Wyden put into the NDAA a

19 requirement that TAMP benefits do not begin

20 until you leave the Warrior Transition Command

21 or the Warrior Transition Unit. There has

22 been some discussion on whether that was

1 implemented in a timely manner, but you do run
2 the risk in your TAMP benefits beginning
3 before you even leave the station, that was to
4 be corrected and we could take a look at
5 whether, in fact, any of these service members
6 have fallen into problems with that by being
7 held in the demob station for 21 days or 30
8 days and then ended up with only 150 days of
9 TAMP benefits.
10 But you are exactly right, but we
11 need to look at NDAA, I believe it was 2011,
12 that it was in. It might have been 2010.
13 LT GEN GREEN: So when is our next
14 meeting? When do we get together next?
15 MS. DAILEY: May, the middle of
16 May, sir, May 15, 16, 17.
17 LT GEN GREEN: And so really we
18 don't have an opportunity to talk with anybody
19 from TRICARE prior to when we started the
20 report? Is that --
21 MS. DAILEY: Correct. That's
22 correct.

1 LT GEN GREEN: So we can ask them
2 to give us the current guidance for that, so
3 we could all look at it which would be useful.
4 So I think we need to ask them for the TRICARE
5 guidance on TAMP and when it starts and what
6 the benefit is and how it is executed.
7 I mean, we just -- because, I
8 mean, the question here is if it's really that
9 difficult to execute that nobody is using it,
10 then this is a waste. Okay.
11 DR. TURNER: Again --
12 LT GEN GREEN: I mean,
13 technically, if they have 100 percent coverage
14 for 180 days, then the Guard and Reserve
15 should have that period of time to not have to
16 worry about health care while somebody goes
17 back home and do line of duties based on
18 whatever is coming up out of their normal care
19 with TRICARE.
20 DR. TURNER: Again, I would just
21 have to say when we read this plan as we heard
22 before, DoD and TMA, they come up with great

1 plans, it's just the problem is in the
2 execution of the plan.
3 LT GEN GREEN: But once -- if we
4 get that before the team goes to Iowa, we may
5 be able to get a reality check on what is
6 going on to where we could then talk to it in
7 the report.
8 DR. TURNER: We need the plan so
9 we can see how well they are able, in reality,
10 to effect the plan.
11 LT GEN GREEN: Okay. And then I
12 guess we don't have time this year, but I
13 would go beyond the Army Guard Surgeon, I
14 would bring the Guard and Reserve Surgeons in
15 and let's ask them what kind of problems they
16 are experiencing with this, as kind of the
17 start to next year.
18 Okay. So we don't have to rush it
19 in this year, we can deal with the Iowa and
20 the TAMP and we could even ask the length of
21 time each service takes to do line of duty
22 orders, okay, which kind of scratches the

1 initial -- the immediate itch. And then we
2 can go after, all right, so what are you
3 seeing?
4 Okay. We ended this year with a
5 new problem being identified to us and so
6 let's start next year with how do we go after
7 that.
8 MS. DAILEY: Yes, sir. That we
9 can move into the Reserve component more
10 aggressively next year and their medical
11 processes for demobilization is a good
12 direction for us.
13 I have to say, ladies and
14 gentlemen, you all did identify this last year
15 just by going to the two states we went to,
16 California and Florida. We identified that
17 the demobilization was not taking care of the
18 Title 10 needs.
19 And your recommendation, your
20 recommendation, for the Department of Defense
21 to craft a strategic solution to these issues
22 has not been executed in any way. I mean,

1 this is why captain -- our captain from the
2 Navy got into trouble yesterday, because that
3 recommendation for a strategic solution to the
4 Reserve component demobilization issues was
5 trying to be answered by the Navy Safe Harbor
6 guy.
7 At one point in time in my
8 discussions with them, they said they were
9 going to talk to the Reserve guy in the Navy,
10 but no one has come to us with a strategic
11 solution and answer to that recommendation for
12 their Reserve component.
13 We still have the Marine Corps
14 this afternoon, maybe they will have some
15 ideas for us on how they see a strategic
16 solution to their Reserve component
17 demobilization. But we haven't seen it yet.
18 And they have not taken that recommendation to
19 the table for serious resolution.
20 All of our findings are in last
21 year's reports where we already identified
22 this.

1 DR. PHILLIPS: I just can't help
2 thinking that perhaps the 180 days should
3 start at the first referral for medical care.
4 You know, maybe within a period of three
5 years.
6 LT GEN GREEN: Let me raise one
7 other thing before we -- because we are kind
8 of coming towards the close of the admin
9 session and that is the other thing that I
10 wondered if we wanted to bring in next year,
11 because we haven't done this yet is we've got
12 some inklings in the open forum yesterday of
13 issues that may be going on and then later in
14 the discussion, I tried to pursue whether or
15 not anyone is looking at the data associated
16 now with the Disability Review Board.
17 In other words, what are the
18 common problems the Disability Review Board is
19 seeing? And so do we want to bring in the
20 Disability Review Board to actually kind of
21 highlight to us the kinds of things they are
22 seeing that lead to changes in decisions by

1 the services?

2 Just because I think that that

3 might give us some insight as to what are some

4 of the problem areas. They didn't have enough

5 experience last year, but now they have been

6 in the operation for almost two years and I

7 think they might be able to give us some data

8 with regards to what they are seeing in terms

9 of problem cases.

10 Denise is that appropriate?

11 MS. DAILEY: It is, sir, but I am

12 concerned. One of the committees we talked

13 about yesterday was the Discharge Review

14 Board. And then there is an -- Anne, what's

15 the name of it? The --

16 LT GEN GREEN: It's the PDBR, I

17 think, is the new one.

18 MS. DAILEY: -- PDBR is the one

19 you are interested in.

20 LT GEN GREEN: Yes, the PDBR.

21 MS. DAILEY: Which is the Physical

22 Disability Review Board. Okay.

LT GEN GREEN: Yes, I think that they are the ones who are actually charged with looking at concerns from any service to try and make certain that there is equity within the system.

And so the question would be what are they seeing?

MS. DAILEY: Okay. Sir, I will look into that.

LT COL KEANE: I would like to throw my name in the hat. If the trip does, indeed, go 21, 22 March, those dates work for me and my background six years as a Reservist may help.

MS. DAILEY: Okay. We do have the --

LT GEN GREEN: We have two others from Iowa that were interested. Can we get the team together, so we know who is going?

MS. DAILEY: Okay.

MR. REHBEIN: I can make those dates work.

DR. PHILLIPS: I can make those dates work.

LT GEN GREEN: Okay. So I think you have your team.

MS. DAILEY: Okay.

LT GEN GREEN: Okay.

MS. DAILEY: Good, good. Okay. Steven. We do have our next briefing at 08:30. Is there anything else we need to close out with Iowa? Okay.

MSGT MacKENZIE: I'm sorry, there is one thing I would also like the team to look at, too, was as we have gone to these other units and we have seen this delay in identifying problems, bringing up problems and although we saw it in the demob stations that were at an MTF, I wonder if that concept is exasperated because there was no MTF where people aren't identifying stuff when we look at that.

Because I think we are still seeing an element of that. You know, I want

to go home or I'll just go home and get it. And I just don't think we saw the numbers, because there was an MTF right there. And now that we have been exposed to this Iowa piece, that problem may have been exasperated because there was no MTF.

So a real objective look on that part.

MG STONE: So, Mack, the logical extension to that is to go up to Fort McCoy where there is no MTF. I am unavailable to go to Fort McCoy until all the snow is off the ground in Northern Wisconsin. So you may go if you would like to, but I can't make that trip.

MR. REHBEIN: You would probably be interested to know that there is going to be snow in Iowa today then, General.

MS. DAILEY: Thank you. Thank you, ladies and gentlemen.

LT GEN GREEN: Okay. Folks, yesterday we heard from the Defense Centers of

1 Excellence for Vision and Traumatic Extremity
2 Injury and Amputation. And today we have
3 Captain Paul Hammer, the Director of the
4 Psychological Health and Traumatic Brain
5 Injury Defense Center of Excellence, providing
6 an update to the Task Force.
7 Captain Hammer, I have several
8 people here listed, but I won't introduce
9 them, since I don't see them right now. I'll
10 let you introduce your team as you proceed.
11 CAPT HAMMER: Aye, aye, sir, or
12 yes, sir. I don't speak Navy. I notice that
13 there is a box of Kleenex up here, does that
14 bode poorly for me or what?
15 Let's go ahead and go to the next
16 slide. And I do have members of my team here
17 sort of as backup, but I'll let them off the
18 hook.
19 So first of all, ladies and
20 gentlemen, thank you for the opportunity to
21 brief you here today. This is the agenda that
22 I propose to go through. I want to give some

1 background and talk a little bit about where
2 we have been in 2011, where we are going in
3 2012 and then specifically answer the
4 questions that the Committee provided for us.
5 And then any other answers to any questions
6 that I can for you.
7 Next slide. When I came on board
8 in January of last year, Dr. Kilpatrick came
9 before the Committee and the Task Force to
10 brief you all literally as I was coming on
11 board, like that week. So this is my first
12 opportunity to brief the Task Force.
13 And I wanted to talk a little bit
14 about what we have done in 2011 and then where
15 we are going in 2012.
16 Next slide. When I came on board,
17 we had a number of difficulties that the GAO
18 had identified, particularly in terms of
19 strategic execution, but I provided a letter
20 with my director's intent and talked about
21 what we wanted to do and my direction for DCoE
22 was, number one, let's get organized, let's

1 get better at developing our strategy, let's
2 focus on execution and let's deliver quality
3 products for our stakeholders.
4 Next slide. Actually, I can do
5 that right? Okay. So in my intent or our
6 director's intent letter, I talked about that
7 our purpose at DCoE was to develop a thorough
8 and comprehensive base of knowledge on
9 evaluation, diagnosis, treatment and
10 rehabilitation of PH and TBI injuries.
11 What I was trying to do was focus
12 on some of the criticisms that DCoE had with
13 trying to be all things/all people regarding
14 psychological health and traumatic brain
15 injury. So by focusing on what was defined
16 previously by DoD as what is the Center of
17 Excellence and what is the Center of
18 Excellence supposed to be doing, I tried to
19 focus on that treatment, diagnosis --
20 evaluation, diagnosis and treatment of those
21 core disease processes.
22 We wanted to be able to provide

1 consistent and accurate focused information on
2 PH and TBI, develop a thorough and
3 comprehensive analysis of gaps and advocate to
4 fill those research gaps and then leverage our
5 knowledge and clinical expertise to improve
6 the system of care.
7 One of the things I did was look
8 at this particular thing here is the continuum
9 of care all the way from surveillance and
10 prevention all the way to through diagnosis,
11 treatment, rehabilitation and reintegration.
12 And I wanted to highlight just a
13 couple of things. And what I did was I asked
14 our folks to track and put some of the
15 accomplishments, some of the things that we
16 have got going on -- and map them to which
17 particular area we are focused on in order to
18 help us organize ourselves and figure out
19 where are we at in terms of our sweet spot,
20 which is the evaluation, diagnosis and
21 treatment of the PTSD and Traumatic Brain
22 Injury.

1 So these are just a few of the
2 highlights of some of the various things that
3 I think we have accomplished that have come to
4 fruition in the last year. Things like, you
5 know, joint publication on total force fitness
6 for resilience, standing up the Suicide
7 Prevention Office for DoD, a number of new
8 mobile applications launched, RESPECT-Mil from
9 our Deployment Health Clinical Center, screen
10 their one millionth soldier, data collection
11 from theater and the eventual transition this
12 year to a DoD instruction and a number of new
13 tool kits in clinical guidance have been
14 developed.
15 And one of our most successful is
16 the co-occurring conditions tool kit and I
17 think it is important to note that we have had
18 11,000 of those tool kits downloaded in
19 January, in one month, over 100,000 since they
20 were first developed.
21 And then, of course, there are a
22 number of things that don't fit on that

1 continuum of care and, you know, things
2 relating to resilience and you see that we're
3 the lead for 18 integrated mental health
4 strategy actions, 18 to 27. Co-chaired a
5 number of initial progress review research
6 panels with the joint research planning
7 committees.
8 And one thing is helping the
9 medical education and training command look at
10 their psych health curriculum, hosting a
11 number of annual conferences where we train
12 thousands of people in care for PTSD and TBI.
13 MSGT MacKENZIE: Sir?
14 CAPT HAMMER: Yes?
15 MSGT MacKENZIE: Real quick, how
16 much of this is available to civilian
17 providers, the tool kit that you had just
18 mentioned or any of this training? Because
19 what we are finding on the Guard and Reserve
20 side is that they are reaching out. We have
21 service members reaching out to the outside
22 sector, but the civilian sector doesn't know

1 how to deal with PTSD.

2 CAPT HAMMER: Yes.

3 MSGT MacKENZIE: How much of this

4 training, how much of this knowledge that you

5 have is available outside of DoD?

6 CAPT HAMMER: The tool kits are

7 available on-line. And I suspect that many

8 civilian providers are downloading those. And

9 recently, we presented at part of the Joining

10 Forces Initiative that Dr. Woodson and the

11 First Lady, as well as the VA, were kicking

12 off.

13 And I spoke at the AMA and had a

14 number of folks from local medical societies

15 where they have strong or large Guard and

16 Reserve populations talk about trying to get

17 access to some of these things and have people

18 come out to talk about the military-specific

19 issues that they need to deal with.

20 So it's available to them as in

21 it's out there on the Internet that they can

22 search for and find. In terms of actually

1 teeing it up for them, so that oh, yes, here
2 it is and this is what I know about, not yet.
3 But we are working on it.
4 Well, that was 2011. I want to
5 talk a little bit about where we are going in
6 2012 to give you some perspective.
7 One of the things that I wanted to
8 do was sharpen our mission and vision
9 statements in terms of getting us, again, more
10 focused. That our mission at DCoE is to
11 improve the lives of our nation's service
12 members, families and veterans by advancing
13 excellence in psychological health and
14 traumatic brain injury prevention and care.
15 And our vision is to be DoD's
16 trusted source and advocate for PH and TBI
17 knowledge and standards and again, profoundly
18 improve the system of care.
19 And I think values and operating
20 in terms of we provide excellent products and
21 we do things in an excellent way, integrity
22 and team work are important.

1 What value do we provide? And I
2 think it is an important thing to look at what
3 is our value proposition in terms of how we
4 address things and what -- you know, why do we
5 exist?
6 I think anybody is ripe for
7 cutting in terms of the current budget and
8 climate, unless you can really justify who you
9 are and what you are all about. And our job
10 is to be the principal integrator and
11 authority on PH and TBI knowledge and
12 standards for DoD.
13 I believe we are uniquely
14 positioned to accelerate improvements and
15 outcomes in policy impacting the continuum of
16 care and further reduce variability across
17 services. And again, our job, our sweet spot
18 is right there in terms of evaluation,
19 diagnosis and treatment of these disorders.
20 But I think the significant thing is looking
21 at what we do across the services.
22 I like this slide because I think

1 it conceptualizes in a somewhat graphic way --
2 I'm going to get out from behind this podium,
3 because it drives me crazy. This
4 conceptualizes who we are and what we do.
5 And I see us here DCoE with our
6 three component centers, T2, National Center
7 for Tele-Health and Technology, the Deployment
8 Health Clinical Center, and the Defense and
9 Veterans Brain Injury Center. This is DCoE.
10 Having a number of different
11 connections to a number of different things,
12 whether it is the research community with the
13 VA, military treatment centers with our other
14 partner centers that were formerly a part of
15 us with various academic institutions with
16 Government agencies.
17 We have connections with what goes
18 on in the joint staff and anybody else that
19 could fit in any other ovals that you want to
20 put in there. And our job is to improve this
21 system of care all the way from initial care,
22 what happens in theater in Level 2 and Level

1 3, what happens in CONUS at the MTFs and then
2 ultimately looking at transitioning in terms
3 of long-term rehabilitation and treatment.
4 We need to collect data and get
5 data from various data sources, identify,
6 evaluate and analyze that data, digest it with
7 this and bring back clinical guidance and
8 knowledge. And data is not knowledge. Data
9 is information, but to turn it into something
10 actionable and something that can actually be
11 clinical guidance that can affect what happens
12 in the system of care, I think, is an
13 important role for us. And that's the niche
14 that I think that we fill.
15 These are the big major issues
16 that we have going forward in 2012. We are
17 going to be transitioning to the -- under the
18 medical research and materiel command of the
19 Army. This should help get us much more or
20 much better integrated with what is going on
21 in the research community. And it will help
22 us get a great deal of integration with the

1 services.

2 The other major thing is service

3 integration. And getting much more connected,

4 much more involved with what is going on with

5 each of the uniform services medical

6 communities and not be isolated in sort of an

7 ivory tower academic institution that thinks

8 great thoughts, but doesn't have any impact on

9 what is actually going on in the real-world.

10 So our goal and the only way to do

11 that, the only way to have that impact on what

12 goes on in the real-world is to have some

13 relationship with the military medical

14 services that actually provide that care here,

15 because we don't do this. This is done by the

16 Army and the Navy and the Air Force medical

17 communities.

18 I want to much better integrate

19 our component centers and have a much more

20 tight integration and I think that's a

21 difficulty internal to us and then better

22 improve our strategy in terms of what are we

1 doing, what are we trying to accomplish in
2 terms of the big picture?
3 So that briefly is on overview. I
4 just wanted to provide a brief overview
5 without belaboring that too much, but I
6 specifically wanted to respond to each and
7 every one of those questions that the Task
8 Force had provided to us earlier.
9 But in order to answer the
10 questions, I needed to do it within that
11 context to help you understand, you know,
12 where I think we sit.
13 So the first question, and I'm
14 going to go through these just as we got them,
15 Question No. 1, Question No. 2, and just march
16 through each question with the answer. And
17 then if you have questions, that's great. If
18 not, you can -- we can talk about that at the
19 end and answer any other questions.
20 But the first question is what
21 programs does DCoE, PH and TBI audit and
22 evaluate? And what is the purpose of the

1 evaluations and how are these utilized?
2 So let's take that first part,
3 what programs do we audit or evaluate? I
4 would first want to say we don't audit
5 programs. We are not in any way concerned
6 regarding financial aspects or accounting
7 sorts of things. It is more a program
8 evaluation.
9 And the idea behind that is are
10 these programs effective and do they have some
11 good thing out of them that we can either
12 leverage as a best practice and promote more
13 system-wide?
14 So the first thing is we are the
15 lead agency in conducting program evaluations
16 and effectiveness of 18 pilot projects that
17 were first proposed and funded under a LoA2
18 back in 2007 when they -- 2008 when they were
19 presented to the Force Health Protection
20 Council and this was early on and a lot of the
21 large amount of bolus of funding was sent down
22 from Congress to DoD in order to address

1 wounded warrior care.
2 So our task was to look at some of
3 these pilot projects and then determine what
4 were good, what were bad and what, you know,
5 we could do to leverage those further.
6 More recently, we have been tasked
7 by the Defense CAPE, the Cost Assessment and
8 Program Evaluation, Program at DoD to look
9 more broadly and develop and entire system of
10 program evaluation in order to assist in
11 understanding what programs -- what we need to
12 do with those programs.
13 You may have heard recently about
14 a 2011 RAND study that we commissioned
15 earlier. This looked at a number of different
16 programs and it was a study to develop a
17 compendium of existing programs. What kind of
18 an evaluation framework do we have for those
19 programs? What are promising practices coming
20 out of them?
21 And then we are going to
22 specifically do a deeper dive on 20 different

1 program evaluations in progress or scheduled.
2 There is another question that relates to that
3 later where I have more detail on those --
4 that particular thing and a couple more
5 questions.
6 And then in FY12, we are looking
7 at conducting program evaluations of six
8 resilience and prevention programs and, again,
9 in order to look at those, find out are there
10 any best practices that we need to promulgate
11 more widely or are there some things that we
12 need to provide recommendations to improve
13 those programs?
14 What's the purpose and results of
15 these evaluations? Well, it's to make
16 recommendations on how to leverage the pilot
17 programs throughout the military system to
18 kind of use a transparent collaborative
19 process, to support recommendations on policy,
20 clinical practice, program structure and
21 processes.
22 We are tasked as in the CAPE-1 to

1 build a comprehensive list, cost at impact and
2 make recommendations on consolidating some
3 programs. And this may be used, I think, at
4 some point by CAPE or somebody else to make
5 budgeting decisions about whether or not
6 programs need to be eliminated.
7 One of the things that we have
8 come up with is a Program Evaluation 101
9 course. We actually provided this at a recent
10 conference and it was quite well-received in
11 terms of training and guide for program
12 managers to help them understand how to put
13 metrics and how to put things together so that
14 a program can be evaluated.
15 So you don't just throw money at
16 it and stand something up, because it's a
17 great idea. It's, okay, well, how exactly are
18 you going to measure your effectiveness and
19 tell whether or not you are effective?
20 And then we have a program
21 evaluation tool kit which we have provided to
22 the Quad Service Group portfolio managers,

1 these are the groups from all four services,
2 who look at these various programs and, again,
3 a tool kit that can help them out to say if
4 you don't already have metrics or measures of
5 effectiveness that you can point to, here is
6 a way to do that and here is a way to do it in
7 a structured way.
8 DR. PHILLIPS: Captain, thank you.
9 I think you probably heard our previous
10 discussion about the 180 days.
11 CAPT HAMMER: Yes, sir.
12 DR. PHILLIPS: I'm wondering would
13 it be within your area to make a
14 recommendation? I mean, review the TBI and
15 PTS and we know that they often occur late.
16 CAPT HAMMER: Yes, sir.
17 DR. PHILLIPS: And somehow come up
18 with statistics to nail down peaks perhaps of
19 occurrence and maybe we could connect that
20 with this 180 day that we are struggling with
21 for Guard and Reserve.
22 CAPT HAMMER: Yes, sir.

1 DR. PHILLIPS: Something like
2 that.
3 CAPT HAMMER: Yes. Actually,
4 there is, this is sort of an aside, a very
5 interesting, and this again speaks to being
6 connected to the research community, thing
7 called the Marine Resilience Study that is
8 being done in Southern California with Camp
9 Pendleton and Twentynine Palms Marines that
10 shows the various symptoms at various levels
11 post-deployment.
12 And it is fascinating to see that
13 the people who may be symptomatic one week
14 after they get back, you know, how they split
15 up. They are actually studying how
16 symptomatic they are at say 120 days or 90 to
17 120 mark after they get back.
18 So, yes, I mean, that's something
19 we look at and can provide information
20 regarding.
21 LT GEN GREEN: Yes, Paul, if I
22 could?

1 CAPT HAMMER: Certainly.
2 LT GEN GREEN: So is it possible
3 to get a list of the 18 programs you are
4 evaluating now?
5 CAPT HAMMER: Yes, sir. I have
6 them here in sort of my backup materials.
7 LT GEN GREEN: Okay.
8 CAPT HAMMER: But, yes, we can
9 provide you with a list.
10 LT GEN GREEN: And I may be -- I'm
11 assuming that you are doing this and, you
12 know, it's not going to be a single report on
13 the evaluation. So have you actually done
14 some evaluations and made decisions to
15 continue or stop certain programs?
16 CAPT HAMMER: We have not made
17 recommendations on continuing or stopping
18 programs yet. Of those 18 original LoA2
19 programs, some were closed down on their own.
20 I know that the Army currently is involved in
21 an extensive program. They are actually way
22 out front in terms of this stuff in terms of

1 really looking at all of the Camp Pendleton
2 programs and I think they reduced a number of
3 their programs down to like 20 or 24,
4 something like that.
5 But I don't think -- I don't
6 believe that we made any recommendations for
7 any programs to be discontinued or not. I
8 think it was more about how do you improve the
9 program or how do you become more accountable?
10 The problem with the vast majority
11 -- the vast. I mean, I'm talking, you know,
12 80 to 90 percent of the programs is they don't
13 have measures of effectiveness. So in the
14 climate in the last couple of years, the
15 default was well, it's a good idea. It seems
16 okay, let's keep doing that, rather than I
17 think in the coming years, hey, what are we
18 getting for our money.
19 And so I think the default was let
20 it go or start to look at how can we make it
21 more effective.
22 LT GEN GREEN: So does your list

1 include the ones that have been closed down?
2 CAPT HAMMER: Yes, sir.
3 LT GEN GREEN: And so do we have
4 an assessment for the ones that have been
5 closed down as to whether or not there was any
6 merit in using them? I mean, you said you
7 called them pilots, so obviously if they have
8 closed down, does that mean that they have
9 decided there was no merit in the pilot?
10 CAPT HAMMER: Yes, sir. In
11 general, yes, sir.
12 LT GEN GREEN: If you see where
13 I'm going, since you folks are doing the
14 analytics to try and get us to clinical
15 guidelines and to expand the knowledge, the
16 question becomes how are we getting feedback
17 on the things that we have already invested
18 in, so that we don't invest in them again?
19 CAPT HAMMER: Yes, sir.
20 LT GEN GREEN: Okay. And then
21 some of the things that you are working on,
22 for instance, the RAND study, I'm assuming

1 that you don't have the final RAND study yet,
2 since this was a 2011 study.
3 CAPT HAMMER: No, sir. The report
4 that you may have heard about in the media
5 recently in the last several months is the
6 initial part of it. And I'm going to talk
7 more about the RAND study and specifics on
8 some of the programs that they have later on
9 and it's in one of the later questions here.
10 LT GEN GREEN: When it is
11 available, we would be very interested in
12 getting the RAND study, obviously.
13 CAPT HAMMER: Yes, sir. Yes, sir.
14 And we can provide you with the current level
15 of study that they have now as well as
16 documents on the tool kits, program evaluation
17 information, that sort of thing. Okay.
18 Question No. 2, describe the
19 clinical study that DCoE has initiated and
20 what are we learning about the effectiveness
21 of specific PTSD and TBI treatment modalities?
22 The 2010 National Defense

1 Authorization Act mandated an independent
2 study of PTSD and DoD and VA. And, in fact,
3 they also mandated, I think, that the
4 Institute of Medicine be the organization that
5 be the lead agent for that study.
6 We did start that study last year.
7 I briefed the Institute of Medicine on their
8 mandate in, I believe, February or March of
9 last year. And the study is designed to
10 explore, but is not limited at operative
11 programs and methods available for prevention,
12 screening, diagnosis, treatment and
13 rehabilitation of PTSD.
14 Description of various programs,
15 comparison and methods of treatment. And
16 again, this is looking broadly at what is the
17 current state of knowledge on PTSD? And
18 what's the best way to treat it?
19 They also were tasked to look at
20 current projective future annual expenditures
21 by DoD and VA for the treatment and
22 rehabilitation of PTSD. Again, anticipating

1 what is the long-term tale that we are going
2 to have, even once conflict, you know, has
3 ended if that all goes as anticipated and
4 everybody comes home by 2014, we all know that
5 the natural history of the disease is that
6 there is going to be more people coming up
7 with PTSD as time goes on.
8 So what is the projected costs and
9 expenditures? And then also looking at
10 gender-specific racial ethnic groups, specific
11 mental health treatment services available for
12 the Armed Forces. And a number of groups are
13 looking at this, but asking them specifically
14 to look at this as well.
15 The first phase of this report is
16 due this fall. And it will be submitted to
17 the Secretary of Defense, Secretary of VA and
18 Congressional Committees that were named in
19 the legislation.
20 And then we are going to get a
21 courtesy copy 10 days prior to delivery to
22 these individuals, so that we can make an

1 assessment of what they said.
2 Question No. 3, evidence-based
3 treatment modalities. This is a question with
4 numerous sub-questions, so we will take these
5 one at a time.
6 What's a short list of the most
7 empirically supported treatment modalities?
8 What's the availability of these modalities?
9 How faithfully are the protocols followed?
10 What is DCoE's role in gathering data,
11 answering questions related to availability
12 and faithful implementation of evidence-based
13 treatments?
14 And what we did was break this up
15 to -- each question is broken up as PTSD and
16 TBI separately.
17 So for PTSD, what is a short list
18 of the most empirically supported treatment
19 modalities? We used the DoD/VA Clinical
20 Practice Guidelines for evidence-based
21 treatment of PTSD therapy and this is -- these
22 guidelines came out after an exhausted review

1 by the DoD/VA Clinical Practice Guideline
2 Group, which surveyed the literature.
3 And you have evidence-based
4 psychotherapies and evidence-based
5 pharmacotherapies. The main psychotherapies
6 are trauma-focused and re-exposure types of
7 therapies, like prolonged exposure, cognitive
8 processing therapy, I believe, cognitive
9 behavioral therapy is in there as well as
10 stress inoculation training.
11 There are others that have a less
12 rigorous form of -- or less rigorous level of
13 evidence like EMDR, but, in general, these are
14 the primary evidence-based therapies that we
15 promote as part of the DoD/VA Clinical
16 Practice Guidelines.
17 DR. PHILLIPS: Captain? I'm
18 sorry. Is there any work going on related to
19 trauma-focused therapies to precondition,
20 predeployment?
21 CAPT HAMMER: Well, stress
22 inoculation training is.

1 DR. PHILLIPS: Okay.

2 CAPT HAMMER: And also each of the

3 services has various resilience training

4 programs that they do. Probably the hugest or

5 the largest is the Army's Comprehensive

6 Soldier Fitness Program. And that's designed

7 more broadly to be a resilience training

8 program.

9 The Air Force has one as well and

10 so does the Navy and the Marine Corps.

11 In terms of preconditioning

12 people, I would actually point out that

13 that's, essentially, what the military

14 services do in just run of the mill regular

15 training, that's -- their job is to, you know,

16 condition people with as much realistic

17 training as they can.

18 So there are a number of places

19 that do that. In Camp Pendleton I know that

20 they have the emergent -- infantry emergent

21 trainer and it's a building that they actually

22 have very realistic training that the Marine

1 Infantry Units go through where they actually
2 look at, you know, physiologic measures and a
3 number of things related to their performance
4 of say a building clearing task, or, you know,
5 combat within a closed environment like that.
6 So there are a number of programs
7 out there that people are doing. These are
8 all non-medical things. This is more focused
9 on treatment.
10 And then in terms of
11 pharmacotherapy, the only evidence that we
12 have in the literature for evidence-based
13 pharmacotherapy is with the antidepressants,
14 the selecting of serotonin reuptake inhibitors
15 and the serotonin norepinephrine uptake
16 inhibitors and those are the only evidence-
17 based medications that are out there.
18 I will note that a lot of
19 providers do use other medications for
20 specific symptom complexes, but, again, this
21 is what the evidence tells us so far.
22 Now, if we look at the same thing

1 for TBI, what's the short list of the most
2 empirically supported treatment modalities for
3 TBI? Again, exhaustive literature search with
4 the VA/DoD Clinical Practice Guidelines Group,
5 the basic strategy from my old traumatic brain
6 injury is education and the positive
7 expectation of recovery, as well as rest.
8 And this has been promulgated in
9 the Directive-type memorandum regarding policy
10 guidance from management of concussion in
11 deployed settings. And again, education,
12 positive expectation of recovery and rest.
13 And I want to emphasize because
14 that sounds kind of like really, that's it?
15 Education and rest? That's all we do? It is
16 profoundly simple and yet dramatic when you
17 look at how it has been executed in theater or
18 not executed as it was in previous years.
19 That what this does is really when
20 you get real rest, not pseudo-rest where
21 people are, you know, walking around and it's
22 like no, I mean, the current practice in a

1 concussion care center is, and this is
2 happening in theater now, you sleep and sleep
3 and sleep and sleep until you can't sleep any
4 more and then you sleep some more.
5 And they really do enforce and
6 provide rest which has resulted in a profound
7 change in how well we are getting people back
8 from injury from TBI or mild TBI.
9 The next segment of this question
10 is what is the availability of each of these
11 treatment modalities across DoD treatment
12 sites? And we will start with regarding PTSD.
13 So psychiatrists, nurse
14 practitioners, primary care physicians, every
15 military treatment facility are generally
16 trained to prescribe the evidence-based
17 medicines for PTSD.
18 Their level of training and
19 practice, obviously, varies with, you know,
20 what setting they are in and what they do, but
21 everybody pretty much is trained in terms of
22 doing this.

1 In addition, therapists, in terms
2 of the psychotherapy, the Center for
3 Deployment Psychology is a DoD resource that
4 has trained almost 7,000 providers, both in
5 the military and to answer the Sergeant
6 Major's question in the civilian community as
7 well regarding evidence-based therapies for
8 PTSD.
9 So CDP has gone out and they have
10 provided a lot of training, 7,000 in the
11 military, but for other providers as well, on
12 prolonged exposure therapy and cognitive
13 processing therapy.
14 In addition, DoD increased
15 availability of these treatments through tele-
16 mental health and a number of virtual reality
17 systems, so there is a lot that is out there
18 that is available.
19 In terms of TBI, what's the
20 availability of each of these treatment
21 modalities? Well, there are over 60 service-
22 specific TBI programs with the military

1 treatment facilities at various areas across
2 the country and in theater.
3 So the service-specific programs,
4 the Army is by far the largest and has a
5 number of programs at all the major MTFs as
6 well as the Navy and the Marine Corps and the
7 Air Force as well does have TBI programs. So
8 all the services have TBI programs at their
9 major MTFs and smaller ones as well.
10 In Afghanistan, the clinical
11 algorithms and recommendations are implemented
12 in all 11 concussion care centers that are all
13 over the country. And in particular, of
14 special note, at Camp Leatherneck, in Southern
15 Afghanistan, there is a wide variety of even
16 enhanced things that the concussion care
17 center there, in terms of providing a lot,
18 they have a huge population at the camp there.
19 And the concussion care recovery center is
20 quite robust there.
21 CAPT EVANS: Captain Hammer? So
22 all the TBI programs are standard across the

1 MTF? They are the same? So if a service
2 member was to transfer to a facility, the
3 criteria to get into that program, assessment
4 and everything, that is the same?
5 CAPT HAMMER: They are similar,
6 somewhat the same. They all -- there are
7 slight variations. The Army is probably the
8 most consistent. There are some variations I
9 know between the Navy with NAVMED East and
10 NAVMED West. I'm not sure about the Air
11 Force. And but I know that -- and I think the
12 Marines -- on the Marine bases, I think, it is
13 fairly consistent.
14 But each service is responsible
15 for promulgating their own training. And so
16 it's relatively consistent, but, again, there
17 are some variations based on the service and
18 they may do things a little differently.
19 But in general, for the TBI thing,
20 it's rest, recovery and then evaluation as
21 needed in various places.
22 I would also note that as far as

1 DCoE assets, one of our component centers is
2 Defense and Veterans Brain Injury Center and
3 they are located at 13 military MTF sites, two
4 VA polytrauma centers as well. So they are
5 involved in this process as well in terms of
6 providing state of the art kind of care for
7 TBI.
8 CAPT EVANS: Okay. The reason I
9 asked that question, we had a Congressional
10 visit and one of the Marines said I was not
11 evaluated for TBI. And he stated he was in
12 seven -- six or seven different blast
13 injuries. And so I was trying to figure out
14 where the gap and why wasn't he evaluated?
15 CAPT HAMMER: That's a good
16 question. And I think we -- it's what's the
17 policy? And then what's the execution of the
18 policy? And how well is it executed at the
19 location in question? You know, that's part
20 of the difficulty is, you know, resources and
21 capabilities and all the kinds of things that
22 go into that.

1 So, in general, we have the
2 policies and we have the state of the art
3 treatment. We know what we need to do. We
4 are trying to promulgate that. We have two
5 quad service groups that we work with where we
6 have representatives from each of the services
7 in terms of putting out the policy.
8 But, you know, I don't have an
9 answer for what happens when it doesn't
10 happen. So thanks.
11 MS. DAILEY: Real quick. Yes. I
12 would like to just follow-up on that. We have
13 found a great program down at Naval Medical
14 Hospital Camp Lejeune, but I think we were
15 surprised to find that it was just this year
16 under the new commander of the hospital there
17 that they pulled together a comprehensive TBI
18 program under their own resources. They
19 didn't have to send it out into the community
20 any more.
21 CAPT HAMMER: Right.
22 MS. DAILEY: And it is, you know,

1 10 years after the war has been going on, so
2 that was our biggest look at there is a wide
3 range of TBI services being presented, even
4 after this many years of conflict.
5 CAPT HAMMER: Yes.
6 MSGT MacKENZIE: And, sir, that's
7 one of the things I was going to get to as
8 well is when we looked at -- especially on the
9 National Guard side, you know, the information
10 available versus directives or being sent as,
11 you know, you are part of the chain of this
12 distribution. And we go to one Joint Force
13 Headquarters and we see that they have got a
14 robust program.
15 CAPT HAMMER: Right.
16 MSGT MacKENZIE: You know, they
17 are doing a lot of things, they are trying to
18 train their civilian providers, but it's not
19 standard because we go to another location and
20 they are not having the same success or are
21 aware of the successes.
22 CAPT HAMMER: Right.

1 MSGT MacKENZIE: And the
2 information you find is -- you know, I have
3 only seen a couple of the areas, but it looks
4 like it is based on the motivation and
5 ingenuity of the staff at that location, not
6 the presentation or delivery of the
7 information to all agencies.
8 CAPT HAMMER: Right. And I think
9 that speaks to what we are trying to
10 accomplish within the system, in terms of when
11 I talk about improving the system of care,
12 that speaks exactly to what you are talking
13 about. You know, if you go to McDonalds and
14 you get a Big Mac and you do it in D.C.
15 versus, you know, Richmond or Louisville,
16 you're going to get a Big Mac and you pretty
17 much know you are going to get a Big Mac.
18 And I think the difficulty is, I
19 mean, we can't quite equate medical care to
20 Big Macs, but, you know, what you point out is
21 that if we say this should be the procedure,
22 this should be how it is done, then we need to

make sure that we are executing in that way.

So we can have the policies and we can have the training and we can put out the resources and put out the materials, but there is a way to get in and you've got to reach into the system to make sure.

I mean, one of the other questions later on is, in fact in this particular segment, how faithfully executed is this? And I'll be honest with you, I don't know yet. I mean, and that's an honest answer. I don't know.

And that's one of the things that I think that is DCoE's responsibility to try to figure out is how do we get that faithfully executed and how can we do that in a way that encourages people to do the right thing, rather than, you know, we're the Spanish Inquisition and we're coming in to beat you up, because you are, you know, failing in doing this.

So it's a great point.

1 MSGT MacKENZIE: It has come up
2 several times in these meetings where, you
3 know, as an aviator, my definition of
4 standardization is similar to that of
5 McDonalds' definition of standardization --
6 CAPT HAMMER: Right.
7 MSGT MacKENZIE: -- which is it's
8 standardized. And the interpretation of the
9 word standardization, I think, isn't always
10 the same.
11 CAPT HAMMER: Well, and let me
12 play devil's advocate for just a second
13 regarding this. Medical care is difficult.
14 And when we talk about evidence-based
15 treatments, okay, that evidence comes from
16 research studies and research studies are done
17 on weird patients.
18 And by weird patients, I mean,
19 patients that have absolutely pure PTSD that
20 everything else got screened out. And that's
21 just the way it is in almost all medical
22 research. It's in order to understand the

1 problem, you have to screen everything else
2 out so you can focus in on that.
3 So the problem is that you get a
4 guy with PTSD and he responds to prolonged
5 exposure therapy and he does great and say
6 great, let's give everybody prolonged exposure
7 therapy, train everybody, run them all
8 through, we've got all these guys, you know,
9 let's do it.
10 And then you get the guy who also
11 has the alcohol problem and oh, by the way, he
12 has got legal issues because, you know, he got
13 mad and beat up his wife. You know, all of a
14 sudden I'm having trouble doing the protocol
15 that it says to do in the evidence-based
16 therapy for prolonged exposure because oh, the
17 guy misses an appointment this week because he
18 is getting his legal thing done and oh, he had
19 to go to court, oh, on and on and on, were the
20 normal complexities of real people and not the
21 isolated academic instance of PTSD.
22 And that's the difficulty is

1 getting people when they are ready for
2 therapy, making sure they can do the therapy.
3 And I will tell you from -- you know, I'm a
4 psychiatrist, therapy is hard. It's really,
5 really hard.
6 So when you say evidence-based
7 therapy, prolonged exposure therapy, that's
8 great, but getting people to do it, you know,
9 other than the really highly motivated
10 selected group that went through the research,
11 now, we've got real people that aren't so
12 motivated, that are gaming the system or that
13 are angry or that are alcoholic or they have
14 legal problems or on and on and on.
15 That becomes a little more complex
16 and difficult and it is harder and harder to
17 make your Big Mac, you know, when the bread is
18 soggy and the lettuce isn't working and then,
19 you know, see that's difficult.
20 MSGT MacKENZIE: And I'm sorry,
21 sir, I think I may have presented it in a way
22 that drilled it down too far. I guess what I

1 was getting at was that, you know, as we
2 travel around as a Task Force, I should be
3 able to -- we should be able to visit each one
4 of these centers and they have all the same
5 data.
6 CAPT HAMMER: Right.
7 MSGT MacKENZIE: They have all the
8 same tool kits, they have all that stuff.
9 That's really where I'm going.
10 CAPT HAMMER: You're exactly
11 right. And that's our goal.
12 MSGT MacKENZIE: Because it's not
13 happening. Thank you.
14 CAPT HAMMER: Yes.
15 MG STONE: Mack, let me spend just
16 a minute with this. The VA has embarked upon
17 an aggressive establishment campaign for
18 traumatic brain injury centers and has over 65
19 centers, at this point, or about 65 centers.
20 In addition to the 11 concussion
21 centers within theater under the DTM
22 establishment of which Leatherneck is, as Paul

1 mentioned, you know, an extraordinary center
2 to place service members brains at rest post-
3 exposure.
4 The Army has established 47
5 different centers across our delivery system
6 in various intensities from the need for mild
7 traumatic brain injury to the more complex
8 patient, as Paul more accurately talked about.
9 In addition, the National Intrepid
10 Center of Excellence on the Bethesda Campus is
11 to take the most severe traumatic brain injury
12 and integrate that with the research that
13 Paul's team really worked to integrate across
14 the delivery system.
15 The Fisher family has just donated
16 nine additional National Intrepid Center of
17 Excellence satellites that we will start
18 building at Lejeune and at Fort Belvoir Campus
19 beginning this spring, but the effort is a
20 comprehensive integrated system that reaches
21 out everything past the most mild traumatic
22 brain injury and allows multiple places.

1 So the Guardsman who is in North
2 Dakota has a local VA with TBI services. But
3 we look to the DCoE to really work to help us
4 identify the white space. I come back to the
5 cell phone commercial. You know, where is the
6 white space that we just don't have access to?
7 Remember also, we are 10 years
8 into this, but traumatic brain injury, the
9 whole pathophysiology of traumatic brain
10 injury is just now becoming understood,
11 whether Tal protein has something to do with
12 this, how we look at it, how we look at the
13 use of oxygen therapies, rest therapies, we
14 are still at the point of placing the brain at
15 rest as the most effective therapy.
16 And as we move beyond that, you
17 know, Paul's work in being able to get us to
18 the point of having a blood test that will
19 help us identify the traumatic brain injury
20 patient is within the foreseeable horizon.
21 We are coming along with this
22 disease process, but this and PTSD as the

1 signature injuries of this war, we have made
2 great progress. We are impatient to make
3 more, but we do have more than 100 centers
4 today that our service members have access to.
5 CAPT HAMMER: Yes. And, General
6 Stone, by the way, you mentioned the VA, the
7 VA, I think, is getting -- is much further
8 ahead than DoD on this, in terms of
9 religiously looking at evaluating everybody
10 for the TBI.
11 So the guy that, you know, you
12 talked about Captain that said hey, I didn't
13 get it, in the VA system they are much better
14 at catching those guys and making sure that
15 everybody that comes in, you know, every
16 veteran from the recent conflict gets
17 evaluated for TBI.
18 CAPT EVANS: He caught all of us
19 off-guard, because we thought we had a pretty
20 solid system of identifying, so all of us were
21 just like it was one of those aha moments.
22 CAPT HAMMER: Right.

1 CAPT EVANS: But do we, speaking
2 of blood tests, utilize CAT scan or CT scan
3 for -- that has been another question coming
4 from the warriors, why didn't I get an
5 immediate --
6 CAPT HAMMER: CT scans generally
7 aren't helpful for mild TBI in acute setting.
8 They are helpful for ruling out more severe
9 brain injuries, but not for mild TBI.
10 MG STONE: And on an experimental
11 basis, we have just placed MRIs into theater.
12 CAPT HAMMER: Yes.
13 MG STONE: Although the clinical
14 algorithms you know better than I.
15 CAPT HAMMER: We are just barely
16 trying to -- starting to figure out what those
17 are.
18 MG STONE: Yes,.
19 CAPT HAMMER: Yes.
20 LT GEN GREEN: I think that if I
21 could just summarize the one area that I think
22 that is being alluded to here, a lot of work

1 has been done with DTM to standardize
2 treatment in theater for people with
3 concussions. Catching the early, trying to
4 eliminate longer term problems.
5 And so I think there is a lot of
6 things that I have seen now that are doing
7 very well in terms of that standardization.
8 But these 100 centers that are coming up,
9 okay, all of the things that are now designed
10 to treat TBI, my question to you would be when
11 is the DCoE going to evaluate the cognitive
12 rehab programs at these various sites or what
13 are we doing to bring together what works and
14 what doesn't, so that the 100 sites will offer
15 evidence-based therapy?
16 I don't think you have addressed
17 that part of it.
18 CAPT HAMMER: No, I haven't. And
19 we are actually doing -- we have the SCORE
20 trial which is the -- and we are also looking
21 at the cognitive rehab. We have a cognitive
22 rehab pilot program looking particularly at

1 cognitive rehabilitation to see how they are
2 doing it at various MTFs here in CONUS.
3 That brings us to the next bullet
4 is the cognitive rehab issue is a complex one.
5 But I think it is misunderstood by a lot of
6 people and that cognitive rehabilitation is
7 like sort of like saying orthopedic treatment.
8 You know, it covers a lot of stuff.
9 The orthopedic treatment could be
10 a knee surgery, it could be your hip, it could
11 be, you know, splits and bandages all the way
12 to surgery and pins. It could be a lot of
13 different things.
14 And it's the same way with
15 cognitive rehabilitation. Cognitive
16 rehabilitation is not one thing. It's a
17 collection of things. And it's a collection
18 of a whole bunch of different treatments that
19 are used to look at the various aspects of
20 cognition with individuals who have a mild
21 traumatic brain injury, so -- or actually more
22 severe traumatic brain injuries as well.

1 So the point is is that it's
2 available and there is no actual set
3 collection of cognitive rehabilitation
4 therapies that are -- would be prescribed for
5 everybody with a mild TBI.
6 You have to do what does this
7 individual need versus what that individual
8 needs and in any place where cognitive
9 rehabilitation is provided, it is provided
10 specific to that individual and to meet their
11 specific clinical needs.
12 So one person may have difficulty
13 with memory. Another one might have with
14 attention. Another -- so you have to do it
15 based on that particular individual. And,
16 generally, it hasn't been found that if we
17 bundle it all together as one big blob of
18 cognitive rehabilitation, you know, it exists
19 that way. That's not how best to provide it
20 to service members. So it does need to be
21 individualized. And it is available to
22 service members.

1 How faithfully are these protocols
2 implemented? First off for PTSD, well, we
3 don't know. And I talked about the difficulty
4 of doing therapy with a more complex patient.
5 What we are working on is the Center for
6 Deployment Psychology is working on developing
7 a fidelity model to measure the degree to
8 which a PTSD treatment is delivered as
9 intended.
10 And we really don't have that
11 going yet. We have not yet studied this with
12 MSH providers. We have recently been tasked
13 to develop PTSD pathways of care and this will
14 be a part of that in looking at how faithfully
15 and how well-implemented these therapies are.
16 But we are working to standardize outcome
17 measures to analyze effectiveness of care and
18 we continue to review input from operational
19 research and material community to work on
20 that.
21 How faithfully are the protocols
22 for these models being implemented for TBI?

1 I think we kind of discussed that already.
2 But again, we have the DTM in theater, that's
3 fairly faithfully followed. We have mandatory
4 requirements for the MTFs and that may not be
5 as faithfully required, but we are still
6 working on that.
7 One of the things we are trying to
8 do is out -- get the standardized outcome
9 measures to make sure that we analyze
10 effectiveness of care. And again,
11 standardized outcome measures so that we can
12 look at outcomes and focus on outcomes. And,
13 you know, again, make sure that we understand
14 what is going on in the system.
15 What's our role in gathering data
16 to answer questions regarding the availability
17 and faithful implementation of these treatment
18 modalities? Well, we play an important role.
19 Like I said, we are the integrator. It is our
20 role to gather data to answer these questions.
21 The specific things that we are
22 involved in in terms of gathering data is the

1 DoD/VA integrated mental health strategy
2 actions. There are 27 of these initiatives
3 and we have two specific ones related to
4 implementation of treatment programs that we
5 are tasked with among the others.
6 We have been tasked specifically
7 by the -- by Health Affairs to develop the
8 psychological health optimization. And what
9 that is is a dashboard of measures, so that we
10 can actually say, we can tell you how well we
11 are doing, based on, you know, the number of
12 people returned to duty, number of people
13 getting treatment, you know, a lot of
14 different measures that we have difficulty
15 getting now.
16 We are also required periodically
17 to report to Congress and senior leadership on
18 various issues. We are -- I would note that
19 DCoE is not the only organization involved in
20 this effort. Now, we have a number of other
21 partners, both of the VA as well as the Force
22 Health Protection and Readiness, clinical

1 programs and policy, the services, there are
2 a number of people involved in this effort to
3 make sure that we are faithfully implementing
4 these things.
5 We develop ways to assess our
6 Clinical Practice Guidelines and clinical
7 support tools. And again, we are working on--
8 okay, we have developed a clinical tool that
9 supports a Clinical Practice Guideline. Okay.
10 How well is it implemented?
11 And then standardized systems to
12 gather quality fidelity outcome measures. And
13 we are looking at clinical pathways for care
14 for PTSD to include measures of adherence,
15 quality and outcome, but, again, we are not
16 there yet.
17 Question No. 4, in January and
18 March of last year, we stated the innovative
19 practice study was leading the way to
20 determine the current universe of DoD
21 programs. And this is the RAND study that we
22 talked about. As of January 2011, 20 programs

1 were evaluated and provided the update.
2 So this is the RAND report. It
3 was released in November of 2011 and what RAND
4 did was go out and catalog existing programs.
5 They found 211 of them. They had a fairly
6 specific criteria, set of criteria that -- how
7 they defined a program.
8 And you should also note that the
9 specifically excluded clinical programs. So
10 these are more other types of programs, not,
11 you know, we are going to hire 10 more
12 psychologists, that kind of program.
13 They identified a number of
14 things. They looked at a row of programs.
15 They provided recommendations on the gaps,
16 barriers faced by the programs and then helped
17 to build the evidence-base and that's the
18 website if you want to look it up.
19 So what they did was once they got
20 this catalog list of 211 programs, then they
21 said now, we are going to look at 20 of them.
22 And the 20, they say two are completed: The

1 Marine Corps Warriors Strengthening Program
2 and the Real Warriors Campaign are completed
3 and in review.
4 There are three data collections
5 under way. The Marine Corps OSCAR Program,
6 the Airman Resiliency Training Program and the
7 RESPECT-Mil, which is one of our programs with
8 the Deployment Health Clinical Center.
9 There are a couple just getting
10 started. The inTransition is a program to
11 help folks inTransition from either PCSing in
12 between duty stations or getting out of the
13 military. The regional care coordination with
14 DTC, the Deployment Transition Center, the Co-
15 Occurring Disorders Program and an IT solution
16 called SimCoach.
17 And I believe NYCO actually just
18 signed up to be evaluated as well. We are
19 still -- that was one of the programs that was
20 listed in the 211 and we are looking at, you
21 know, probably 10 more that are going to be
22 selected very soon.

1 Question No. 5, in January we
2 identified a number of challenges as internal
3 and external factors preventing us from
4 fulfilling our mission. And so, yet, a number
5 of issues regarding collaboration with the VA
6 and a number of things.
7 I think the biggest one that this
8 answered is the tasking authority one, in
9 terms of the authority to do things and get
10 stuff done.
11 So part of the difficulty is in
12 the past. We faced the challenge of not
13 really having the authority. So a couple of
14 things that we are working on. DCoE
15 strategically identified key stakeholders to
16 collaborate with.
17 We are having a more proactive
18 role in engaging with the SMMAC, the Senior
19 Military Medical Advisory Council, and its
20 supporting Integrated Councils. That is our
21 way to reach into and assist the services and
22 coordinate with the services in terms of our

1 actions.

2 Recently, as part of the whole

3 overhaul of the CoE system, the military

4 health system stood up to the Center of

5 Excellence Advisory Board, which we report to

6 along with the other CoEs, and we are working

7 with quad service calls. We have both a PH,

8 a psych health, and a TBI Quad Service Group,

9 both groups are quite active. And my deputy

10 directors for PH and TBI run these quad

11 service calls and coordinate a lot of

12 activities with them.

13 There were two recommendations

14 that you all had regarding -- from the Task

15 Force from last year that we needed to

16 address. Recommendation No. 9 said align

17 DCoE, PH and TBI to the Army's executive agent

18 to promote more aggressive dissemination of

19 Clinical Practice Guidelines.

20 We are working currently with the

21 U.S. Army's Medical Research and Material

22 Command to be aligned as an executive agent

with them. We have had -- we expect to have initial operating capability in October and we are expecting full operational capability in October of 2013.

There are a number of issues involved in moving an entire organization under another one and as you can imagine, there is personnel. We are going to go from the DoD to the Army Personnel System. We have IT issues. So it's going to take a while to get there, but we are doing that.

In October of 2011, we had the initial planning meetings. We had progress review last January, just last month and then in April we've got another one planned with General Gilman. But we are actively working to get ourselves organized and aligned in that way.

And then question -- or Recommendation No. 10.

CSM DeJONG: Sir, when you say fully operational October 2013, is that fully

1 staffed, manned, funded, equipped?
2 CAPT HAMMER: Well, we are
3 generally at full operational capability right
4 now. There are some personnel issues
5 regarding the hiring freeze with DoD and
6 particularly we fall under TMA for those sorts
7 of personnel issues now. So we are not quite
8 fully manned in terms of our manning document.
9 A lot of that, in terms of full
10 operational capability, means we have a UIC.
11 We have IT support from the right people. We
12 are -- all of our personnel actions are going
13 through the Army and MRMC, you know.
14 All of those kinds of things are
15 going to take a long time to sort out. So
16 that's why we are saying full operational
17 capability.
18 But in terms of our ability to
19 function, that will continue. It is fully
20 underneath and aligned. It probably won't
21 happen officially until next year.
22 Question No. 10, timing and

1 routine access for PTSD. Yes, we should. We
2 have added over 2,000 behavioral health
3 providers to the military health care system
4 and over 10,000 on the networks since 2009 to
5 increase care availability.
6 One of the major initiatives that
7 is going on right now is embedding mental
8 health care providers in the line units. The
9 Army has an embedded Behavioral Health
10 Provider Program that has really went very
11 well at Fort Carson and is being expanded
12 across the service.
13 The Marine Corps has a different
14 program called OSCAR that they are working on.
15 And I think the Navy is considering something
16 similar to that as well.
17 The Navy has long had
18 psychologists on carriers and found that to be
19 quite a value-added sort of a thing. So a lot
20 of the embedded mental health providers is an
21 important part of that.
22 We are also working to get

1 behavioral health providers integrated into
2 the primary care clinics. One of our
3 component centers, Deployment Health Clinical
4 Center, is critical in part of that effort.
5 But this also dovetails on what the DoD is
6 doing with a patient-centered medical home.
7 And again, embedding providers in primary
8 care.
9 And in May of 2011, the VA's
10 authority was expanded to provide readjustment
11 counseling and mental health services to
12 members and veterans under the -- for three
13 years, up to three years after return from
14 deployment, extending their TAMP benefits.
15 So we are making headway and
16 getting the access to care there.
17 MR. REHBEIN: Captain, just one
18 minor point. When you talk about embedding
19 mental health providers into the Army aligned
20 units, what level are they going in at? Are
21 they brigades, battalion?
22 CAPT HAMMER: Brigade level.

1 MS. DAILEY: Yes, I have a
2 complete briefing on that also for those of
3 you who didn't get to see it.
4 CAPT HAMMER: Yes.
5 MS. DAILEY: We have been briefed.
6 CAPT HAMMER: The Fort Carson
7 experiment has been really interesting and
8 that seems to be quite well-received, because
9 you have providers right there in the brigade
10 area.
11 Again, we are implementing
12 inTransition, which is a program that assists
13 service members, to make sure that they can
14 get connected up if they have been in therapy,
15 for example, and they are getting out. How do
16 they get connected to a therapist either in a
17 new duty station or in a new place where they
18 are going?
19 We are developing innovative
20 technology for web-based telemental health
21 care to provide access to remote areas. And
22 we are also looking at innovative IT tools to

1 use their smart phones and, you know, iPhones
2 to manage PTSD symptoms before and after
3 behavioral health appointments.
4 So trying to expand out of just
5 the traditional therapeutic thing to use
6 technology to assist.
7 And I know that was long and I
8 probably went way over my time, but --
9 MS. DAILEY: You're right on time.
10 We have time for questions.
11 CAPT EVANS: One of the problems
12 we have back over where I work is that we
13 can't seem to get the technology that we need
14 for our warriors. So I'm not sure, we're
15 fighting that constantly trying to get the
16 iPads and the iPhones.
17 You know, we have a lot of -- we
18 work with a lot of benevolent organizations
19 that assist us, but I think that really needs
20 to be addressed how we can work closely with
21 NYCO to keep them well-equipped with some of
22 that technology.

1 So I'm not sure what's the best
2 way to get that equipment.
3 CAPT HAMMER: I don't know that I
4 have a good answer for that. What I can tell
5 you is that the use of smart phone technology,
6 for example in cognitive rehabilitation
7 things, is reminders or, you know, that sort
8 of thing can be a helpful tool.
9 But in terms of structuring the
10 supply system or the acquisition system in
11 order to get that might be a little bit out of
12 my lane.
13 MS. DAILEY: Let me put that on my
14 list of briefings, particularly for next year.
15 There is an agency, a DoD agency, that has a
16 big office in the Pentagon. They have got all
17 their tools spread out in the office for
18 addressing disabilities. And we ought to get
19 them in to talk to you, if that's a concern.
20 MSGT MacKENZIE: You're referring
21 to the CAP Program, ma'am?
22 MS. DAILEY: Yes, yes.

1 MSGT MacKENZIE: The interesting
2 part is that with that, everything is based on
3 funding, you know, and the amount of time
4 precludes the -- I mean, you look at the part
5 that they put in for myself, it has been
6 ongoing now awaiting delivery since September
7 of last year.
8 So that timing to the folks that
9 are trying to implement that with the
10 individuals, also creates complications. And
11 this goes why outside of what we are doing.
12 But one of the things that I want
13 to ask you, sir, in regards to that is is DCoE
14 working at all with these technology folks as
15 far as, you know, what are these applications
16 that really work?
17 Because depending upon which
18 medical professional, which person you talk
19 to, you know, these different things that you
20 can embed into these devices to assist you --
21 CAPT HAMMER: Yes.
22 MSGT MacKENZIE: -- nobody really

1 -- is there a list out there or a site that
2 you can go to on DCoE that says hey --
3 CAPT HAMMER: Yes.
4 MSGT MacKENZIE: -- here is these
5 apps --
6 CAPT HAMMER: Yes.
7 MSGT MacKENZIE: -- that you may
8 want to use? Is that actually available?
9 CAPT HAMMER: Yes. You have the--
10 what we have is a National Center for
11 Telehealth and Technology, T2. And one of
12 their jobs, in terms of the research portfolio
13 that they have, is to look at usability and
14 effectiveness of these various apps.
15 So they will -- they have 10
16 mobile apps out. There are four that I can
17 think of right off the top of my head in terms
18 of breathe to relax, there is a tactical
19 breather, there is the PTSD Coach. The other
20 one I'm forgetting about.
21 But one of the things that they
22 do, that they are looking at, is not just

1 okay, we've built an app and throw it out
2 there and it's on the Apple website and off
3 you go, download it for free.
4 They also look at well, how usable
5 are they? How effective are they? Are they
6 doing anything? Are they -- so that's what
7 T2's job is is to look at, okay, everybody had
8 a great idea about technology, but, again, is
9 it effective? Are we measuring it? How
10 effective? Are we doing something to really
11 answer that question?
12 And that -- some of that research
13 has been done in terms of like using -- you
14 know, we used to call it a PDA for, you know,
15 reminders for cognitive rehabilitation
16 therapy. But really looking at how well does
17 it manage your symptoms for PTSD, that hasn't
18 been examined yet.
19 So they are looking at the -- the
20 T2 folks are looking at a lot of that research
21 and how does the technology help us
22 understand, you know, what it does? And

1 that's part of their whole portfolio. They
2 actually have been -- they are out at Fort
3 Lewis or Joint Base Lewis-McChord in
4 Washington.
5 What they will do is they have a
6 local brigade, an infantry brigade or maybe
7 it's a striker brigade, that they actually are
8 very cooperative about saying hey, send us a
9 bunch of guys. We need you to look at, you
10 know, how useful this is and have a usability
11 lab where they bring these guys in, have them
12 use the little smart phone application and,
13 you know, give feedback and comments.
14 And they are doing research and
15 have research proposals on the use of avatars
16 with virtual reality kinds of things and that
17 sort of stuff. So there is a lot of stuff
18 that they are doing, but the research basis,
19 the evidence basis isn't that great. It's all
20 in the technology, not in how effective is the
21 technology in reducing symptoms.
22 DR. PHILLIPS: Captain Hammer,

when I asked earlier about the preconditioning, above and beyond what is going on at the virtual reality programs around the country, about a year and a half ago I was out in San Diego and there is a program associated with --

CAPT HAMMER: Yes.

DR. PHILLIPS: -- the University of California, San Diego --

CAPT HAMMER: Right.

DR. PHILLIPS: -- where it had a movie studio.

CAPT HAMMER: Yes. Yes, Stu Segall Studio in Kearny Mesa there.

DR. PHILLIPS: Yes.

CAPT HAMMER: Yes.

DR. PHILLIPS: Where they --

CAPT HAMMER: It's great.

DR. PHILLIPS: -- have active amputees, so I was wondering -- and they told me that they were able to run a company of Marines through.

1 CAPT HAMMER: Right.
2 DR. PHILLIPS: And I was just
3 wondering if -
4 CAPT HAMMER: Virtual Iraq is what
5 they were doing, yes.
6 DR. PHILLIPS: Exactly. You know,
7 IEDs and civilian population.
8 CAPT HAMMER: Yes. They even have
9 an Iraqi woman who is an amputee.
10 DR. PHILLIPS: Yes.
11 CAPT HAMMER: That they blow her
12 up basically as part of this thing and the
13 Marines will come up on her and go oh, my God,
14 she really doesn't have a leg, you know. So
15 it's mobilize her up and everything, yes.
16 DR. PHILLIPS: So I was wondering
17 if there was any information related to the
18 returning units that went through this and
19 what their level of post traumatic stress and
20 so forth might be? I didn't know if there was
21 any follow-up or funding follow-up?
22 CAPT HAMMER: Well, I'm not sure

about Stu Segall's Virtual Iraq or what they do at Mojave Viper at Twentynine Palms or even what Fort Irwin does as well.

I can tell you about the Marine Resilient Study, which is really -- that's also a UCSD study with a whole consortium with the National Centers for PTSD. And what they are doing is they take -- they have actually got, I think, over 2,000 Marines have gone through this that have deployed both to Iraq and Afghanistan.

So what they do is they bring them through before and, you know, they -- as part of their predeployment work-up, they go -- they have a whole trailer out there in Camp Pendleton and Twentynine Palms that they run them through. They get paper and pencil tests. They draw blood. They get saliva. They get urine samples.

And then they are looking at genetic markers. They are looking at blood markers, a bunch of biomarker types. They

1 look at symptom complexes as they are now.
2 Then when they get back, immediately after
3 they get back within a week of getting back,
4 they run them all through again and then at
5 120 days or 90 to 120 days, they run them
6 through the whole process again.
7 And that's where in the Marine
8 Corps combat stress doctrine, they use that
9 green, yellow, orange, red and so the red is,
10 you know, you're diagnosed, but the orange
11 zone is sort of that it could go either way.
12 Where are they?
13 So what they do is, and that's
14 what I was referring to, they actually can tag
15 who is in the orange zone and they actually
16 are tracking that the guy that is in the
17 orange zone a week after may not be in the
18 orange zone or the red zone later on.
19 But some of the guys that say oh,
20 I'm yellow, I have no symptoms now, 120 day
21 mark, they are either orange or red sometimes.
22 So it's an interesting thing and looking at --

1 you know, looking even further advancing the
2 question of how do we do screening? And how
3 do we rationalize what we do with the PDHA and
4 the PDHRA? Is that really the way to do it or
5 is there a different better way that we can
6 look at that?
7 So that's kind of some of the
8 stuff that we are looking at and kind of --
9 and, again, like I say, as we DCoE in the
10 center of that diagram, have our fingers in
11 the pulse of what is going on either at MRMC
12 or out in Twentynine Palms and Camp Pendleton
13 or down at Camp Lejeune or what is going on at
14 Fort Bragg or how is Fort Carson doing?
15 That's the whole idea that we can
16 say, hey, here is what they are learning.
17 Let's bring that in and do something with that
18 to improve the system.
19 MS. CROCKETT-JONES: Can I ask a -
20 -
21 DR. PHILLIPS: And I actually
22 tried to -- I couldn't get funding, but

1 working with BUDS training and trying to get
2 those fellows to do these biomarkers -
3 CAPT HAMMER: Yes.
4 DR. PHILLIPS: -- to see whether
5 or not they could --
6 CAPT HAMMER: Well, there have
7 been studies done on SEALS and they have, I
8 think, neuropeptide Y, they like self-select
9 for, you know, high or no -- but, you know,
10 that's really esoteric stuff.
11 Yes, ma'am?
12 MS. CROCKETT-JONES: One of the
13 things that we sort of get an impression from
14 our installation visits, at least I have, is
15 that there seems to be some discomfort within
16 the level of clarity on diagnosing PTSD, in
17 that there seems to be, we hear almost
18 everywhere we go, folks with ideas that there
19 are people being diagnosed with it who do not
20 have it.
21 CAPT HAMMER: Yes.
22 MS. CROCKETT-JONES: And people

1 who are not being diagnosed with it who do
2 have it. So I'm wondering if there is any
3 research into maybe getting more clear on
4 diagnosis? It seems to be a commentary we
5 hear --
6 CAPT HAMMER: Yes.
7 MS. CROCKETT-JONES: -- across the
8 board. And a secondary thing to that, just as
9 sort of my own question, it seems to be that
10 the same diagnosis of PTSD is given to someone
11 who responds well and has, you know, greatly
12 increased functionality after eight cognitive
13 behavioral therapy visits has the same
14 diagnosis as someone who is in constant
15 treatment for --
16 CAPT HAMMER: Yes.
17 MS. CROCKETT-JONES: -- you know,
18 years and sees very little improvement. And
19 I'm wondering is it -- are they really having
20 the same?
21 CAPT HAMMER: Do they really have
22 the same diagnosis --

1 MS. CROCKETT-JONES: Yes.
2 CAPT HAMMER: -- if they are so
3 very different? The answer is yes. And the
4 answer to your question is at its core, that
5 PTSD, number one, is not that well-understood
6 or well-known as we think we know it.
7 It is extraordinarily complex.
8 And there is a tremendous amount of co-
9 occurring illness along with it. So in other
10 words, the person you just described that may
11 have a fairly pure PTSD and he does pretty
12 well with eight to 10 sessions and he is, you
13 know, back to functioning, oh, it was great
14 and therapy was wonderful and everybody should
15 do it, that's great.
16 But then you have the other guy
17 who is -- you know, has alcohol problems going
18 on or anger issues or whatever. He may also
19 have a co-occurring, you know, other anxiety
20 disorder. He may have panic attacks. He
21 could have depression.
22 So part of it is the variation

1 among individuals. And the other part of it
2 is is what is our understanding of what this
3 disorder is?
4 One of the major changes that they
5 are looking at in trying to examine as the
6 American Psychiatric Association started a
7 roll-out DSM-V, which is the next iteration of
8 the diagnostic and statistical manual, one of
9 the things that we're looking at is what -- it
10 appears to be somewhat different.
11 The combat PTSD with say accident
12 victim or natural disaster civilian victim
13 PTSD. In that with most military folks, they
14 don't complain of that intense fear kind of
15 response, that reaction of horror, that sort
16 of thing and terror. They don't have that.
17 And that's what a major -- that's the A
18 criteria for PTSD is that you had an
19 experience and it caused that problem for you.
20 A lot of military people do not
21 have that. They say, you know, I wasn't
22 terrified. I was doing my training, but now,

1 I'm reacting to it. So I think there is a
2 long way to go to understanding just what it
3 this animal that we call PTSD and what do we
4 do with it and how do we treat it?
5 So when people say well, you've
6 got PTSD, go get therapy, you should be
7 better, well, for the guy that did eight to 10
8 sessions, you know, that's that population.
9 There is a whole other population that has co-
10 occurring substance disorders. We have a
11 whole other population that has other
12 psychiatric disorders piled on top of it. And
13 then there is a population or subpopulations
14 that are overlapping in these sort of Boolean
15 algebra of PTSD that you have got to deal
16 with, but they are all -- they all have PTSD.
17 So, you know, it's like cancer.
18 You know, there is some types of cancer that
19 are easily treated and there are others that
20 aren't. And, you know, you have to drill down
21 into what exactly are we dealing with? And
22 that's part of the difficulty of doing the

1 evidence-based therapy is it's not quite as
2 pure when you get down to individual patients.
3 MS. DAILEY: Real quick then, sir,
4 we will need to wrap up. Just what we have
5 noticed as we have gone around, these
6 communities, the Lejeunes, the Carsons, the
7 Pendletons, they are major deployment
8 platforms. They are going to be deploying
9 troops and troops are going to come back with
10 PTSD and TBI and remain in these communities,
11 and these whole communities are changing,
12 because of this new population of individuals
13 who need this treatment, need this care, their
14 families, their children, it trickles down.
15 And I'm just asking are these
16 resources being put into these communities
17 that are going to be affected for generations
18 pretty much? Are we putting our PTSD, our
19 mental health, our centers --
20 CAPT HAMMER: Oh, yes.
21 MS. DAILEY: -- in these major
22 platform communities that are going to be

1 dealing with these -- with this illness for
2 generations pretty much?
3 CAPT HAMMER: Yes. And that is
4 the major effort that all of us within the --
5 you know, all the services and all of us
6 within the DoD hierarchy, you know, are
7 working and looking at trying to optimize.
8 MS. CROCKETT-JONES: Well, thank
9 you very much. I know we have pulled you from
10 one topic to -- you know, we have really
11 pulled you all over your own map there.
12 CAPT HAMMER: No, I --
13 MS. CROCKETT-JONES: So thank you
14 very much.
15 CAPT HAMMER: You're welcome. I
16 enjoyed talking about this stuff.
17 MS. CROCKETT-JONES: Thank you
18 very much.
19 CAPT HAMMER: Okay. Thank you.
20 MS. DAILEY: Break time, ladies
21 and gentlemen. Just a reminder, we have a
22 PTSD Panel coming up at 10:00, so your

1 exposure to PTSD is not over. You will have
2 another two hours to talk at depth and in
3 length with experts on the services. Thank
4 you.
5 (Whereupon, at 9:53 a.m. a recess
6 until 10:07 a.m.)
7 LT GEN GREEN: Okay. Ladies and
8 gentlemen, welcome back. The Task Force is
9 interested in more information regarding
10 evidence-based treatment modalities for post-
11 traumatic stress disorder.
12 And with us to discuss this topic
13 are Dr. Charles Hoge, okay, Senior Scientist
14 in Neuropsychiatry Consultant at the Office of
15 the Army Surgeon General.
16 We also have, I believe, Commander
17 Jean Lord, who is the Director of Clinical
18 Support Services for the Navy.
19 Commander Rosemary Malone, okay,
20 who is the Director of Deployment Health,
21 Wounded, Ill and Injured.
22 And then Lieutenant Colonel David

1 Dickey, the Chief of Mental Health at the Air
2 Force Medical Support Agency attached to the
3 Pentagon.
4 If you will look at your agenda,
5 the specific questions they are addressing and
6 the information is in Tab P.
7 And, Dr. Hoge, over to you.
8 DR. HOGE: Thank you very much,
9 sir, and Committee. It's an honor to be here.
10 I'm not a program manager for the Army, but I
11 am the Senior Subject Matter Expert in PTSD
12 for the Army with considerable background in
13 research publication in this area and clinical
14 work. I work over at Walter Reed in Bethesda
15 treating service members and their family
16 members.
17 I was on active duty for 20 years
18 and retired two years ago and then came back
19 as a GS employee with the Office of the Army
20 Surgeon General. So it's a pleasure to be
21 here.
22 I'm going to keep my comments

1 fairly focused around the questions, but I am
2 going to, I think, broaden the discussion a
3 little bit when we talk about evidence-based
4 care.
5 Just some quick background. I'm
6 sure that you all are well-aware of the
7 statistics, baseline prevalence of PTSD in the
8 general population and then new exceptions to
9 the military who have never seen combat is
10 around 3 to 6 percent.
11 When service members come home
12 from combat, if they are in regimental combat
13 teams or brigade combat teams, we have
14 documented prevalence rates of PTSD fairly
15 consistently around 15 percent, but there is
16 a very wide range depending on the level of
17 combat intensity that they experience.
18 In terms of diagnosis, a
19 relatively small percentage of service members
20 who have -- who actually have PTSD get
21 diagnosed with PTSD and there is a lot of
22 reasons for that. A lot do not seek

1 treatment, a lot who do seek treatment get
2 coded under other diagnoses, because they view
3 PTSD as stigmatizing and they don't want that
4 in their record. There is a lot of reasons
5 why that happens.
6 But about 3 percent get diagnosed
7 with PTSD in the Army and of all the services,
8 the Army has the largest prevalence rate.
9 There is a high impact on
10 functioning and there is a high, very high
11 coexisting condition which really can
12 complicate treatment and sometimes diagnosis.
13 There can be significant work and social
14 impairment. PTSD is very highly associated
15 with depression, grief, anxiety, alcohol,
16 relationship problems, risky behaviors and
17 other health conditions, including generalized
18 physical health conditions.
19 There is an injury, if you are
20 injured in the combat zone, any type of
21 injury, including concussions, that increases
22 your risk of PTSD.

1 I think there is a -- I think sort
2 of the next frontier is sleep deprivation. We
3 really had 10 years of war and, you know, line
4 infantry units still get about five hours
5 sleep for 24 hours in the combat zone, which
6 has, you know, some pretty profound
7 physiological effects. And I think there is
8 a strong relationship with health conditions
9 when they come back because of that.
10 PTSD is also -- there is also an
11 occupational context of PTSD and it is helpful
12 to think of it not just as a medical
13 condition, but also understand the
14 occupational context for this condition among
15 warriors.
16 Everything that we label a symptom
17 also has an adaptive beneficial function. So
18 being hyper-alert and hyper-vigilant, which
19 are symptoms when individuals come home,
20 actually is adaptive and beneficial and
21 necessary and helpful in the combat zone,
22 being able to channel anger in a certain way

1 is like, you know, a shot of Ritalin, a shot
2 of adrenalin.
3 It helps you focus, concentrate,
4 shut down pain, so there is a beneficial
5 effect to anger. It is not only a negative
6 thing. It also has a beneficial effect.
7 There is a beneficial effect to
8 numbing out emotions in the combat zone. If
9 you lose a team member, you have to be able to
10 continue to function in that environment and
11 you shut down your emotions. And that's a
12 normal beneficial helpful adaptive thing that
13 service members learn to do and it's part of
14 their training.
15 They are trained to respond to
16 traumatic events. They are not victims of
17 traumatic events. There is a lot of
18 differences between PTSD and civilian victims
19 of trauma and PTSD within a military
20 occupational context. And I would also add
21 first responder context, like police and fire
22 fighters.

1 And this is important because a
2 lot of our service members come into see us
3 and then they leave treatment. Sometimes they
4 leave after one or two sessions of treatment
5 and we don't fully know the reasons why they
6 leave treatment, but some of the research that
7 we are doing suggests that they have very
8 negative perceptions of their interactions
9 with mental health care.
10 And I think that sometimes it's
11 because the mental health professionals
12 themselves and the organization doesn't really
13 know how to discuss and normalize their
14 experiences within their occupational context
15 and really help them to feel that no, you
16 know, these are normal expected reactions.
17 They are causing you some
18 difficulties now, for instance, in your
19 marriage or your, you know, social functioning
20 here back at home. But, in fact, many of
21 these responses are exactly what your body has
22 been trained to do, because of the training

1 that you have been in and the experiences that
2 you have had.
3 So there are ways to normalize
4 things. And I think there are opportunities
5 for better education in how to communicate
6 with warriors when they come back about their
7 health condition, so that they don't feel as
8 if they are automatically getting labeled as
9 having a mental disorder.
10 In terms of evidence-based
11 treatment. The first question that was asked
12 was what constitutes empirically supported
13 evidence-based PTSD treatments? And I think
14 a lot of policy makers and experts in the
15 field equate evidence-based treatment with
16 prolonged exposure and cognitive processing
17 therapy. And, indeed, those are the two most
18 popular treatment packages.
19 But those are not -- that does not
20 constitute the full gamut of evidence-based
21 treatment. Those are only two ways to deliver
22 evidence-based treatment. What constitutes

1 evidence-based treatment is much more broad
2 than that.
3 The DoD/VA Clinical Practice
4 Guideline provides our current evidence-based
5 guideline. And I'll show you the evidence
6 tables if you haven't seen them already. A
7 Level is very good evidence for effectiveness
8 and benefit outweighing harm.
9 And the wording, specific wording,
10 is trauma-focused psychotherapy that includes
11 components of exposure and cognitive
12 restructuring and/or stress inoculation
13 training. And then there is a number of other
14 evidence-based treatments, but that don't have
15 the same level of evidence or the same strong
16 recommendation.
17 A C Level recommendation is we
18 can't really tell that -- you know, we can't
19 really determine that harm really
20 significantly out -- that benefits
21 significantly outweighs harm, but it's still
22 recommended in some patients.

1 And I is we really don't have
2 sufficient information.
3 In terms of medications, the SSRIs
4 like Zoloft and Paxil are the two that are
5 FDA-approved, but there are a whole bunch of
6 others and the SNRIs are medications,
7 antidepressant medications, that are very safe
8 to use, very commonly used, about 5 percent of
9 our Army soldiers are deployed on these
10 medications and do well in combat on these
11 medications.
12 They don't have -- you know, they
13 don't cause drowsiness. They don't cause
14 cognitive side effects and so forth. And they
15 have good evidence for benefit in PTSD. And
16 there is some perception that psychotherapy is
17 better than medications, than these
18 medications for treatment of PTSD, but, in
19 fact, the evidence would suggest that you get
20 fairly comparable levels of recovery from
21 medication treatment and from psychotherapy.
22 But many people need both or, you

1 know, really I think that, in many cases,
2 individuals really need to talk out what has
3 happened.
4 And then there are a number of B
5 and C category treatments, which are still
6 evidence-based and are used quite frequently
7 that are not FDA-approved. And in particular,
8 Prazosin, which is a blood pressure medicine,
9 really is showing some significant benefit in
10 reduction of the physiological symptoms
11 related to PTSD, which in turn helps with
12 nightmares, because the nightmares are
13 associated with physiological hyperarousal.
14 In other words, when you have a
15 nightmare, your heart rate goes up, you start
16 sweating, you know, and that actually leads to
17 the person waking up.
18 So you give them a blood pressure
19 medicine, Prazosin, and it reduces the
20 physiological reactivity and actually has a
21 beneficial effect in terms of nightmares and
22 sleep and then that in turn helps with

1 cognitive performance and the whole bit.
2 So what are the core components of
3 trauma-focused therapy? It is not the -- the
4 packages that can be delivered in various ways
5 and prolonged exposure, cognitive processing
6 therapy and EMDR are the most popular
7 treatment packages.
8 But the components of those
9 packages, and a number of other ways to
10 deliver treatment, you know, fundamentally
11 involve narration of your traumatic events,
12 which may include you could do it in writing,
13 you can do it orally, you can do it orally
14 past tense, orally present tense, but there is
15 a number of ways to, you know, talk about your
16 experiences.
17 That's a very important component
18 of treatment. There is cognitive
19 restructuring where you essentially work on
20 things like perceptions of guilt and service
21 members very often feel as if they are
22 responsible for things they have no control

1 over and that's a very important topic of
2 conversation and therapy.
3 An then there is stress
4 inoculation or stress management training,
5 which is, essentially, relaxation exercises,
6 which is inherent in all of the treatments
7 that are given.
8 Again, prolonged exposure, PE,
9 CPT, cognitive processing therapy and EMDR are
10 the most popular treatment packages and they
11 are equivalently effective. EMDR is just as
12 good as CPT and PE, but there are also a
13 number of ways to deliver those core
14 components that are just as effective as PE,
15 CPT and EMDR.
16 And the reason why this is
17 important is because I think that the most
18 important thing that we can do for our service
19 members is to engage them in therapy and help
20 them to stay with therapy long enough for
21 recovery.
22 And if that means that they -- I

1 don't want to do narration with my eyes closed
2 and present tense doc, fine, no problem.
3 Okay. That is the treatment manual for PE,
4 but if you want to do it another way, then
5 let's do it another way, because the most
6 important thing is that we do narration in
7 some form and there is good evidence to
8 suggest that narration works. But we don't
9 have to do it according to the manual.
10 And I'm not saying manuals aren't
11 important, but it's more important actually in
12 many respects to provide patient-centered care
13 and there are ways to deliver these core
14 components in different ways that are patient-
15 centered, if that makes sense.
16 Just a quick piece of data from
17 the Cognitive Processing Therapy Dismantling
18 Study that Patty Resick, Dr. Resick, did. She
19 actually showed that if you have individuals
20 write about their traumatic experiences alone
21 in a room, and then read the narration to the
22 therapist, who provides supportive feedback,

1 but no therapeutic techniques, other than just
2 support, listening and support and empathy,
3 that that alone resulted in, essentially,
4 equivalent recovery as the full cognitive
5 processing treatment package.
6 There was a little bit of a
7 difference, but it was not statistically
8 significant at the end of the study. So, in
9 fact, this is one of the many pieces of the
10 data that we used in the formulation of the
11 Clinical Practice Guidelines in the
12 recommendation that there are different ways
13 to deliver narrative therapy.
14 This is the key issue though in
15 evidence-based treatment. More than half of
16 our service members who need PTSD treatment
17 don't come in to see us to begin with. Of
18 those that do come in, a large percentage, and
19 I don't really have an exact percentage, I
20 would say in randomized clinical trials, it's
21 usually around, you know, a quarter or a third
22 of people drop out of care when they start

1 treatment.

2 But in clinical practice, it's

3 more like 50 percent is very common that

4 individuals drop out of care. So a large

5 percentage don't come in to see us. Of those

6 that do come in to see us, a large percentage

7 leave therapy and don't -- and, therefore,

8 don't have the opportunity to get better.

9 These are some of the things that

10 they tell us. And we have studied this

11 systematically in various research studies

12 that we have published. There is stigma. I

13 would be seen as weak. And there is also

14 negative perceptions. I don't trust mental

15 health professionals. Mental health care

16 doesn't work. Getting mental health treatment

17 should be a last resort.

18 And these are the types of

19 questions that actually more strongly

20 predicted individuals not using or dropping

21 out of mental health care in our research.

22 So this negative perception, this

1 if we are really going to improve evidence-
2 based care, it's going to be the improvement
3 of these perceptions.
4 Recovery from treatment overall is
5 not as good as we would like. It is widely
6 reported that treatment effectiveness is about
7 80 percent, but the reality is the treatment
8 effectiveness is 80 percent only in those
9 individuals who stay with treatment for the
10 course of treatment sufficient to get better,
11 you know, the 12 sessions of cognitive
12 processing or prolonged exposure treatment.
13 And since a large percentage drop
14 out, the actual treatment effectiveness among
15 everybody who starts treatment is only around
16 40 percent. So we have a ways to go.
17 And the way we are going to get
18 from 40 percent to a true 80 percent figure is
19 going to be improving retention of treatment,
20 not necessarily improving the way in which we
21 deliver care, as far as the specific
22 techniques that are utilized or whether

1 individuals are following treatment manuals.
2 MR. REHBEIN: Sir, may I ask a
3 question quick?
4 DR. HOGE: Yes, absolutely.
5 MR. REHBEIN: The reasons for
6 those folks that drop out, does that go back
7 to these negative perceptions or has there
8 been some kind of surveys that have been done
9 to delineate those reasons?
10 DR. HOGE: We are only beginning,
11 in the work that my group that I work with at
12 Walter Reed Army Institute of Research, we're
13 only beginning to really delve into what are
14 the reasons that people leave treatment.
15 We have one survey that we just
16 completed with the 101st with some, you know,
17 data where we are looking at how many people
18 said they dropped out of care and then what
19 are the reasons. And there is a lot of
20 reasons. These are some of them.
21 Sometimes individuals just feel --
22 sometimes it's simple things like I can't

1 juggle work and treatment. And so they
2 prioritize work. And service members get very
3 good at, you know, locking down their emotions
4 and driving on and, you know, then it may be
5 a year later or two years later or 10 years
6 later when they decide to actually address
7 their PTSD symptoms that are -- that, you
8 know, have resulted in three marriages and,
9 you know, so forth.
10 So we don't know. We don't know
11 for sure, but we do have some evidence that
12 the negative perceptions are actually driving
13 this more than, for instance, stigma. Stigma
14 might be seen as weak. But, in fact, these
15 negative perceptions more strongly predicted
16 individuals' willingness to utilize mental
17 health services in our research.
18 DR. TURNER: Something, I think,
19 we would like to ask you --
20 DR. HOGE: Yes.
21 DR. TURNER: -- to look at or if
22 you have some anecdotal thoughts about it,

prior, is one of the things we look for is programmatics or things that are built into the existing hierarchy that may promote this to happen.

So as you look through, do you have any comment about things that are built into policy or programs currently enacted that may actually, you know, abet the development of these kinds of negative perceptions?

DR. HOGE: There is massive stigma education campaigns, stigma reduction education campaigns going on throughout the organization, both in the Army and at the DoD and DCoE level.

But in all honesty, we don't know how effective those are. And I think some times when we focus on stigma reductions, we are not necessarily focusing on what is it that enhances the engagement within the clinic setting itself?

And there is -- you know, General Horoho is talking about the culture of trust

1 and -- you know, in her, you know, campaign
2 plan for behavioral health throughout the
3 Army. And there is a lot of policies focused
4 on really trying to facilitate care and
5 enhance, you know, a willingness to come into
6 care.
7 But as far as what is it, you
8 know, what is it that really helps people to -
9 - you know, what are the key factors that help
10 people to engage? We don't know for sure what
11 those are.
12 I think that one of the areas that
13 we are moving into now is to do some simple,
14 very simple, quality satisfaction surveys at
15 the end of each visit. There is some research
16 that suggests this.
17 We are not starting to do this
18 yet, but there is some research that suggests
19 that if you ask patients at the end of their
20 session, you know, did we address your
21 concerns? And, you know, is there anything
22 else that -- you know, do you feel like you

1 were heard and understood? Did we address
2 your concerns and is there anything else that
3 you would like to discuss?
4 This is something that is being
5 built into patient-centered medical home and
6 I think patient-centered medical home really
7 is a change in the system that is going to
8 lead to better, you know, satisfaction with
9 care over all. And I'm very excited about the
10 fact that the behavioral health is embedded
11 into that program.
12 Very quickly now, going back to
13 sort of the core, the most popular treatment
14 packages, you know, prolonged exposure,
15 cognitive processing therapy and EMDR, what is
16 the availability? The second question you
17 asked is what is the availability of A Level
18 PTSD treatment modalities?
19 And since those are the most
20 popular treatment packages, we have focused
21 most of our attention on those. And very
22 quickly, we have about 5,400 behavioral health

1 providers, this is active duty Army, about
2 3,500 or so fall into the credentialed, you
3 know, independent practitioner credential
4 provider and then the rest are support
5 personnel or technicians, including our
6 enlisted mental health technicians.
7 And then of the 3,500, out of that
8 pool of providers, we have trained about
9 2,400. Now, it is not an absolute, you know,
10 the numerator and denominator are not
11 absolute, because there are providers who
12 leave, you know, and take other jobs who may
13 have had the training and so forth.
14 So it's not -- but we train about
15 20 percent of all of our behavioral health
16 providers in one of these modalities each year
17 in the Army, about 20 percent get trained, go
18 through our training programs.
19 These are channeled out of AMEDD
20 Center and School, but are generally brought
21 to the post where the providers are and they
22 have tried to be -- to tag them with returning

1 brigade combat teams, so the train-up
2 providers just before a big brigade is coming
3 back from combat. And we have trained, you
4 know, about 2,400 providers. These are four
5 to five day trainings in EMDR, CPT and PE.
6 Now, the third --
7 MR. CONSTANTINE: Sir?
8 DR. HOGE: Yes?
9 MR. CONSTANTINE: What do mental
10 health techs and support counselors do?
11 DR. HOGE: I'm sorry? Oh, the
12 mental health technicians? The mental health
13 technicians do a lot of -- they do a lot of
14 triage. They do a lot of the initial
15 interviewing of soldiers when they come into
16 the clinic. They will gather information from
17 the soldiers to why they are there and what
18 the key, you know, problems are that they are
19 experiencing. And then they will present that
20 information.
21 They will, basically, facilitate
22 the care that is provided by the credentialed

1 provider. They also do outreach. They, you
2 know, interact with the units to some extent.
3 MR. CONSTANTINE: Okay. You have
4 them listed as behavioral health provider, but
5 it doesn't really sound like they are a
6 provider.
7 DR. HOGE: I agree. I agree. The
8 third -- out of the 5,400 or so, really, these
9 are our providers right here.
10 MR. CONSTANTINE: Okay.
11 DR. HOGE: These are our
12 independent practitioners who can -- and
13 nurses cannot prescribe, but nurse
14 practitioners can prescribe, psychiatrists can
15 prescribe and then psychologists and social
16 workers have -- you know, are credentialed to
17 provide psychotherapy.
18 MR. CONSTANTINE: Thanks.
19 MR. DRACH: Doctor?
20 DR. HOGE: Yes?
21 MR. DRACH: Going back two slides,
22 I think it was, you mentioned about the --

1 those that complete treatment.
2 DR. HOGE: Yes.
3 MR. DRACH: How do you define
4 complete treatment?
5 DR. HOGE: Well, you know, most of
6 the -- I draw a lot from the literature of
7 randomized control trials. So it's a little
8 bit of a select population and it's not
9 necessarily the real-world that his going on
10 in the clinic.
11 But among those patients who are
12 enrolled in clinical trials and are -- and,
13 you know, receive either the treatment or they
14 are in the controlled condition, treatment
15 completers are defined as completing a certain
16 number of the sessions. If they had 12
17 sessions, usually there is some definition
18 that varies between studies, but treatment
19 completers are, you know, either completing
20 all of those sessions or a certain acceptable
21 number, say 9 out of 12 or something like
22 that.

1 MR. DRACH: The second question
2 not related to that, I read something a couple
3 weeks ago about, what I think is something
4 new, mental health first aid?
5 DR. HOGE: Yes.
6 MR. DRACH: Is that -- can you --
7 DR. HOGE: Yes. Psych first aid,
8 psychological first aid or mental health first
9 aid are efforts to provide immediate support
10 right in the aftermath of a traumatic event.
11 And there is quite a lot of efforts going on
12 to do that in different ways in which that --
13 you know, those types of things have been --
14 you know, it's, essentially, supportive
15 therapy that is done immediately after an
16 event.
17 And there is not a lot of strong
18 evidence that it's effective. But it was
19 actually addressed in the Clinical Practice
20 Guideline. There is a whole section on the
21 evidence-based treatment or the, you know,
22 availability. And most of it, I think, was

1 rated as C Level evidence, not -- they were
2 not A Level evidence.
3 MR. DRACH: Is the Army doing
4 anything to train?
5 DR. HOGE: The most important and
6 key thing that they are doing in the psych
7 first aid area is the training, and I probably
8 should have brought slides on this, the combat
9 operational stress control teams.
10 So we have in every brigade a
11 combat team that deploys. We have one mental
12 health officer and one technician and that's
13 going up to, I think it is two and two. I
14 think every battalion is going to have a
15 mental health officer projected in the future.
16 But right now, we have embedded
17 behavioral health officers within each brigade
18 and then in addition we have combat stress
19 control detachments that provide additional
20 support within the operational theater. They
21 go through an intensive training program
22 before they deploy and their focus is on the

1 immediate -- you know, providing immediate
2 care to units and immediate support to units
3 in a not -- and it's a non -- it's both
4 medical and non-medical.
5 Very often when service members
6 experience traumatic events, they just need
7 rest and normalization and reassurance and,
8 you know, expectation that they will be okay.
9 And the commands need the same kind of
10 reassurance and support.
11 And so a lot of this is -- and
12 soldiers have legitimate disabling reactions,
13 but they are not -- that's not a disorder.
14 They may -- it may be a combination of sleep
15 deprivation, extreme physical stress and the
16 trauma that they are going through and they
17 may just, you know, decompensate and not be
18 able to function.
19 But you pull them out for a day or
20 two and you give them a rest and they are good
21 to go. And so those are considered combat
22 stress reactions. They are not considered a

1 medical disorder.

2 And I think that there is -- we

3 don't have good evidence that they are -- I

4 mean, I think that it is so much incorporated

5 into doctrine that we believe it is effective.

6 And I think it is effective when you look at

7 return to duty rates. You know, over 95

8 percent, 96, 97 percent of individuals who are

9 treated by Combat Stress Teams are returned to

10 duty usually within a day or two, three days,

11 something like that.

12 The other thing that Combat Stress

13 Control Teams provide is they provide the

14 ongoing treatment to individuals who are

15 deployed with mental health conditions. We

16 have 5 percent of the force on Zoloft and

17 Paxil and other antidepressants, for instance,

18 and the combat stress control providers and

19 the embedded behavioral health providers

20 provide that treatment support in theater.

21 How am I doing on time? I feel

22 like I'm running over. Let me just very

1 quickly look at the -- Questions 3 and 4, I
2 combined. And that has to do with the
3 fidelity and monitoring of treatment.
4 And we don't have systematic
5 ongoing things. We do have -- there is a
6 number of ways in which we monitor care in
7 general, but I want to talk specifically about
8 a study where we looked at this specific
9 question for PTSD.
10 But just in general, there is a
11 system of care that includes, you know,
12 credentialing. It includes supervision within
13 clinics and a very rigorous process by which
14 people can be, you know, licensed and
15 credentialed to provide treatment services.
16 So but when we look more
17 specifically at the question of how are we
18 monitoring the delivery or fidelity of
19 individual treatment techniques within the
20 clinic? The only study that I'm aware of that
21 any service has done is this survey of
22 behavioral health providers that we did.

1 We finished this a little over a
2 year ago. We collected the data. It was
3 2010, but it was actually late. It was late
4 fall 2010 when we got the data collected. And
5 we sent the survey out to about 2,300
6 providers across the Army. We got only about
7 a 30 percent response rate, which was 543, so
8 there are some limitations in the study in
9 terms of the response rate.
10 But we did compare the responders
11 with the entire population of behavioral
12 health professionals and they looked
13 representative in terms of specialty, whether
14 they were military or civilian and their case
15 loads. And we also did some weighing and some
16 statistical adjustment based on their case
17 loads.
18 We looked -- so among those 500
19 responders to our survey, we looked -- we also
20 had them go into AHLTA Records and randomly
21 select patients. And we had a certain way to
22 do that and then they provided patient

1 information that was anonymous to us, which
2 allowed us to bore down into specific details
3 of what those patients were receiving in
4 treatment.
5 What we found is among the survey
6 respondents, 84 percent reported confidence in
7 treating patients with PTSD. We think this is
8 representative, again, in comparing with the
9 general population of behavioral health
10 professionals. Almost 80 percent reported
11 that they had received formal training in
12 EMDR, PE, cognitive processing therapy or
13 stress inoculation training, which is
14 consistent with what we expect.
15 And of the service members who we
16 pulled the individual data on, 93 percent had
17 documentation of having received an A Level
18 evidence-based treatment, including trauma-
19 focused psychotherapy or antidepressant
20 medications or, in many cases, the combination
21 of the two. Now --
22 MR. CONSTANTINE: Sir?

1 DR. HOGE: Yes?
2 MR. CONSTANTINE: Did you say that
3 84 percent of the Army providers were
4 accomplished? Did you say that's similar in
5 the civilian sector as well?
6 DR. HOGE: I actually don't know
7 what it is in civilian sector.
8 MR. CONSTANTINE: I thought you --
9 DR. HOGE: I think it's higher.
10 I'm sure it's higher than in the civilian
11 sector because of the systematic way in which
12 we are encouraging providers get training and
13 these specific skills.
14 MR. CONSTANTINE: Does 84 percent
15 seem low to you, since these are --
16 DR. HOGE: It should probably be
17 100 percent.
18 MR. CONSTANTINE: Right.
19 DR. HOGE: Right. But many of
20 these providers, some of these providers are
21 just primarily providing medication support,
22 for instance, and so it could be 100 percent

1 if you factor in, you know, medication. You
2 know, for instance, there is a lot of
3 antidepressant prescriptions, that would be
4 considered an evidence-based treatment.
5 But I think in terms of trauma-
6 focused psychotherapy -- so it could be 100
7 percent if you add medications. But in terms
8 of trauma-focused psychotherapy, 84 percent of
9 the -- you know, it's about 80 percent. And
10 I think that's probably pretty good.
11 LT COL KEANE: Sir, I have a
12 question about Bullet No. 3. If I understood
13 you correctly, I thought you said that 93
14 percent were of those cases that were pulled.
15 Is that correct?
16 DR. HOGE: Right. Of the 500
17 responders, of the 500 behavioral
18 professionals who then we asked to go into
19 their record and we had about 110 patients
20 with PTSD that were treated by those
21 individuals within the week, you know, the
22 same week that they did the survey and we had

1 a random way to do that.
2 So we had about -- data on about
3 110 patients treated by these providers. And
4 of those, 93 percent had documentation of
5 receiving an A Level evidence-based treatment.
6 LT COL KEANE: That was my follow-
7 up question what the number was.
8 DR. HOGE: Right.
9 LT COL KEANE: Thank you.
10 DR. HOGE: Now, this looks pretty
11 good. Okay. The 93 percent, but then we
12 asked the survey participants exactly what did
13 they provide? What skills, you know, what
14 specific techniques did they provide? And so
15 we had questions that we put on the survey in
16 a kind of random order, so that they didn't --
17 they weren't linked to any particular
18 treatment modality.
19 But we asked the developers of
20 cognitive processing therapy, prolonged
21 exposure and EMDR to provide us with five or
22 six things that they, you know, would think

1 are most critical that clinicians provide in
2 order to meet the standard of care for that
3 particular practice.
4 And then we had questions related
5 to that. So for prolonged exposure, the most
6 important thing is recounting the traumatic
7 event allowed and, you know, with the details
8 of that traumatic event.
9 Some people -- another part of
10 treatment is recording, taking a recording at
11 the time of the -- when the person recounts
12 their experiences, they actually record it and
13 then listen to it afterwards. Very few people
14 did that. That is part of treatment though.
15 93 percent reported practicing
16 breathing and relaxation techniques. So when
17 you added it all up, and there were a couple
18 of others on it. I think there is an error on
19 this slide. I think there were a couple of
20 others that I mistakenly didn't put on here,
21 but 100 percent received one of the main
22 procedures for EMDR.

1 But if you look at how many
2 received all of the manualized, you know,
3 procedures that you are supposed to do if you
4 do EMDR, only about a quarter or 21 percent
5 and about two-thirds received four or more.
6 Okay. So it's fair to say that --
7 so for EMDR it's fair to say that not all
8 patients receiving EMDR are receiving all of
9 the techniques that one would consider as part
10 of the manualized treatment. Does that make
11 sense? Is everybody tracking? Okay.
12 And if you look at cognitive
13 processing therapy, the specific techniques
14 that the developers of cognitive processing
15 therapy say are most important that you do if
16 you are going to do cognitive processing
17 therapy, these are the things you have to do.
18 Well, and then you add it all up,
19 only 80 percent of the patients received one
20 of these, but only 15 percent received all and
21 only a third received four or more of these
22 procedures. So cognitive processing therapy,

1 the fidelity of treatment, was not as high as
2 it was for EMDR or as high as it was for --
3 I'm sorry, that was prolonged exposure therapy
4 or for EMDR where, you know, about half
5 received the key treatment, you know,
6 techniques that are used.
7 Okay. So does that -- again, so
8 it's fair to say that a large percentage of
9 our service members that we are treating are
10 getting evidence-based care, but they are not
11 necessarily getting all of the techniques for
12 those specific treatments.
13 MR. REHBEIN: So if I -- let me
14 make sure I understand what you are saying and
15 try to put it in a little broader context.
16 We continually hear that the
17 largest barrier is getting people into
18 treatment.
19 DR. HOGE: Yes.
20 MR. REHBEIN: And I believe it is.
21 DR. HOGE: Absolutely, sir.
22 MR. REHBEIN: But now, we are also

1 hearing that there are two other significant
2 barriers, one keeping them in treatment after
3 the initially get there and then, two, that
4 they receive the full course of treatment,
5 even if they stay in treatment, that they may
6 not receive the full course of the recommended
7 treatment?
8 DR. HOGE: Well, here is the
9 dilemma. Yes, yes, on the first two. So
10 getting them into treatment and keeping them
11 in treatment are the two critical barriers.
12 The third barrier which is that a
13 lot of service members -- I think there could
14 be a relationship, if you say if I'm a
15 prolonged exposure practitioner and I tell the
16 service member you need 12 sessions of therapy
17 and we are going to focus on your worst
18 traumatic experiences and I want you to do --
19 to recount that experience with your eyes
20 closed and present tense, tape record it and
21 listen to the tape recording, a lot of service
22 members will look at you like you're crazy and

1 will walk out and not come back.
2 Okay. Similarly, with cognitive
3 processing therapy. If I say, you know, you
4 have got a lot of distorted thinking, you
5 know, in relation to your combat experiences,
6 I have suddenly -- that sounds like a
7 judgment. Service members will look for any
8 excuse to leave therapy. Judgment is one of
9 the key things why they leave therapy.
10 So it's very -- it's more
11 important that we work with the service member
12 to find how is it that you are most
13 comfortable talking about your story? How is
14 it that you are -- you know, let's talk about
15 how you are thinking about these experiences.
16 And why you are thinking that way,
17 rather than labeling these thought patterns as
18 a distortion. And so there are ways to
19 deliver evidence-based care that are patient-
20 centered.
21 And if we -- what the VA has done,
22 they have the Uniform Services Handbook and

1 they have decided that their formula, that
2 every veteran is going to be entitled to
3 cognitive processing therapy or prolonged
4 exposure therapy. Well, a lot of veterans do
5 better with the EMDR. And EMDR is just as
6 effective as is those other two modalities of
7 therapy.
8 But clinicians are kind of being
9 forced into providing those two treatment
10 modalities when there are other ways to
11 deliver care. I have had veterans come in and
12 say I don't want to talk about my experience,
13 but I'm willing to write about them. Fine.
14 Are you willing to read to me what you write
15 after you write it? Well, I guess I could do
16 that, doc. Okay. Then we have got narrative
17 therapy.
18 We start the narrative therapy
19 process, right? And the key is that -- and
20 the key is patient-centered care that
21 facilitates retention and care. It's not
22 necessarily driving, you know, I only do it

1 this way. If you tell them I only do it this
2 way, you lose them.
3 And so, you know, we want people
4 to follow treatment manuals. And we know they
5 are not following treatment manuals, you know,
6 with 100 percent fidelity. In fact, you know,
7 it's much lower than 100 percent. But I'm not
8 sure that that's necessarily a bad thing, if
9 that makes sense, because if it -- because if
10 you try to do it with 100 percent fidelity of
11 the treatment manual and you lose people,
12 then you are not going to get effect -- then
13 it's not going to be effective, even if you
14 are doing it -- even if you are adhering 100
15 percent with 100 percent fidelity to the
16 treatment protocol.
17 So that's kind of the paradox or
18 dilemma. Yes, sir?
19 DR. PHILLIPS: Sir, how
20 aggressive, if at all, is the program
21 involving spouses and care givers?
22 DR. HOGE: You mean treatment of

1 spouse? Treatment for spouses?
2 DR. PHILLIPS: Well, not
3 necessarily treatment, but just to keep them
4 informed and to -- for them to -- I know it's
5 very difficult to answer that, but we get the
6 impression that if the family somehow can
7 engage and be involved, that treatment
8 appointments and --
9 DR. HOGE: Yes. It's very, very
10 important and clinicians know this and we try
11 as hard as we can to work with family members
12 and bring them -- you know, have them be part
13 of the treatment planning and, you know, part
14 of the sessions, because if you have --
15 because social support is probably one of the
16 strongest predictors of recovery.
17 And if you have got a good social
18 support system and good strong family behind
19 you, then you have a lot higher likelihood of
20 recovering. And there is a host of programs
21 out there and I didn't really come prepared to
22 talk about them, but there are -- you know, it

1 is very, very important.
2 Are we doing enough in that area?
3 I think probably the answer is no. And I
4 think a lot of service members when, you know,
5 we give briefings and we talk -- when I give
6 briefings and I talk to service members about
7 some of this stuff about, you know,
8 understanding PTSD, both from the occupational
9 and the medical perspective, a lot of them
10 come up to me afterwards and say I need my
11 wife to hear that, you know, because she
12 doesn't understand and she is treating me like
13 I'm crazy all the time, but I'm really just
14 reacting like I did in combat and that kind of
15 thing.
16 So there is an -- I think there is
17 more need for better training in that area.
18 Real quickly, in summary, the
19 Clinical Practice Guideline is an important
20 resource. Army behavioral health providers,
21 according to our survey, report high
22 confidence in treating PTSD. And there is

1 wide dissemination of training.
2 And we are estimating, and it's a
3 rough estimate, but we are estimating, that
4 more than 90 percent of service members under
5 treatment for PTSD are receiving an evidence-
6 based modality of one type or another, but the
7 fidelity to specific manualized techniques is
8 not always there.
9 However, as we talked about the
10 fidelity of treatment is not necessarily the
11 most important question or concern. The most
12 important concern is how do we better engage
13 people to stay in treatment? Come in and stay
14 in treatment. And that's really a very
15 critical thing.
16 And in terms of priorities for
17 improving PTSD care, I think one of the top
18 priorities is design interventions to improve
19 willingness to engage in care. And there is
20 soldiers' perceptions, you know, it's what is
21 it that drives their behavior? It's what
22 clinicians are doing in the clinic that may

1 facilitate their engagement. And then it's
2 also what treatment modalities are we offering
3 and which ones are more acceptable to them?
4 All of those are important
5 factors. I think we can better deliver
6 trauma-focused therapy in patient-centered
7 manner. I think we can better communicate
8 within the occupational context. I think the
9 patient center medical home is really doing to
10 be is really shifting the paradigm of care in
11 a very positive way to address the coexisting
12 health conditions because warriors come back.
13 They don't come back with just PTSD.
14 They typically come back feeling
15 10 or 20 years older than they did when they
16 deployed a year ago and their bodies reflect
17 that and they have got physician health
18 problems and sleep disturbance and
19 concentration of memory problems.
20 And so holistic care within the
21 privacy care setting is really very important.
22 And then I think there is, you

1 know, a lot of, you know, good opportunities
2 in the peer-to-peer programs and marital and
3 family support.
4 So thank you very much for your
5 attention.
6 CDR MALONE: Good morning,
7 everyone. I'm Commander Rosemary Malone. I
8 work at the Bureau of Medicine and Surgery,
9 that's where our Surgeon General is
10 headquartered. And I am the Director of
11 Deployment Health for the Wounded, Ill and
12 Injured Code, that's a code at the Bureau of
13 Medicine and Surgery. And our code actually
14 has grown since last year.
15 Captain Keefer presented here last
16 year. We used to have four directorates and
17 now we have six. We have added the Naval
18 Center for Combat and Operational Stress
19 Control formally to us as well, as well as we
20 separated out Traumatic Brain Injury, just
21 because of all of the need to focus on that
22 particular mission.

1 Originally, you know, I want to
2 thank everyone here, Ms. Daniel, Mr. Booten
3 and everyone for the patience that was
4 afforded to us. Originally, Captain Scott
5 Johnston was going to present this. He is the
6 Director of NCCOSC, the Naval Center for
7 Combat and Operational Stress Control when we
8 were initially putting everything together,
9 I'm, obviously, not Captain Johnston, but I
10 want to thank him because he and his staff
11 helped tremendously with us to put this
12 together.
13 Commander Lord also works within
14 my particular directorate. She heads
15 resilience. And in my directorate, it also
16 includes the Behavioral Health Integration
17 Program embedding mental health providers in
18 primary care, as well as PDHRA, as well as
19 focus in family programs. So it's a diverse
20 directorate.
21 Commander Lord actually had the
22 opportunity to go out to San Diego and work

1 with the staff out there to help put this
2 together.
3 The brief that is on the slides
4 here is different from the one that is in your
5 handout and that will be afforded to you. Our
6 PAO had to approve the final brief and that
7 was -- there was a bit of a delay and I
8 apologize for BUMED because of that.
9 And, again, these -- after the PAO
10 reviewed, I had to put my disclaimer statement
11 on there.
12 So I'm an adult and a forensic
13 psychiatrist, so I usually testify in a
14 courtroom in a very adversarial setting, so I
15 know this is going to be different. And I
16 want to thank everyone for the opportunity.
17 I'm planting that in you, so that I minimize
18 questions coming to me.
19 I want to thank everybody for the
20 opportunity to come here and actually address
21 these questions. Following Dr. Hoge, we
22 trained in the same residency program together

1 and it's always an honor and I appreciate the
2 other panel members as well and everybody
3 here.
4 So these are our latest statistics
5 that we have that were recently pulled because
6 of -- actually the Institute of Medicine, that
7 Captain Hammer talked about, has asked us to
8 gather some data. These recently were pulled
9 by our, basically, public health command to
10 look at all the cases since '01 and '11 and
11 look at numbers.
12 We have had 25,077 new cases of
13 PTSD. We break it down by Marines and we
14 break it down by sailors and we talk about
15 incident rates.
16 Clearly, post-traumatic stress
17 disorder, as everyone has said and as you have
18 heard before, is one of those disorders that
19 is significantly associated with this
20 particular -- with these wars.
21 I'm going to do something
22 different though, I'm going to jump ahead and

1 hopefully I'm going to be able to get back.
2 Because I think it is worth talking about when
3 we talk about PTSD and I have listened to the
4 questions about standardization and I just
5 heard, I was going to call him Colonel Hoge,
6 what Dr. Hoge was saying also about well, how
7 do we do therapy and why don't things
8 necessarily work all the time for patients and
9 how can one patient have chronic symptoms and
10 acute?
11 If you look at our diagnostic
12 criteria for PTSD, again, that the Criterion
13 A, that Captain Hammer had mentioned, said
14 well, you have to have this traumatic event
15 and you either have -- you had to have both,
16 the serious injury or threats or -- and then
17 your response had to involve this fear and
18 hopelessness or horror, which again for
19 probably military, that's probably not
20 necessarily the case, because of the training
21 and everything else that the military goes
22 through before we put them in these

1 potentially traumatic situations.
2 And then Criterion B, you can
3 experience -- you need to reexperience it in
4 one or more of five ways. So that could be
5 one way, it could be two of five, it could be
6 three of five, it could be four of five, it
7 could be five of five.
8 Going down their avoidance, you
9 need three of seven. So you could have three,
10 four, five, six, seven. And then you go down
11 and increased arousal, two or more of five.
12 So you could have between two to five.
13 Well, I went to my SME, who is my
14 daughter, who actually taught high school math
15 for a couple of years, and I said well, how
16 many different presentations potentially could
17 you have with these types of symptoms? I knew
18 it was a factorial kind of thing. And I don't
19 have neurons that have that information any
20 more, so she did the calculation and when you
21 look at all the different combinations of just
22 pure PTSD, you are talking almost over 1,000

1 possible combinations of these symptoms.
2 And is that clinically relevant
3 when we are talking about treatment?
4 Absolutely. If I have a service member who
5 comes in, for example, who is experiencing
6 horrible nightmares, a lot of irritability,
7 these arousal symptoms and can't concentrate,
8 I'm not going to be able to have him engage in
9 these type of prolonged exposure therapies or
10 the cognitive processing therapy initially.
11 I need to be aware that this is
12 where, as a psychiatrist, I will say that
13 medications can help get someone to be able to
14 do the work of therapy. They may be able to
15 control their symptoms. They may be able to
16 get them to a point where they can tolerate
17 therapy, which is very, very difficult work at
18 times.
19 So I just want to bring this up
20 again, because when we talk about PTSD, we
21 tend to emphasize a singular, you know,
22 diagnosis. Absolutely. But there are a lot

1 of different presentations, there is a lot of
2 different combinations and symptoms that that
3 particular service member could present from
4 the same IED blast that he may have
5 experienced with others within his unit or her
6 unit.
7 So let's see if I can get back
8 here.
9 CAPT EVANS: Commander?
10 CDR MALONE: Yes?
11 CAPT EVANS: I'm really surprised
12 at the number for the Navy, considering what
13 we see the injuries in the Navy, we see
14 corpsmen, SEALs, EOD, so to me, and maybe it's
15 just my -- that number seems high and maybe
16 not. Maybe that's a --
17 CDR MALONE: Well, you know, when
18 I first saw it too, again, this is over a 10-
19 year period of time. When you look at how
20 they are defined and how the research command
21 defines it, there may -- it has some
22 statistical relevance to their definition of

1 it.

2 I think though over the course of

3 those years, you know, the PTSD cases are

4 certainly combat-related, but there is other

5 PTSD -- incidents that can also lead to PTSD.

6 So this doesn't just factor out military

7 exposure cases, combat cases, per se either.

8 But I will certainly -- to get a

9 better reference point, I could do -- again,

10 this is brand new off the press type of data

11 that we are collecting for the Institute of

12 Medicine. So I would be happy to try and get

13 a better perspective as well for you.

14 Any other questions on that?

15 Okay. So again, our providers -- we encourage

16 our providers to use the practice guidelines.

17 And the reason for that is, again, that when -

18 - in psychiatry, as we have talked about and

19 as you have heard or in mental health for that

20 matter, we just don't have blood tests. We

21 just don't have certain diagnostic procedures

22 that can allow us to not only identify and

1 diagnose with 100 percent certainty, but also
2 then to say well, this is the course of
3 treatment.
4 So when these guidelines were put
5 together, based on many, many years of reviews
6 and research, these are the things that,
7 again, providers want to be able to go to and
8 use. They are committed to being able to,
9 obviously, take care of the patient that is in
10 front of them, who is coming for care.
11 And this is a repeat of some of
12 the information that you have received already
13 and I understand that. But again, the
14 psychotherapies, the trauma-focused therapies
15 and the stress inoculation therapy, as was
16 previously mentioned, and the
17 pharmacotherapies, again, as a psychiatrist,
18 I would never get up here and pretend to say
19 that, you know, if I give someone Zoloft,
20 their PTSD is going to go away. We know that
21 is not true.
22 The way I see it and the way when

1 I train residents and other individuals is to
2 say you have to be able to get that person
3 through the therapy. If their symptoms
4 interfere with their even ability to sit down
5 in the room and to talk, if they can't even
6 give that initial narrative because their
7 thoughts aren't -- because they are so
8 distracted or their concentration is off or
9 they are not sleeping well and their story
10 just doesn't flow, one of the things that some
11 of the medications can help with is to treat
12 those anxiety symptoms, to treat those
13 symptoms to get them to that point to be able
14 to engage in therapy.
15 We train our providers, too, and
16 the Center for Deployment Health or Deployment
17 Psychology, I apologize, has also been
18 training, basically, Navy providers. We know
19 since 2007 129 providers have attended the
20 Topics in Deployment Psychology course, an
21 overview of deployment-related issues.
22 We have had training at various

1 sites, including Portsmouth, San Diego where
2 our major MTFs are. We have also had them at
3 Camp Lejeune and Camp Pendleton and at some of
4 our smaller hospitals as well.
5 And we know, in general,
6 approximately, 400 active duty, contract civil
7 service, Navy and Marine Corps providers have
8 received this training from the CDP.
9 I also have information similar to
10 Dr. Hoge on our total number of providers. I
11 can provide that to you. I have it on a slide
12 actually on my Blackberry and I'll be more
13 than happy to give you an overview of the
14 total providers.
15 I want to say I just looked at it.
16 I believe it also includes our techs, our
17 mental health technicians or psychiatric
18 technicians. And before I give you the final
19 number, I know it was over 1,000, I don't --
20 it's not, obviously, as large as the Army, but
21 I will have that specific information for you
22 to put these numbers anyway into a better

1 perspective.
2 We also have BUMED, the Bureau of
3 Medicine and Surgery, programs that we fund.
4 And we have funded an on-line cognitive
5 processing therapy training through the
6 Medical University of South Carolina, which
7 happens to be my alma matter and no connection
8 between those.
9 Basically, it is 9 CEUs. It is
10 available 24/7. Again, when we talk about
11 training and web-based training, this is
12 something that is available. Providers,
13 basically, can access this at their -- when
14 they are able to and competing interests
15 during the day that may make it an attractive
16 modality.
17 So to date, 60 of our Navy staff
18 have completed the training. This is a
19 program that we monitor at Bureau of Medicine
20 and Surgery, so we look for individuals using
21 it and we get feedback as far as what the
22 providers thought, how it helped or how it

1 didn't help.
2 And, in general, just for
3 medications, how do we make sure our
4 prescribers know what they are doing? Well,
5 we all receive training initially in
6 medications, if you are a prescriber, whether
7 you are a primary care doc, whether you are a
8 nurse practitioner or a psychiatrist.
9 Part of our whole process of
10 credentialing, you have to, you know,
11 obviously, get an education, continuing
12 education. I had the privilege just of going
13 through the recent 10-year recertification in
14 psychiatry, so after getting Board-certified,
15 10 years later, you have to take another exam
16 to make sure you are up to date on these
17 modalities.
18 So we have those type of controls
19 available when we are talking specifically
20 about medications.
21 I will also tell you for the
22 primary care physicians, one of the programs

1 in my directorate is the Behavior Health
2 Integration Program. And that's the one where
3 we are embedding into primary care our
4 internal health consultants as well as
5 external behavioral health consultants.
6 And part of that training, too,
7 and part of what goes on within the primary
8 care clinic is to provide and have primary
9 care docs have access to individuals who have
10 prescribing -- maybe some more prescribing
11 history or experiences for them as well.
12 So we are trying to make sure that
13 our prescribers do stay up to date. Again,
14 the things like Zoloft and Paxil and Prozac
15 for the SSRIs and the other class of
16 medications like Effexor can also be
17 effective. And so that's -- those are the
18 medications to which I'm referring.
19 So how faithfully are the
20 protocols for these modalities being
21 implemented? This again, I don't have this
22 nice packaged answer for you. We did reach

1 out to our regions. The majority of our
2 marines and sailors are seen by either NAVMED
3 East or NAVMED West.
4 Commander Lord actually reached
5 back to the points of contact for those and we
6 do know that our active duty are typically
7 enrolled in either the prolonged exposure or
8 cognitive processing therapy for PTSD.
9 Do I have hard and fast numbers?
10 No, I don't, at this point in time. Will we
11 in the future? Yes, we are working to get to
12 that point.
13 In general, when I put the
14 challenges here, AHLTA is our electronic
15 record, I'm sure you have heard of it, but as
16 a provider, if I see a patient and I do
17 medication management and psychotherapy when
18 I go to code it in AHLTA, all I could do is I
19 can make a choice that says how many minutes
20 I did this for, let's say 45 to 50 minutes.
21 And I can say I either did psychotherapy
22 individual or I did psychotherapy individual

1 with medication management.
2 It doesn't drill down into I may
3 have used prolonged exposure or I may have
4 used the cognitive processing therapy. In
5 that particular system, we are not capturing
6 it yet. And if we want to give -- if I want
7 to be able to give you hard and fast answers,
8 I need to either do that or do a survey
9 similar to what the Army did. And we have not
10 done that survey.
11 I think one of the other things
12 with the evidence-based psychotherapies, the
13 integrated mental -- there is an integrated
14 mental health strategy strategic goal that
15 actually looks at the evidence-based
16 psychotherapies. And one of their recent
17 updates shows that when we train these
18 individuals in these therapies, it's important
19 to have individuals on site to be able to work
20 with individuals who are newly trained to
21 provide them with, you know, supervision and
22 answer questions.

1 And having individuals on-site to
2 be able to do those things, in other words, to
3 secure providers to serve as these trainers
4 and counselors within the MTFs has been
5 something that that particular strategic
6 action reported out on that it has been
7 difficult to achieve.
8 Not to say it's not achievable,
9 but it's still perhaps one of the challenges
10 we face with making sure that the providers
11 are -- after they have gotten trained, that
12 they continue to use the therapies. And when
13 they have questions that may arise, that those
14 individuals are there available for them.
15 And how do we monitor the
16 availability and implementation of these
17 particular modalities? Again, what we do, at
18 this point in time, as in any other facility
19 across the military or across civilian
20 facilities for that matter, peer monitoring
21 right now is our tool to be able to make sure
22 clinicians, basically, are practicing -- are

1 safe providers, are practicing using
2 modalities that are known to have the
3 capability or the ability to assist the
4 patient.
5 And whether that is the
6 medications and/or therapies, this is how we
7 review charts and, basically, you get feedback
8 provided to you about certain elements within
9 your practice. So every quarter so many
10 charts get reviewed. There is questions that
11 are filled out, comments, feedback is given to
12 the provider.
13 And then based on that, you know,
14 the provider, you know, either individually
15 will need to, you know, make some changes or
16 if it's a more global problem then other
17 interventions will occur.
18 And once again, when Dr. Hoge
19 talks about the fact that, yes, patients who -
20 - I mean, one of the barriers is getting them
21 to come into the door, absolutely. And then
22 the other thing, the other challenging issue

1 is to make sure they stay in therapy and to
2 make sure they engage in it.
3 So we know the core components of
4 these therapies that work. I will tell you
5 that one of the most important things that can
6 happen with a patient is to have a strong
7 therapeutic relationship. And what that means
8 is recognizing where that patient is when they
9 are in the room, recognizing what aspects of
10 those particular therapies are going to be
11 best suited for that patient and to allow them
12 to continue making progress in the therapy.
13 So again, some patients will -- if
14 you say here, this is how we are going to do
15 this, here is your homework every day, you
16 know, every session you are going to bring
17 this back, that may be the show stopper and
18 they may not want to come back, because based
19 on how they -- what their symptoms are and
20 where they are at and how they seek change or
21 how they believe they need to change it's not
22 going to be effective.

1 And the whole idea behind engaging
2 somebody in therapy, which again is very hard
3 work and sometimes people get a little worse
4 before they get better and we know these
5 things is to make sure that whatever --
6 however you address their concerns in therapy,
7 however you use these core components of these
8 evidence-based psychotherapies that work, that
9 you adjust it to meet the patient and their
10 clinical presentation in front of you. So --
11 LT GEN GREEN: Just for
12 clarification.
13 CDR MALONE: Yes.
14 LT GEN GREEN: Are the majority of
15 therapies actually individualized? So in
16 other words, it's patient and provider or is
17 some of this done in group settings?
18 CDR MALONE: The question about
19 whether these are just given individually
20 and/or groups, is that correct, sir?
21 LT GEN GREEN: Yes.
22 CDR MALONE: Some of these -- as

1 far as just cognitive interventions and
2 cognitive behavioral therapies, those can be
3 done in groups and/or individually. The
4 practice guidelines here were referring to
5 individual types of approaches, but certainly
6 we know for depression, anxiety and PTSD is an
7 anxiety disorder, that doing group therapy
8 using these type of core functions is very
9 effective, because then you get the benefit of
10 a group of individuals, who are experiencing
11 similar symptoms, who provide feedback to
12 those other patients and that could be much
13 more effective than me as a provider coming in
14 and just individually giving someone feedback.
15 LT GEN GREEN: And so --
16 CDR MALONE: So that can be done
17 on both settings.
18 LT GEN GREEN: -- in terms of
19 trying to get people to complete therapy, is
20 it more effective when you involve some peer-
21 to-peer, particularly because of the
22 sensitivities about the therapist perhaps not

1 having the same experience or not being
2 credible with the people who are seeking help.
3 CDR MALONE: As far as hard and
4 fast data, I don't know that. I will tell
5 you, as a clinician, that when you devise the
6 treatment plan, there are some individuals who
7 after you do your intake and your interview
8 and your assessment, you realize that they are
9 going to be better suited for a group therapy,
10 simply for the reasons you are saying.
11 They may view me as a clinical
12 psychiatrist as not being someone who would
13 ever be able to relate and get to some of the
14 issues with which they are experiencing
15 distress. Whereas, in a group where there are
16 facilitators, there is clinicians there, they
17 may feel more at ease to discuss some of these
18 experiences.
19 And then, of course, you have the
20 individuals who don't want to be participating
21 in groups. They don't think it is going to be
22 helpful for them. They don't want to share

1 these things with other people. They would
2 rather just keep it in the room between the
3 therapist and the patient.
4 Any other questions? Again, I
5 mentioned the Strategic Action No. 9,
6 developing a system to develop evidence-based
7 psychotherapies. That is ongoing. Dr. Eric
8 Gekka, who is at Walter Reed National Military
9 Medical Center is our Navy rep on that
10 particular strategic Action.
11 And then our Navy Center of Combat
12 Operational Stress Control, again, Captain
13 Johnston, there is a pilot going on out there,
14 Psychological Health Pathways Pilot, for PTSD
15 and for individuals who have gone and deployed
16 and have symptoms related to deployment-
17 centered disorders.
18 It was begun in August of 2009 and
19 we are actually -- it's a pilot, which, you
20 know, is multi-disciplinary in their approach.
21 We are tracking or they are tracking evidence-
22 based treatment outcomes. And this is

1 something that I think we are going to be able
2 to provide better answers to you in the
3 future, again, based on what we find in this
4 particular pilot.
5 And again, this is out in the
6 California, San Diego area. And again, some
7 of the things that we can better collect
8 evidence or data for you on evidence-based
9 treatment outcomes, basically, if we can have
10 better IT program solutions.
11 Again, short of doing surveys and
12 going and doing chart reviews to seeing what
13 types of therapies providers used, if we can
14 gather that information ahead of time, that
15 may also help us to get more information on
16 these particular therapies and, you know, how
17 many sessions the person remained and those
18 type of things.
19 And again, that's just again PTSD,
20 very diverse presentations for the same
21 clinical disorder. And then DSM-5 which may
22 be out or is, I think, supposed to be out some

1 time in 2013 or afterwards, there are proposed
2 changes to the diagnostic criteria of PTSD.
3 They have not been accepted, but
4 they are on the website if you were to go
5 there and you could kind of see how the
6 individuals are thinking about, especially,
7 the A-2 criteria for the military. That we
8 don't want to -- if someone is a purist, they
9 may say well, if you didn't experience intense
10 fear, helplessness or horror, technically, you
11 don't meet the DSM-IV criteria for PTSD.
12 So I may call you anxiety disorder
13 not otherwise specified. That's a significant
14 disorder. It's still a mental disorder in
15 that book. Is it missing something? Are we
16 missing something by potentially doing that?
17 Yes, we may be because, you know, are there
18 Clinical Practice Guidelines for just anxiety
19 disorder not otherwise specified? No.
20 So you want to capture the
21 diagnosis the best you can, but, again, you
22 know, we are up to DSM-5. I think when I

1 first started churning, we were DSM-IIIR or
2 something like that. So this -- our specialty
3 is always evolving trying to incorporate, you
4 know, what we know and what we learn about
5 these disorders as time marches by.
6 And that's all I have for you this
7 morning.
8 MR. REHBEIN: Maybe my question is
9 coming too early, maybe I need to wait until
10 after all of the presentations are made, but
11 we heard from the DCoE folks and we have heard
12 now a couple of times from Dr. Hoge and from
13 you that combat-related PTSD presents
14 differently than non-combat-related?
15 CDR MALONE: It may be when you--
16 MR. REHBEIN: And so my question,
17 I guess my question is --
18 CDR MALONE: -- look at these.
19 MR. REHBEIN: -- do you see a
20 difference in outcomes because you have a
21 significant population of non-combat related
22 PTSD, sexual trauma.

1 CDR MALONE: Right.
2 MR. REHBEIN: Those causes. Do
3 you see a difference in outcomes based on
4 whether or not it is combat-related?
5 CDR MALONE: I would have to look
6 back and see if we have research or data on
7 that. I know again clinically having taken
8 care of many individuals who have experienced
9 sexual assaults or alleged sexual assaults and
10 have PTSD from that versus combat, my n is too
11 small to be able to answer that.
12 But, Dr. Hoge, do you have a
13 better response?
14 DR. HOGE: The research suggests,
15 it's somewhat limited, but the research
16 suggests that combat-related PTSD is more
17 difficult to treat, more refractory, it has
18 more relapses and so forth, that it can be a
19 more chronic course than a single episode
20 trauma related to a natural disaster. Assault
21 and rape can be associated with very high
22 prevalence rate of PTSD and can be very

1 difficult to treat.
2 But things like automobile
3 accidents or natural disasters, that type of
4 thing, generally, can -- you know, is easier
5 to treat and can, you know, resolve more
6 quickly, at least that's the perception in the
7 field.
8 MG STONE: Does the literature
9 support a difference in this population, in
10 this conflict versus World War II, Korea, or
11 Vietnam?
12 DR. HOGE: Sir, we don't really --
13 every generation of war has had different
14 labels and different ways in which the health
15 conditions were characterized and understood.
16 But fundamentally, if you look back at
17 previous wars, you see, essentially, the same
18 constellation of symptoms and many of the same
19 concerns, although they were called different,
20 you know, had different names.
21 For Vietnam, you know, PTSD was
22 not defined until 1980, but it was largely the

1 Vietnam generation that, you know, led to the
2 definition, you know, being defined in 1980.
3 And from what we have, you know, seen from the
4 Vietnam literature and from the OIF, OEF
5 literature, we have pretty similar rates of
6 PTSD.
7 I think the nature of warfare has
8 changed a lot, but for the guy on the ground,
9 their experience is, in many ways, very
10 similar to the Vietnam, you know, experience.
11 And hopefully, we are not going to have -- you
12 know, the problem with the Vietnam generation
13 is a lot of these guys really never made the
14 transition home until 20 or 30 years later
15 when they finally started to address some of
16 their health concerns.
17 Hopefully with this war, we have
18 gotten a handle on it much earlier, because
19 there has been such a tension on this problem
20 from the beginning of the wars.
21 MR. REHBEIN: Do you --
22 MG STONE: I'm sorry. With this

1 large number of constellation of presenting
2 symptoms, are you satisfied that all three
3 services and the VA make this diagnosis in a
4 similar manner using the same standards?
5 CDR MALONE: From a training
6 standpoint regarding mental health diagnoses,
7 whether you are a social worker, a
8 psychologist, psychiatrist, you receive
9 training about the DSM, Diagnostic and
10 Statistical Manual, what the criteria mean and
11 how to approach making a diagnosis.
12 I believe that training, yes, is
13 fairly standardized. I think, again, when you
14 are dealing with individuals presenting with
15 symptoms, a lot of times they don't
16 necessarily read the textbook to know all of
17 the criteria for say -- and I say that not --
18 I say it like an anatomy, you know, when all
19 of a sudden you get a vessel that has
20 something coming off of it that's not in the
21 textbook.
22 Well, there are variations on

1 presentations and some of their symptom
2 constellations may not fit into all these
3 things as nicely as one would like.
4 And there is where clinical
5 judgment comes in and there is where you may
6 see some variations on whether someone may say
7 this is, you know, PTSD, provisionally call it
8 PTSD. You have other factors such as perhaps
9 service members don't -- you know, are very
10 concerned about having a label of PTSD, which
11 is valid.
12 It's just like when we see someone
13 who may have schizophrenia, you want to make
14 sure that you have a diagnosis pretty -- that
15 you are fairly certain of it before you
16 actually write it down, too.
17 So a lot of those other factors
18 may go into this which may -- you may see some
19 variation on it. But, in general, the
20 training on, you know, the criteria and how to
21 approach a patient and do an assessment,
22 that's pretty standard across the disciplines.

1 Again, it's the patient and their
2 presentation that may cause me to say one
3 thing and Dr. Hoge may see the patient and say
4 something else. But it's probably still along
5 the same spectrum. In other words, we are
6 probably going to say it's an anxiety
7 disorder. I may more specifically say PTSD.
8 Someone may say well, I'm going to call this
9 not otherwise specified until I get more
10 information.
11 LT COL DICKEY: And this is also
12 why you have kind of national certification
13 agencies that have oversight of the training
14 program. So, for example, the American
15 Psychological Association, the American
16 Psychiatric Association are -- you know,
17 provide a level of oversight to our training
18 programs to ensure that kind of the minimal
19 standard.
20 If you would say now, certainly,
21 we trained more than the minimal standards,
22 but you also have kind of this oversight body

1 that is invested in making sure that your
2 training program is in the DoD and, obviously,
3 also through the civilian world that they
4 certify, are doing exactly what you say.
5 Are they adequately training the
6 people who are in these internships and
7 residencies and such in the basics of PTSD and
8 other mental health diagnoses.
9 DR. HOGE: If I can add to the
10 discussion a little bit? I think the one area
11 that -- where there is quite a bit of
12 variability is in how we conceptualize health
13 concerns in the post-war health concerns that
14 individuals come back from war, they have
15 physiological changes, they are reactive.
16 They are having health concerns, generalized
17 health concerns and behavioral health
18 concerns.
19 And the lens is very, in some
20 respects, fairly specifically focused on PTSD
21 and TBI and attributing these health concerns
22 to one of these two conditions, when the

1 reality is much more complex than that. And
2 that these health concerns have similar
3 underlying physiological processes going on,
4 but they are very complex.
5 And, you know, I think that the
6 Patient-Centered Medical Home is an
7 opportunity to address health -- post-war
8 health concerns holistically and -- because
9 sometimes when we focus too narrowly on
10 specific diagnoses, we really don't see the
11 whole picture as well as maybe we should.
12 So that's where -- that's an area
13 where, I think, there is clinicians have a
14 perspective -- you know, they are trained,
15 clinicians are trained, to think in the
16 disease model. They are not necessarily
17 always trained to think in the functioning.
18 You know, to think of functioning
19 in a general -- more general manner or
20 symptoms in a more general manner, to think of
21 well, what are the areas of functioning and
22 what are the various symptoms that are

1 contributing to dysfunction and how can we
2 address those holistically?
3 And so some of these -- you know,
4 there is a great clinical practice guideline
5 which is way out of date, which is the
6 Deployment Health Practice Guideline, which I
7 think is getting revamped, if I'm up to speed
8 on that, but that Deployment Health Guideline,
9 Clinical Practice Guideline actually really
10 talks specifically to this issue of how do you
11 treat warriors when they come back from
12 combat?
13 MR. REHBEIN: Just a question for
14 the panel as well. Do you, any of you, have
15 any data, experience or a clinical comment on
16 the value and resilience training or its
17 affect on the later diagnosis of PTSD?
18 DR. HOGE: Everybody is looking at
19 me, because I'm representing the Army. There
20 is a lot of great resilience training going
21 on. And it is well-accepted and people find
22 it helpful and useful. Whether it prevents

1 PTSD, I have no idea. And there is no
2 research, you know, to really say whether it
3 does or doesn't.
4 And I think the tough realistic --
5 I think in the DCoE, in the DCoE presentation
6 there was also a question, a similar question.
7 And I agree, the tough realistic training, the
8 tougher the more realistic the training, the
9 better prepared soldiers are going to be when
10 they go into combat.
11 But we also don't know, you know,
12 that that actually prevents PTSD.
13 MR. REHBEIN: So in a resource
14 constrained environment in which we operate,
15 you would agree that there is still value in
16 funding resilience training?
17 DR. HOGE: I think there is --
18 well, I'm not going to make a policy comment,
19 but I think there is value in doing systematic
20 research, because it is an empirical question.
21 CDR MALONE: Yes, sir. And I had
22 the privilege of participating in the cost

1 assessment program effectiveness analysis of
2 our programs at the Bureau of Medicine and
3 Surgery and resilience programs were very much
4 discussed.
5 And what did come out of there,
6 too, is well, these sound like they should be
7 making a difference. Do we have the evidence
8 to say that yes, they are? No. Should we
9 further study them to see what works and what
10 doesn't? Yes.
11 And so, you know, from our
12 standpoint, from a Navy standpoint or from a
13 Bureau of Medicine and Surgery standpoint, you
14 know, we supported that particular idea as
15 well. We don't know what the effective
16 components may be and but we want to make sure
17 that we are going to look at it first before
18 saying this just doesn't work at all.
19 LT COL DICKEY: And I also think
20 sometimes when you have this discussion, it's
21 important to point out that there isn't an
22 evidence basis right now for all of these

1 resilience efforts in the military or most of
2 them. But there is an evidence basis behind
3 the idea, in the sense that not necessarily
4 the application, but, for example, for
5 comprehensive soldier fitness, the UPenn kind
6 of principles they are trying to teach, it has
7 been demonstrated that they are associated
8 with people who are -- who kind of do better
9 in life.
10 People who are optimistic tend to
11 be happier. People who have a sense of
12 purpose tend to have a better adjustment to
13 life. So in a sense, that part is
14 empirically-based, just not the part where you
15 say, okay, here is how we train this to
16 300,000 people and does this work? Nobody has
17 been able to demonstrate that.
18 LT GEN GREEN: May I ask all of
19 you are kind of highlighting, the Air Force
20 hasn't presented yet, the increase from 2001
21 to 2010 in terms of the rates. A tenfold
22 increase, I think, was what was in your slides

1 for the Navy.
2 And so in addition to that, all of
3 us kind of anticipate that as the wars do draw
4 down, that we will see an increase in this,
5 based on historical experience with both
6 Vietnam and Desert Storm/Desert Shield.
7 So from your experience, okay, can
8 you folks tell us do you believe that this is
9 purely a clinical diagnosis or is some of the
10 increase that we are going to be seeing
11 disability related?
12 CDR MALONE: Well, I'll address
13 this as I'm both an adult and a forensic
14 psychiatrist, so a lot of what -- I think any
15 time a patient comes to you and tells their
16 story, especially with post-traumatic stress
17 disorder, if you look, a lot of those are
18 self-reported symptoms.
19 When the person comes in the room
20 and they tell me they are having nightmares,
21 you know, I may be able to get collateral from
22 a spouse who would say, yes, you know, kickers

1 are being -- or, you know, the covers are
2 being thrown. I'm kicked multiple times and
3 all these type of things.
4 But a lot of it is self-report.
5 And as a clinician, when I'm treating a
6 patient, you know, we are trained to meet the
7 patient where they are at and to basically
8 help them.
9 I think, again, as a forensic
10 psychiatrist where the training is you are
11 doing evaluations for others, for third-party
12 individuals, and that includes, for example,
13 in the civilian sector disability evaluations
14 and those type of things or when I do
15 competency or criminal responsibility
16 evaluations.
17 When I'm wearing that hat, I get
18 more collateral context. I do more digging.
19 And I think part of our training is you always
20 have to think about is there any gain going on
21 for this person? Is there -- do they want to
22 get something that they may be exaggerating

1 some symptoms, for example, or is that a part
2 of it?
3 I think most clinicians and
4 initially when you are taking care of an
5 individual, again, we meet them where they are
6 at and we try and make sure that we take care
7 of them. And that trust of I'm going to
8 believe what you tell me, because you are in
9 my office, and I know you came to seek care
10 and I know it is hard to even think about
11 doing that, so I'm going to take care of you.
12 I will tell you though as a
13 clinician, too, at times though if, in fact,
14 there may be some of that component, you want
15 to address it, because you don't certainly
16 want to have someone get a diagnosis, for
17 example, that they may not have, because that
18 may further set them up for treatment that may
19 be harmful.
20 Again, they may get prescribed
21 some medications down the road. They may not
22 necessarily need if they don't really have

1 those particular -- that particular disorder
2 or if they may be exaggerating symptoms.
3 So what's the short answer to
4 that? It's all a matter of clinical judgment.
5 I think as a clinician, again, when I
6 initially see patients, that's not one of the
7 things that is in the forefront of what I need
8 to do for that patient.
9 I think with time though,
10 especially if you get evidence or you see
11 things that aren't adding up, like any good
12 clinician, you are going to reassess the
13 diagnosis. Will sometimes those other factors
14 get involved? Yes, sir, they may. You may
15 have to consider them again for the very fact
16 of not wanting to do any harm to that patient
17 by misdiagnosing as well as making sure you
18 take care of that person.
19 DR. HOGE: If I could add to that,
20 the VA did a comprehensive evaluation of
21 disability cases, I think it was, in 2007,
22 2006 they published their report. They

1 reviewed 2,000 disability cases that have
2 received 50 percent or higher rating for PTSD
3 and they found, I think it was, 14 that where
4 there was, you know, evidence of fraudulent --
5 that the information that was provided by the
6 service member, the veteran was fraudulent.
7 So it was less than half of 1
8 percent. And it was data like that that led
9 the VA Secretary to remove the requirement for
10 proving that the individual had traumatic
11 experiences in theater. That if they had just
12 deployed that was sufficient.
13 If they deployed to a combat zone,
14 that was sufficient, because there were far
15 more people who were negatively impacted by
16 sort of the rigor by which they were -- their
17 cases were scrutinized than there were
18 individuals -- I mean, there are individuals
19 who malinger. I mean, there -- but it's a
20 very small percentage of individuals that do
21 that.
22 The other thing is, and I'm not

1 saying that disability -- you know, that
2 disability doesn't play a role. It does play
3 a role. But the other thing about PTSD is it
4 almost never occurs in isolation. You never
5 have a disability case where it's just PTSD.
6 I mean, almost always, it's a whole list of
7 physical and other health complaints that are
8 being evaluated along with that.
9 So I think that it's a small
10 factor. It's not a big factor. It's much
11 more important to facilitate access to care
12 and also to the disability system and make
13 that process as streamlined as possible and as
14 efficient as possible to reduce the stress on
15 the individual and to -- you know, and that
16 that in turn will actually improve care.
17 LT GEN GREEN: And so I guess
18 another way of asking my question would have
19 been do you feel the diagnostic criteria are
20 specific enough for you to arrive at that
21 conclusion? And so I appreciate your input on
22 this. The VA study is very useful.

1 So, essentially, with the
2 diagnostic criteria that you put up in front
3 of us, I would expect it to be a clinical
4 decision. And so that's why I asked. Okay.
5 MG STONE: I wonder -- in the
6 beginning, Charles, you talked about the
7 intensity of combat exposure experience. We
8 have also talked about dwell time in
9 repetitive reintegration. Do the other
10 services agree that what you are seeing in
11 your population of these patients is really
12 based upon the intensity of combat experience?
13 LT COL DICKEY: Oh, I'm sorry.
14 CDR MALONE: Go ahead.
15 LT COL DICKEY: I was just going
16 to say when I do my presentation, I've got a--
17 MG STONE: Sorry.
18 LT COL DICKEY: -- that's one of
19 the statistics. And I think I'm assuming you
20 will say the same thing when we do our data
21 pulls. It really is one of the factors in
22 terms of rates of PTSD diagnosis, that's one

1 of the strongest predictors is intensity of
2 combat experience. Yes, sir.
3 CDR MALONE: And we have
4 behavioral health needs assessment surveys
5 which look at individuals who are experiencing
6 symptoms consistent with post-traumatic stress
7 disorder and depression as well. And we asked
8 questions about their combat experiences and
9 exposures and it would be similar.
10 LT COL DICKEY: You know, I'll
11 take a minute to jump in here, too. When you
12 had asked the question about combat PTSD being
13 different, it's really like a lot of the other
14 discussion where the diversity of experiencing
15 combat is so much that, in a sense, it's kind
16 of difficult to make that a binary
17 distinction.
18 And one of the things that is
19 known in terms of PTSD research is that there
20 are stronger and weaker correlates with the
21 development of PTSD that are based on what it
22 is you actually experience, things like the

level of control you felt like you had over the situation, the less control you feel like you have, the more likely you are to end up with a diagnosis.

The level of kind of physical violation. So for example, somebody who undergoes a violent rape, say example, is more likely to develop PTSD than somebody who maybe just witnesses an event. So there is kind of a whole host of factors that also fit into that idea of combat that are going to be variables that also weigh in in terms of the higher rate of PTSD.

Although again, I would emphasize that we do know that combat experience generally. And we kind of know this, I think, for most of the services really through things like PDHRA and the correlation of how folks answered those questions on whether you fired your weapon, whether you were shot at, whether you saw dead bodies, those types of things.

MS. DAILEY: Ladies and gentlemen,

1 I would like to bring Colonel Dickey up.
2 LT COL DICKEY: So one of the
3 benefits to going third is that a lot of
4 things maybe I was going to discuss are --
5 have been covered to a certain extent, so I
6 appreciate that.
7 And I think hopefully there is
8 really a lot of consensus amongst the
9 services, I think, in terms of what we are
10 doing, what the problems are and I think, as
11 everybody can see, it is a fairly complex
12 problem. And so kind of coming up with the
13 correct intervention is challenging to say the
14 least.
15 I don't have these in my slides,
16 but since it has been brought up, in terms of
17 overall the number of behavioral health
18 providers, we have 1,900 in the Air Force,
19 approximately, 900 of those are technicians.
20 So the other 1,000 or so are nurses, nurse
21 practitioners, social workers, psychologists,
22 psychiatrists and that's just for

1 informational purposes.
2 Okay. So a couple of things I
3 will highlight maybe that we haven't gone
4 over. One of the things that we wanted to do
5 was just in terms of our Air Force population,
6 I think probably folks in the room already
7 know that in terms of the Air Force, in
8 general, our rates of PTSD and PTS are much
9 lower than the Army and the Marine Corps.
10 Now, in a sense, that's important
11 and in another sense it's not, because, as we
12 all know, for example, there are a lot of
13 joint environments where we operate, a lot of
14 joint hospitals where we are treating members
15 of all services. Also, a significant
16 proportion of Air Force mental health
17 deployments are in support of specifically the
18 Army and JEC taskings.
19 And so we spend a lot of time kind
20 of emphasizing the appropriate diagnosis
21 identification and treatment of PTSD.
22 This is a busy slide. I apologize

1 for it. I'm not so interested in going over
2 each one of these lines. The main purpose of
3 this slide though is so if you look at kind of
4 the others, which is the, I guess that is, tan
5 line there at the bottom, this is data from
6 the PDHRA. And it is post-traumatic stress
7 symptoms by Air Force occupation.
8 And what you can see is the base
9 rate for the majority of our folks is very
10 low. And one of the things, whenever you pull
11 statistics like these and you probably already
12 picked this up from your other presentations,
13 sometimes you can pull the actual AHLTA
14 statistics from M2, which are rates of actual
15 diagnosis by going to see a mental health
16 provider.
17 Like Dr. Hoge pointed out, the
18 majority of your folks don't actually ever get
19 to that point, so is that statistic really a
20 very good one? Not necessarily.
21 And we also know that PDHRA is
22 also -- and PDHA are not always the best

statistics either. Why is that? Because if you report things on the PDHRA, what is going to happen? Someone is going to call you and get you an appointment with a behavioral health provider. But these are kind of the statistics that we have.

And what we know is that we have a very low base rate, but we do have a number of career fields that you can see, and this is very consistent over time, are kind of at significantly elevated level in terms of their reporting of post-traumatic stress symptoms.

So the heavy blue line is EOD, bomb disposal folks. Security forces is the red line. Medical folks are always in the top four or five Air Force service codes. OSI and TACP, OSI is Office of Special Investigations, TACP are our air controllers that work with -- typically, work with Army units in coordinating air support.

So this is one of the things that we know about our population. And as a

1 result, we have kind of come up with what you
2 would call a targeted and tiered approach in
3 making sure that (A) we reach everybody as
4 necessary, but also that we focus on what are
5 we doing specifically for these folks who are
6 at a higher risk? And I'm going to talk a
7 little bit about that.
8 CAPT EVANS: So are there other
9 services? Are you able to pull this same type
10 of data? Are you able to -- the statistics
11 shown by the occupation.
12 CDR MALONE: Yes, ma'am. We
13 actually had to pull it for -- I'm sorry.
14 Yes, ma'am. We had to recently pull it. Was
15 it for the report to Congress?
16 LT COL DICKEY: That's right.
17 CDR MALONE: Right.
18 LT COL DICKEY: There was actually
19 recently a report to Congress where all the
20 services were required to pull their PTS data
21 per mission set.
22 CDR MALONE: Or per MOS for --

1 LT COL DICKEY: Right.
2 CAPT EVANS: Per MOS, okay.
3 CDR MALONE: Yes, ma'am.
4 CAPT EVANS: So are we able to
5 have a copy of the other services?
6 MS. DAILEY: Yes, we will get it
7 for you.
8 CAPT EVANS: Okay. Thank you.
9 LT COL DICKEY: Sure. Any other
10 questions on this? Okay.
11 Okay. This is -- now, this is
12 different than the last slide, in that this is
13 based on AHLTA. So these are diagnosed cases,
14 okay? And so the numbers, you can see, have
15 actually dropped significantly in terms of the
16 base rate. What you actually see though is
17 the graph going up over time, the incident
18 rate per thousand.
19 And since it's a per thousand
20 number, what you end up with in 2010, at least
21 for the Air Force, is our base rate of PTSD
22 diagnosis is somewhere around .7 percent. So

1 it's a small number, although significantly,
2 and this is consistent with the other
3 services, you see that number going up over
4 time, which is why I think this diagnosis and
5 treatment have received so much attention.
6 Okay. Okay. The short list of
7 the most empirically supported treatment
8 modalities for PTSD, I will not spend a lot of
9 time on this, because, I think, what you have
10 seen is that the services use the VA/DoD
11 Clinical Practice Guidelines as the standard
12 of care for their PTSD services.
13 Now, I think there have been a lot
14 of good discussions of the caveats associated
15 with that, but that really is kind of the
16 standard of care. What we did was we took
17 that, those Clinical Practice Guidelines and
18 the flow sheets that they have there -- we
19 have an Air Force instruction for traumatic
20 stress response that guides, basically,
21 intervention and combat operational stress in
22 the deployed setting and also with traumatic

1 events at the home station.
2 We actually just integrated those,
3 the VA/DoD guidelines into the AFI, so that
4 that's the standard of care. I mean, it's the
5 standard of care, because it's in the VA/DoD
6 Guideline anyway, but we reinforce that by
7 putting that in the Air Force instruction, so
8 that it would inform kind of clinical
9 practice.
10 Okay. What is the availability of
11 each of these treatment modalities that
12 service -- at treatment sites across your
13 service branch? So we have, I think, a fairly
14 robust training program for our providers and
15 reach back for consultation. Our main
16 training initiatives are through cooperation
17 with the Center for Deployment Psychology,
18 which you all have already heard is run out of
19 DCoE.
20 They provide kind of the subject
21 matter expertise for our trainings. So
22 beginning five or six years ago, we determined

1 that all of the psychology and social work
2 residents were going to attend the evidence-
3 based treatment training that the Center for
4 Deployment Psychology provides.
5 And it is important to know for
6 the majority, the vast majority of our
7 psychologists and all our social workers, they
8 go through a residency year in the Air Force
9 before they go out and go to their clinical
10 practice. And so as a part of that year, they
11 attend the training that the CDP provides.
12 And that's kind of our way of ensuring that
13 our new folks get that training.
14 We also have deployment
15 psychologists embedded in three of our Air
16 Force MTFs, three of the larger ones at
17 Andrews, Wright-Patterson and Travis. And
18 then also, the CDP, I think as you saw part of
19 the Navy's brief, their mobile team comes out
20 and provides base specific training, so they
21 have been very good in terms of facilitating
22 training.

1 They trained 284 of our folks in
2 FY11. And then they also provide reach back
3 consultation on a weekly basis for base level
4 providers who may not have a CDP psychologist
5 there who are treating a PTSD case and who
6 need guidance.
7 The other thing that we have got
8 going on is the Master Clinician Development
9 course through the University of Texas Health
10 Science Centers who have developed a
11 curriculum for development of PTSD master
12 clinicians. We have trained 19 of those so
13 far.
14 Okay. Okay. Other treatment
15 modalities that we have available for PTSD
16 treatment. The Virtual Iraq and Afghanistan
17 is set up at 10 sites. I can't remember if
18 folks spoke about this, maybe they did, that's
19 with the virtual reality.
20 It's really intended for
21 intractable PTSD. It's not necessarily the
22 first line that you go with, but if you are

1 treating an individual who through standard
2 kind of evidence-based practice is not
3 improving, then we will -- may engage them in
4 the Virtual Iraq/Afghanistan, which kind of
5 heightens the level of exposure, because, as
6 you all have already been presented, that
7 exposure basis for treatment is a critical
8 part of what it is that you are doing with the
9 individual.
10 And, you know, it's an impressive
11 program. It uses smells and sights and sounds
12 and you carry a weapon and these types of
13 things.
14 We also have 48 mental health
15 clinics that have received telemental health
16 VTC equipment. 28 more are scheduled to
17 receive. It was very important to us that we
18 made sure that those were going to be placed
19 in the mental health clinics, not that the
20 hospital commander was going to be able to use
21 them for their VTC capabilities or whatever.
22 Those are specifically dedicated.

1 And again, that's beneficial for
2 the large MTFs to be able to lead VTCs and for
3 the smaller MTFs it is beneficial in that they
4 are able to kind of reach back if they have a
5 smaller provider base and they need
6 consultation.
7 Okay. I talked about the next
8 one. And then some of the general education
9 we do. All airmen receive training and self-
10 aid buddy care. There is a PTSD module that
11 they have to complete to complete the overall
12 self-aid buddy care. There is also a TBI
13 module, since we are talking about it.
14 And then we also provide advanced
15 education and medical predeployment training.
16 The Expeditionary Medical Support course and
17 the Combat Casualty Care course provides
18 advanced training to medics who are attending
19 those particular platforms.
20 And then finally, we have PTSD
21 fellow located at the Air Force Medical
22 Operations Agency, who provides guidance to

1 our folks.

2 Okay. I want to take a minute to

3 talk about one of the things that we have done

4 that I think has been one of the more

5 interesting innovations in the last couple of

6 years. If you go back to that first slide

7 where we talked about those different AFSCs

8 that we know are at a different risk level

9 than some of the general population of Air

10 Force Members, one of the questions that was

11 asked was well, what are we doing for these

12 folks?

13 Are we doing anything? And some

14 of them had programs specific to their career

15 field, but there wasn't any kind of Air Force

16 level approach. And what was proposed and

17 accepted was this idea that -- and what we did

18 was we looked around and said, you know, OSI

19 has a reintegration program for folks coming

20 back through in deployment.

21 Also, a couple of other countries

22 do it also. The UK does it, the Canadians

1 also, where they have you on your way back
2 from down range, stop off at what is called a
3 Third Location Decompression Center. They get
4 to do it at -- the Britts and the Canadians do
5 it in Cyprus, which is not bad, right?
6 And what they actually do there is
7 they spend a couple of days there. They do
8 some training with the folks. They let them
9 do some R&R before they head back home.
10 And they have gotten a lot of
11 positive reviews with their program, so it was
12 proposed that -- to our leadership actually to
13 setup a similar effort at Ramstein, Germany
14 for those career fields that you saw. Not for
15 everybody, but for the folks who are more
16 combat exposed. The bomb disposal folks, the
17 combat convoy folks, the TACP folks.
18 And this opened in July '10. We
19 have had over 3,000 airmen attend it. And
20 what is really ingenuous about this program is
21 that it is not led by medics or chaplains or
22 family support folks. What you actually have

1 is you have on the ground folks from those
2 career fields who are experienced NCOs, who
3 are TDY to the Ramstein location and provide
4 the reintegration training.
5 And you have medics and chaplains
6 there to provide kind of advisement and
7 content, if people start getting into medical
8 issues, but it's not a medical intervention.
9 There is no documentation. It's not in AHLTA.
10 And that's on purpose, because it is seen as
11 a training and it's also, in a sense, better
12 than a lot of our medical programs, because it
13 is not targeted to people with symptoms.
14 We don't identify you down range
15 and say oh, my gosh, you look like you are
16 having a hard time. You're going to go to
17 that medical thing in Germany.
18 What you do is you have an EOD
19 Team who is going to be doing services in
20 Iraq. Before they ever deploy, that unit is
21 identified on their orders as going back
22 through the DTC.

1 And then they do. And they go as
2 a unit, as a team and the discussion is led by
3 career field facilitators.
4 What is really interesting is we
5 have had a lot of very positive response to
6 this innovation. We do pre- and post-surveys
7 and it kind of made us nervous when you stood
8 this up, because when you talk to these guys,
9 who are all in one-to-one dwell, high stress
10 career fields, hey, we are going to add two
11 days of deployment onto your deployment. You
12 think you are not going to get a great
13 reaction to that.
14 The pre- and post-surveys, what is
15 interesting is when they get on the ground,
16 they are not terribly excited about the
17 program. When they get off the ground, the
18 ratings of this program is worthwhile are in
19 the 80 to 90 percent range consistently.
20 And it has also gotten a lot of
21 attention, so now the Marine Corps EOD Teams
22 are all going through and some other service

1 teams that are looking at using this program.
2 MS. CROCKETT-JONES: I have a
3 question for you.
4 LT COL DICKEY: Yes.
5 MS. CROCKETT-JONES: I know that
6 at one of the installation visits we had some
7 Air Guard Members who wondered if there was
8 any similar program being considered for non-
9 deployed drone operators who were experiencing
10 some rates of behavioral health issues that
11 were closer to their deployed counterparts.
12 And is there -- is this reducing
13 or aiding in recovery from PTSD? I mean, do
14 we have any idea for the folks who complete
15 this see results?
16 LT COL DICKEY: That's a great
17 question. So let me ask the -- I think I
18 missed a part. Did you say Air Guard?
19 MS. CROCKETT-JONES: Yes.
20 LT COL DICKEY: Okay. So one of
21 the things that we have been very involved
22 with is trying to look at (A) kind of what is

the overall delivery in the force of making sure we are giving what we need to? But also, (B) what are some of the subpopulations?

It was interesting when we stood this up, because we kind of had to comb all of the AFSCs in the Air Force and say who is this appropriate for? Who is this not appropriate for?

And there is a couple of different -- now, one good thing about this, it's a total force initiative. So Guard and Reserve, they are on orders also. They come back through. There is no differentiation for those populations.

But it sounds like you are asking more for population in CONUS or OCONUS at their home base. And one of the things that we have done, for example, is we are very aware that there are populations that -- this was designated as combat-focused.

So it's for outside the wire folks who are regularly -- and the definition is

1 outside the wire, regularly exposed to the
2 risk of death in combat.
3 There is other populations that
4 came up when we were doing this like remotely
5 piloted aircraft or intel folks, who you read
6 a lot about in the news. You have had this
7 explosion of this career field of people who
8 are kind of doing these jobs where they are
9 kind of blowing people up remotely and having
10 to kind of work in this environment, which is
11 really, in a sense, historically
12 unprecedented, right?
13 And so part of the intervention
14 has kind of been, and I could spend a lot of
15 time talking about the different
16 subpopulations we have had to look at, but one
17 of the things we have done with that is kind
18 of one of the things I think you are hearing,
19 the trend across the services is this idea of
20 embedded mental health assets.
21 So, for example, with the RPA
22 folks and some of the intel folks, we are

1 looking at that idea and we have some of that
2 in place. And looking at what is the scope
3 that there ought to be for embedded mental
4 health assets in units that do these types of
5 missions?
6 I don't know if that's the
7 specific --
8 LT GEN GREEN: Yes, if I could?
9 The thing we are finding though when we did
10 embed the psychological folks, is that we are
11 not seeing as much post-traumatic stress, as
12 we are just simply seeing occupational stress
13 and need for better rest cycles and some of
14 the things that go on when you are dealing
15 with 24/7 operations.
16 LT COL DICKEY: Right.
17 MSGT MacKENZIE: Real quick, sir.
18 LT COL DICKEY: Sure. Oh, and by
19 the way, the second part of your question is
20 coming up. We do have some very interesting
21 data. Yes?
22 MSGT MacKENZIE: One of the

1 things, and maybe I'm just reading into this
2 the wrong way, is that you are deliberately
3 not discussing any of the special operations
4 or aviation career fields or do they just not
5 show up on your graph, because they don't have
6 that issue? And then how does that start more
7 discussion within your community?
8 LT COL DICKEY: That's a great
9 question, because that is another
10 subpopulation that naturally you would think
11 yes, why aren't they on my graph? Special
12 operations folks have their own kind of whole
13 set of -- and I believe this is true for the
14 other services also, they actually have their
15 own approach.
16 So, for example, the DTC, special
17 operations is exempted from the DTC. Why are
18 they exempted? Because they actually have
19 that embedded psychological reintegration
20 program that they have that they designed and
21 AFSOC, I think like the other special ops
22 communities and the other services, is kind of

way ahead or historically has been way ahead in terms of knowing that hey, kind of just having a mental health clinic that people can go into is not really going to do it.

Our folks aren't going to go in. And if they are, they need people who are familiar with our mission who can speak our language and who have a similar mindset. And so it has actually been a while ago that they have embedded assets in the AFSOC community.

LT GEN GREEN: AFSOC specifically requested exemption from this, so that they could continue their program, based on their non-standard rotation dates. So a lot of theirs is done based on their non-standard rotations.

MSGT MacKENZIE: Yes, sir. I was actually asking for the group though. I wanted to see that get mentioned, not avoided. Thank you.

MR. CONSTANTINE: Sir, a question?

LT COL DICKEY: Yes?

1 MR. CONSTANTINE: I heard, at some
2 point, anecdotally, that in the UK they use
3 something similar to this where they kind of
4 assume anyone who goes off to war will have
5 PTSD when they come back. So everyone goes
6 through this kind of thing. So there is no
7 stigma. And no one knows how has it, who
8 doesn't. This sounds similar and I think it
9 sounds good.
10 What happens during that three day
11 program? Without taking too much time, but
12 what happens there?
13 LT COL DICKEY: Sure. That's a
14 great question. And I can do it, you know, in
15 three minutes or four minutes.
16 Basically, what happens is you
17 have them integrate through the program with
18 their team, so that's a very important part of
19 the program. So you have your EOD Team of
20 eight folks. You process with your team. You
21 actually have some small group kind of
22 discussions that are facilitated by the career

1 field facilitator with a medic or chaplain
2 also in attendance.
3 The first thing that they will do
4 is an operational lessons learned. And they
5 will review actually was your training
6 adequate to the mission? Was the equipment
7 that you had adequate to the mission? And
8 they will actually write that stuff down and
9 send it up through the career field chain.
10 Part of that is informational for
11 the career field. The other part is to get
12 folks talking about whatever it is that they
13 went through and kind of making them more
14 comfortable with being there.
15 Another part of it is we actually
16 have a section that was somewhat based on kind
17 of the battle-mind videos. We went ahead and
18 kind of shot our own, but show some of the
19 common reintegration problems that people may
20 have, things like adjusting to your sleep,
21 adjusting to being back with your family,
22 hypervigilance and kind of normalizing those

1 reactions and then talking about them a little
2 bit, again, facilitated by the career field
3 facilitator.
4 And then kind of that's kind of
5 basically what the rest of the discussion is
6 kind of focused on. And then another
7 important part of the program is they actually
8 do what is called an experiential outing.
9 They will take them to Heidelberg or they will
10 take them to an off-site place.
11 And you may say well, that just
12 sounds like fun. Well, if you remember, you
13 know, I think most of the folks have been
14 deployed, they are literally right off the
15 plane and they haven't seen green and they
16 haven't been in a car. And what they do is
17 they kind of talk them through this is what
18 it's like.
19 You know, how does this compare?
20 What do you -- what is your reaction? And
21 it's kind of used as a reintegration tool to
22 help the individuals kind of start that

1 reintegration process.
2 Something else you said that I
3 think is key is that expectation of PTSD. And
4 this is another thing that is really
5 important. And I don't think it has been
6 mentioned, but one of the things I think that
7 is important is messaging.
8 Unfortunately, sometimes in the
9 mental health career field, we give folks the
10 expectation that if you have been through
11 combat, oh, my God, you are going to develop
12 PTSD. And what do we know? We know that the
13 majority of people who go through combat do
14 not develop PTSD.
15 They may develop PTS symptoms that
16 will resolve and some people will develop
17 PTSD. But a lot of people will not develop
18 PTSD. And it is kind of co-opting what are
19 the lessons you can learn from that and pass
20 on? That's part of what the effort here is.
21 Take experienced NCOs who have
22 deployment experience in these high-risk

1 career fields and have them talk about hey,
2 you know, when I came back from my third
3 deployment and me and my wife were having a
4 tough time, here is what I did and here is how
5 it worked. Yes?
6 DR. TURNER: Just to get back to
7 the second half of his question, which you
8 didn't address, what is your current thinking
9 on with the diagnosis of PTSD on either
10 temporary or permanent disqualification from
11 flying or PRP duties?
12 LT COL DICKEY: Yes. Well, I
13 think that's a good question. I'm going to
14 have to be honest with you, right now, I don't
15 know what the reg is in terms of flying and
16 PRP in a PTSD diagnosis. I don't know if
17 that's a permanent or a temporary
18 disqualification.
19 So in a sense, I would be speaking
20 a little bit out of turn. I could speculate
21 and say, you know, that the PRP regs are very
22 -- written very restrictively, probably for

1 good reason, because you are handling nuclear
2 materials and so --
3 LT GEN GREEN: Permanent
4 disqualification.
5 LT COL DICKEY: Permanent
6 disqualification. Okay. Right. And with the
7 flying community, there is -- actually, I do
8 know more about the flying community than the
9 nuclear community. I know that you can have
10 a diagnosis of PTSD and get back on flight
11 status, although there is a very involved
12 process to do that.
13 But I think, at the same time, you
14 have to -- I don't think it's necessarily a
15 good idea to say if you had PTSD, you are
16 permanently ruled out from certain missions,
17 because the goal here, and I think one of the
18 slides I have later, is that the majority of
19 people who have been diagnosed with PTSD in
20 the Air Force, and I would assume this is true
21 in the other services, are not MEB'ed and they
22 do not get out of the service.

1 And so it's very important.
2 That's part of that stigma question, because
3 I think probably broadly the perception is,
4 that we are trying to combat is, if somebody
5 diagnoses you with PTSD, you are done. You
6 know, we'll see you later.
7 LT GEN GREEN: Yes, I think it's
8 also an unfair question, because it's a wide
9 spectrum and it depends on the therapy and how
10 long. I mean the expectancy, we see that
11 roughly 70 percent go back to duty.
12 So with treatment, 70 percent go
13 back to duty, so whether or not they should go
14 into certain specialty fields or not really
15 depends on what their follow-on therapies are.
16 MSGT MacKENZIE: And what their
17 specialty is at the time.
18 LT GEN GREEN: Right.
19 MSGT MacKENZIE: On what you are
20 trying to requalify within the diverse
21 aviation specialties.
22 LT COL DICKEY: Right, right.

1 Other questions? Okay. So one of the
2 questions a second ago was well, do we have
3 anything that shows that the DTC works?
4 One of the interesting studies
5 that we did, we had some of the folks down at
6 AFMOA, who actually looked at the first 800
7 folks to go through the DTC, and pulled PDHA,
8 PDHRA and M2 data.
9 Now, ideally, what you want is you
10 want to, you know, cut your group in half.
11 Half of them go through and half of them
12 don't, use them as a control group. We don't
13 get to do that a lot of times in the military,
14 unfortunately, and we weren't able to do that
15 with the DTC, because it is kind of mandated
16 for certain career fields and not others.
17 And it is difficult to find a
18 comparison group for your average EOD Troop,
19 for example, right? There aren't a lot of
20 whole other mission sets doing that mission in
21 the Air Force. There are in other services,
22 but then, of course, you have the confound of

1 different services have different types of
2 people or made different in ways that you are
3 not aware of.
4 One of the interesting things was
5 that in -- but there is a kind of propensity
6 score model that you can use to match
7 individuals and we did that controlling for
8 characteristics like age. You know, the
9 obvious one is age, gender, rank, length of
10 deployment, but also controlling for some of
11 the PDHRA items like exposure to combat, level
12 of symptoms, those types of things.
13 And actually ended up kind of with
14 a propensity score matching control sample of
15 13,000 individuals. And how did they do that?
16 Well, the way that they had to do that was to
17 go back for the three years predating the DTC.
18 And this is the difficulty with the propensity
19 score model, you do have historically a group
20 that predates the other group, but like I say,
21 in the absence of the ability to form a
22 control group, you have to go with kind of the

1 best Plan B.
2 What was interesting about these
3 two groups though is when we compared them, in
4 terms of PDHRA, we kind of got a large
5 statistical effect on three of the items. The
6 first one was the number of PTSD symptoms that
7 were endorsed by the respondents.
8 The second one was whether they
9 endorsed having serious conflict with spouse,
10 family, close friends or at work.
11 And the third one was alcohol use,
12 responses triggering a mandated alcohol
13 screening.
14 What you see is, you know, it's
15 interesting because, for example, the last
16 technical report on comprehensive soldier
17 fitness, the effect size was very small, but
18 the argument is well, it's a population-based
19 effect size, so that's okay.
20 These percentage differences are
21 really quite dramatic in terms of the
22 differences that you see between the DTC

1 sample and the control sample. And so this is
2 very interesting. I think as you saw, DCoE is
3 also doing a study at the DTC and we are
4 looking to kind of replicate this study,
5 because it really shows that some of these
6 reintegration issues, which is what we are
7 targeting, PTSD symptoms conflict and alcohol
8 use.
9 And I should say, in the interest
10 of fairness, when we looked at M2 data, rates
11 of diagnosis, there was no difference between
12 the two groups. And you might say well,
13 aren't you disappointed in that? And I would
14 say well, it would have been great if there
15 was a difference.
16 At the same time though, I think,
17 conceptually, the DTC was not formulated as a
18 medical intervention that was designed to
19 prevent diagnosis. It was designed as a
20 reintegration training. And I think we do
21 have some evidence that it is succeeding in
22 that mission.

1 Okay. Any questions on that? All
2 right. How faithfully are the protocols for
3 these treatment modalities being implemented?
4 Okay. Well, we have it in our peer review reg
5 that you have to use evidence-based guidelines
6 in selecting your treatment. I think probably
7 all the services do that.
8 Unfortunately, I have to say we
9 did an Air Force MTF survey on EBT fidelity
10 last year, but the survey was not very well-
11 designed. And so the statistics that we got
12 from it -- one of the problems that we have is
13 at some clinics, there really are not very
14 many PTSD patients to be honest with you.
15 And the way that the survey was
16 worded, it was not clear when they were asked
17 if they were using EBT treatment with their
18 PTSD patients, whether (A) they weren't using
19 it because they were using something else or
20 (B) they weren't using it because they didn't
21 have any PTSD patients.
22 I apologize for that. The goal is

1 to reaccomplish this survey in April. This
2 will be a survey of all the Air Force MTFs
3 with a better wording of the question to get
4 to the specific types of statistics that Dr.
5 Hoge was talking about.
6 How does your service branch
7 monitor availability and faithful
8 implementation of evidence-based treatment
9 modalities? We track the training of
10 providers in evidence-based treatment, our
11 collaboration with the CDP also in terms of
12 tracking that training and the peer review
13 process.
14 Okay. And then this is the last
15 one. You know, we have had some discussion on
16 stigma. I think this is an important slide,
17 kind of this double pie chart. Basically,
18 what it is saying is what we have said
19 already, if you look at the left side of the
20 pie, individuals with a PTSD diagnosis in
21 FY10, 75 percent of them are not MEB'ed. They
22 remain on active duty.

1 And then you have a certain number
2 that receive a TDRL separation pay, no MEB, 2
3 percent on return to duty. And then on the
4 right hand side, at least in the Air Force
5 population, the majority of PTSD diagnoses
6 that resulted in a medical board were not
7 strictly for combat exposure. And that can
8 mean it may have been a part of it was for
9 combat exposure, but it wasn't strictly for
10 combat exposure.
11 So at least for our patients, and
12 this is one of the messages that we are trying
13 to get out, is that even if you come into the
14 mental health clinic and get a diagnosis of
15 PTSD, the majority of people who get that type
16 of diagnosis return to duty.
17 And, you know, when folks were
18 talking about stigma, I almost kind of jumped
19 in there, because one of the big, as you know,
20 problems or disincentives that people have is
21 if you go to a military medical clinic, your--
22 it is going to be documented and it's possibly

1 going to be flagged for your deployment or
2 your next job or a sensitive duty.
3 And we have done a lot to try to
4 publish the idea that, you know, it really
5 doesn't hurt your career and it doesn't result
6 in a medical board, but that's one of the
7 challenges and that's really the reason behind
8 things like OneSource and the MFLC Program,
9 right, is to give people the option of going
10 to a provider who doesn't go in their medical
11 record, although that has its own set of
12 problems in and of it self, doesn't it? Yes?
13 DR. TURNER: Interesting on your 2
14 percent of the return to duties, how many of
15 those are C-coded?
16 LT COL DICKEY: You know, I don't
17 know this. I didn't do this data pull, that's
18 a good question. I don't -- I guess I'm not
19 sure what percent of C-coded patients are PTSD
20 patients. So that would be a good question.
21 I can find that out, sir. Other questions?
22 MR. REHBEIN: Your comments just

1 now about stigma. I want to go back to the
2 second graph that you showed where you have a
3 continual increase in the number of new PTSD
4 cases.
5 LT COL DICKEY: Yes, sir.
6 MR. REHBEIN: Speculate for me for
7 a minute, is that more people suffering from
8 PTSD or is that more people being willing to
9 admit they are suffering from PTSD?
10 LT COL DICKEY: I think that's a
11 great question. And I don't know if the other
12 services can weigh in on that. You know, from
13 my perspective, I would say I don't know.
14 That's a logical question though is do we see
15 an increase in numbers, because we have been
16 emphasizing PTSD more and destigmatizing
17 coming in for treatment and trying to identify
18 people better? It's possible.
19 Or do we see more PTSD cases
20 because we have been at war for 11 years? And
21 so you have kind of this kind of aggregation.
22 I don't know if folks really know that. You

1 know, part of the thing is is you publicize it
2 more, you're going to get more people into
3 treatment. Well, that's what you want, right?
4 You do want that.
5 And your rates go up, but it's
6 also -- I'm not sure and I don't know if the
7 other services reps have an opinion on that.
8 DR. HOGE: I think a lot of it is
9 the screening programs that have been put in
10 place. 2005 was when the PDHRA was added to
11 the post-deployment health assessment process
12 and we know that the PDEs see a lot higher
13 rate of endorsement of mental health concerns
14 on the PDHRA than you do on the PDHA.
15 So you can see the graph really
16 starts to shoot upward in all the services.
17 I wish I had brought the same Army graph,
18 because it's pretty dramatic what you see in
19 the Army. But I think a lot of it is driven
20 by the screening processes that have been put
21 in place to help identify people and get them
22 into treatment.

1 MS. MALEBRANCHE: Of the TDRL
2 numbers that you have there, I mean, it's not
3 numbers, the percentages, how many -- do many
4 return back to duty?
5 LT COL DICKEY: You know, that's a
6 statistic I don't have with me. Also, I think
7 that's a good question and I can find that
8 out. What is the percentage of specifically
9 PTSD, TDRL patients who end up return to duty
10 versus eventually being medically retired.
11 MS. MALEBRANCHE: So while they
12 are on the TDRL status, they are receiving
13 care from active duty or outside?
14 LT COL DICKEY: And I may ask our
15 Wounded Warrior rep in the back to chime in.
16 My understanding would be that is going to
17 depend on where they are and the clinic
18 availability in a term, because you may be
19 TDRL in a different location and then it may
20 also depend on if you move to a different
21 location, does that clinic have capacity?
22 Colonel Black, I don't know if you

had anything to add to that?

LT COL BLACK: Yes. Most of them are receiving care through the VA, but there is a reveal period and we try to -- you know, as Wounded Warrior Program, we try to keep them and make sure they are being seen by the VA, because there is a reevaluation period that they have to have. And that's through the MTF or the reveal.

MS. MALEBRANCHE: Do you have any idea of the return to duty rates?

LT COL BLACK: I would have to get you that number. I know it is very low.

MG STONE: Yes, in the Army, it's under 15 percent, if I remember correctly.

MS. MALEBRANCHE: Thanks.

LT COL DICKEY: Other questions? Maybe I will sit down and we'll do the panel?

MS. DAILEY: I think we have paneled out.

LT COL DICKEY: Oh, we are paneled out.

1 MS. DAILEY: Right. But I would
2 encourage any more questions. This is your
3 crack at them.
4 MG STONE: One additional
5 question. We aggressively train deployment
6 and mission success. 10 years in, we are
7 beginning to figure out that if we give two
8 days of training on the back end, we can
9 facilitate reintegration. You all have been
10 involved in MHAT studies over many years
11 looking at this process.
12 Can you talk a little bit about
13 your thoughts on reintegration and whether we
14 can train that? You know, and a bit comes
15 back to some of the resiliency discussion in
16 advance, but can we train reintegration?
17 DR. HOGE: I think that program
18 evaluations, such as what you showed, are
19 important to do, but there are a lot of
20 caveats with program evaluation, because it
21 isn't a random control group.
22 We did the early Battle Mind

1 program. We actually tested in a platoon
2 randomized trail with control groups and we
3 showed that there was a statistically
4 significant difference in individuals who had
5 experienced the highest levels of combat in
6 their, you know, rates of PTSD symptoms,
7 depression symptoms, reduction in stigma.
8 So we showed that we could make a
9 difference with the one hour Battle Mind
10 training, either in a small group or a large
11 classroom setting format, but the effect sizes
12 were minuscule. They were tiny.
13 They did show us that we could
14 make a difference, but the degree of
15 difference that we could make was small. So
16 that's now led into and effort which is we are
17 gearing up now to do a platoon randomized
18 trial of an advanced Battle Mind now called
19 Army. It's not called Battle Mind any more.
20 It's called Army Smart. And we are going to--
21 and that's a sixth session reintegration
22 training process.

1 There has been lots of debate over
2 the years about third-country decompression,
3 you know, such as what this program is. And
4 we sort of -- the Army built-in a
5 decompression process of sorts into the normal
6 reintegration process where individuals have,
7 you know, several days or a week of reduced
8 duty, you know, when they first get back where
9 they are still part -- you know, they are
10 still observed in the unit, but they, you
11 know, have a gradual reintegration process
12 with family.
13 But it has not really been
14 systematically studied, I think. So the --
15 and I think the jury is out on third-location
16 decompression. I think the magnitude of the
17 differences that you are showing I, frankly,
18 don't believe it. I mean, I don't believe
19 that you can get that degree of magnitude from
20 a two day reintegration process.
21 Which is right in the point when
22 everybody is sort of -- that surreal period

1 when you get back, you know, and I would like
2 -- you know, you go to Heidelberg immediately
3 coming back from combat. It's a pretty
4 surreal experience.
5 But that would really lead to
6 measurable, you know, 50 percent decrease in
7 PTSD. I don't believe it. But I think that
8 if we are really going to make a difference,
9 it's going to be a systematic transition
10 training focused on, you know, targeting the
11 high-risk individuals.
12 It probably needs several
13 sessions. One session is not enough. And it
14 needs to really be very specific, you know,
15 combat-related, psychological reactions,
16 physical reactions, emotional reactions and
17 thinking reactions and, you know, that's sort
18 of what we are trying to develop with our
19 platoon randomized trial, which is going to
20 kick off in about -- in April actually up at
21 Wainwright.
22 MR. CONSTANTINE: Dr. Hoge, I may

1 have misunderstood you during your
2 presentation, but I thought you said something
3 to the effect that often times just using
4 medication works as well as therapy?
5 DR. HOGE: Yes, there has never
6 been -- I personally think that therapy is a
7 lot better than medications. From a clinical
8 perspective, there is nothing more effective
9 than rolling up your sleeves and really doing
10 the hard work and the narrative work.
11 There has never been a good head-
12 to-head comparison trial between evidence-
13 based psychotherapy and medication. So, for
14 instance, Zoloft compared with prolonged
15 exposure or Zoloft compared with cognitive
16 processing therapy, we don't have good head-
17 to-head trials.
18 If you look at medication trials,
19 where they compare Zoloft with placebo, and
20 you look at the trajectory of recovery and the
21 percent of people who recover, you actually
22 see very similar -- the 40 percent that I

1 showed for psychotherapy, you see the same 40
2 percent for medications.
3 And so it suggests that -- but 40
4 percent is not good. I mean, it's not
5 adequate treatment.
6 MR. CONSTANTINE: Does that mean
7 when say there are on Zoloft or whatever, they
8 are on it for a specific amount of time? They
9 cease when, you know, the symptoms are gone in
10 the first place? Once they are off of that,
11 then they don't have those any more?
12 DR. HOGE: That really varies from
13 one individual to the next. There is a fairly
14 substantial number of individuals who do
15 recover from PTSD and don't need further
16 treatment. But there is also a large
17 proportion of individuals who have chronic
18 symptoms or they have, you know -- and it may
19 not be the degree it was when they first --
20 you know, when they first started treatment,
21 but that it is still significant.
22 You know, a medication like Zoloft

1 and Paxil, they are not cures. They don't,
2 you know, cure PTSD, but they do help to
3 diminish the symptoms and help the person to
4 function and cope with the symptoms.
5 MR. CONSTANTINE: It just seems
6 like it only works as long as you are on it.
7 Obviously, I'm not a doctor. It would seem to
8 me, yes, it treats us until then -- is that
9 when you are convinced that it's all right?
10 LT COL DICKEY: A lot of people
11 can get off the medications and a lot of
12 people end up staying on them for a long
13 duration. And some times, you know,
14 indefinitely. So it really varies from one
15 individual to the next.
16 They are not the -- Zoloft and
17 Paxil are not the type -- you can get people
18 off them. I have taken people -- I have taken
19 soldiers off Zoloft and Paxil, those sorts of
20 medications.
21 The problematic medications are
22 the benzodiazepines, Adovan, Clonopin, you

1 know, those medications, you know, are -- they
2 are anxiety medications that are widely
3 prescribed for PTSD, but they actually are in
4 the D category evidence, more harm than
5 benefits.
6 And unfortunately, they are still
7 widely prescribed, because they work for
8 reducing anxiety symptoms and sometimes, you
9 know, service members and veterans are so --
10 you know, their anxiety is through the roof.
11 You are between a rock and a hard place and
12 you don't know what to do. The clinician a
13 lot of times these get prescribed by primary
14 care clinicians, not psychiatrists or mental
15 health professionals and those medications can
16 actually -- it can be almost impossible to get
17 them off of it.
18 And when you do try to get them
19 off of it, the anger ramps through the roof,
20 the sleep problems go through the roof. So we
21 -- I think that I was very happy to see that
22 CPG, this most recent CPG, rated downgraded to

1 a D Level evidence.
2 But the dissemination of that
3 information out to clinicians tell them don't
4 use benzodiazepines in combat veterans, that
5 kind of message isn't getting out there the
6 way I would like to see it get out there. And
7 that's throughout the system. That's DoD and
8 VA.
9 MR. CONSTANTINE: Thanks a lot.
10 DR. HOGE: My pleasure.
11 LT GEN GREEN: I think that we have
12 challenged this panel and so we thank you
13 folks for enduring the tribunal here.
14 Actually, we really appreciate you sharing
15 some knowledge with us. So thank you very
16 much.
17 For the panel, I think, we have
18 lunch next. Thanks. We will be back at 1:00.
19 LT COL DICKEY: Thank you.
20 (Whereupon, the meeting recessed
21 at 12:17 p.m. to reconvene at 1:04 p.m. this
22 same day.)

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

1:04 p.m.

MS. CROCKETT-JONES: Okay. As we settle down after lunch, last year we had received a briefing from the Interagency Program Office and today Mr. David Wennergren, the Assistant Deputy Chief Management Officer with the DoD, is going to provide us with an update on their programs.

Evidently, it is located in Tab Q. And so we can all have our eyes on it and I know we will probably have a lot of questions for you.

MR. WENNERGREN: No problem. Good afternoon. I'm David Wennergren. As the Co-Chair pointed out, my day job is helping to look after the business mission of the Department of Defense and I agreed to take on an additional responsibility for a few months while we are in the process of recruiting for a permanent Interagency Program Office director. And we are like moments away from

1 announcing that selection. We found a really
2 capable candidate. And so I'll be able to go
3 back to my day job, which amongst other
4 things, is providing strategic advice and
5 direction to the IPO.
6 So from the standpoint of the
7 capabilities that they deliver our office
8 manager is the oversight of what they do along
9 with our partners in health affairs and
10 personnel readiness.
11 There apparently was a briefing a
12 year ago, which was a very different briefing
13 and so the story I'm going to tell you today
14 is, you know, this is not last year's IPO.
15 And so I would like to take a few moments now
16 to sort of walk you through what has happened,
17 because there has been a dramatic change in
18 course.
19 And so some of the issues that you
20 were interested in last year have been, as
21 they say, significantly overtaken by events,
22 as over the course of the last year, DoD and

1 VA have gone from, you know, well, sharing a
2 lot of information, but sharing a lot of
3 information in a sort of sometimes awkward way
4 between two legacy systems.
5 So the DoD Team with its AHLTA and
6 CHTS systems and VA with its VistA systems and
7 both Departments were on a path to modernize
8 their electronic health record systems and --
9 through a number of meetings. And it's great
10 to see my Surgeon General partners here,
11 because they have been so intimately involved
12 in this.
13 I said to General Green, he could
14 have given this talk, but he said no, thanks,
15 I'm happy to have you do it, Dave.
16 So over the course of the last
17 year, the Secretaries of the two Departments
18 have made a significant set of commitments
19 about what we intend to actually do together
20 as opposed to trying to include together these
21 two different information systems that this
22 focus has to be on this continuum of care from

1 the moment that you assess into the military
2 until the end of your life as a veteran. And
3 to also include, you know, all active duty,
4 all Reservists, family members, survivors.
5 So the entire population of care
6 that you are a person and as you progress
7 through your life, you may be treated at a
8 medical treatment facility, at a VA hospital,
9 in theater, at a private sector partner, but
10 all of those are sort of instances of care
11 where you are building up a health record that
12 stays with you through your life.
13 And if you imagine the world that
14 way, you would do things differently than try
15 to glue together the world the way we have
16 been for years. And so, you know, I don't
17 want to shortchange what has been happening,
18 because, you know, DoD and VA already share
19 more information than any other health care
20 providers in the world, but it is, as you all
21 know, and as you all hear in the work that you
22 are doing on this Task Force, it's awkward at

1 best sometimes today.
2 And so if you moved away from this
3 world of two systems, the one integrated
4 electronic health record, we could do a much
5 better job. And if I left you with sort of
6 like two sort of catch phrases, it would be,
7 and I'll explain in a little more detail for
8 you, but it's this idea about like patient-
9 focused data and provider-focused
10 capabilities.
11 So the picture I'm going to walk
12 you through is again to this point that from
13 the moment that you joined the military, you
14 are who you are. And regardless of whether
15 you are still on active duty or you are now a
16 veteran, retiree, you know, it's about you.
17 And so you have an identity that begins with
18 you when you step into the military, we give
19 you a common identifier. For the technical
20 folks in the room, it's called an EDIPI, and
21 that number stays with you.
22 When you become a veteran, you

1 don't move to a new numbering system and
2 things like that. So it's one person, care is
3 provided, information is added and
4 capabilities go on.
5 So that's why I say patient-
6 provided data, patients enter data, right? So
7 you have one database tracking Wennergren all
8 through his life, which will help all sorts of
9 things, not only from the standpoint of any
10 physician to being able to see all the
11 information about me, but also when I want to
12 like be involved in my own care and see my
13 information, it makes it a whole lot easier
14 for me to do things like the Blue Button
15 Initiatives that the Departments have done.
16 And then I talked about provider-
17 focused capabilities. And we will talk more
18 about that. But this idea about the
19 clinicians, you know, really deeply involved
20 in what the functional capabilities are, so
21 that, you know, the pharmacy application
22 really does fit the needs of the pharmacist

1 and things like that.
2 So we are going to walk through
3 that. The reason why I'm doing this sort of
4 big long winded introduction is because I saw
5 the kinds of questions that you were going to
6 ask me and I'll, frankly, say some of those,
7 I wouldn't bother. I would think as you hear
8 me talk for the next 15 to 20 minutes, come up
9 with some new questions, because, again, the
10 nature of what we are doing is very different.
11 And so the work that I think you
12 want to help make sure that you understand and
13 hold as accountable for is how are we doing
14 moving on this path that we have now agreed to
15 together?
16 So how we move through the world
17 of what the last IPO Director told you about,
18 facilitating, interaction and interoperability
19 between two big Federal Departments. We have
20 -- we actually went back to the statute that
21 stood up the Interagency Program Office, ^U
22 16.35 of the 2008 Authorization Act. And it

1 was actually worded really well.
2 I mean, it really talked about one
3 organization that would be responsible for
4 delivering capabilities. So acquisition
5 speaking, you know, our Program Management
6 Team finding the capabilities for both
7 Departments. And, frankly, in 2008, neither
8 Department was ready for that.
9 And so the charter of the IPO that
10 was briefed to you last year was much more
11 watered down than what the statutory language
12 said and it was much more about sort of
13 information sharing facilitation kind of
14 organization and we have changed all that.
15 So the two Secretaries agreed that
16 we would go all in together. We wouldn't go
17 modernize separately, VistA and AHLTA, instead
18 we would replace it with something called the
19 iEHR, the Integrated Electronic Health Record,
20 and so we rechartered the IPO.
21 And so this recharter IPO is what
22 I will talk to you about today. There is word

slides, you will have them for your records. I'm going to do a couple of picture slides and kind of walk you through what all the words about the agreements mean and what is moving out.

We are going to come back to governance. I hate to start on governance. It's, you know, but that tells you about what the IPO Director and the organization does now in this new rechartering. And if you have sort of been following this movie, this reads a whole lot more like what the Congressional intent was of having an Interagency Program Office.

So again, I'm not going to spend a lot of time on it in the word version, because I want to go to this really detailed picture slide and just take you for a high-level walk about what this means, because this sort of is at the heart of it. If you try to glue together big monsters, legacy systems, you have hopeless tasks of interfaces and all that

kind of stuff.

And so again, if you will indulge me, I promise this is the only architecture looking slide I'm going to do for you, but it really sort of gets to the heart of the matter.

The way technology works today, you have these opportunities to use a service-oriented approach to do things much more rapidly in a much more open way than we ever did before. And so if you think about sort of past -- the past world of IT systems development, you know, you would build this big or you would go buy a big monolithic system, proprietary data and tightly coupled to applications and it made it very hard to work with others.

And that's why all the challenges that you have seen about how do you share information between a tightly coupled DoD system and a tightly coupled VA system.

So the set of agreements that the

1 two Secretaries have made and that are now
2 being carried out by the Interagency Program
3 Office is all about that instead, you have a
4 common data model. So there is a -- there
5 will be a database about each and every one of
6 you that has provided care in the system,
7 rather than trying to do bidirectional
8 information exchanges between two systems.
9 The Department of Defense had
10 something called the Health Data Dictionary.
11 It began as a proprietary solution for us by
12 a company called 3M. And the purpose of it
13 was there are these national standards,
14 SNOMED, LOINC, RxNorm, but they are not
15 completely fleshed out yet.
16 So in actually trying to implement
17 the national standards, you have to do a lot
18 of extensions beyond where the standards go.
19 And so the DoD Health Data Dictionary did that
20 extension mapping.
21 And we are making it open, openly
22 available to the public, so that it can become

1 part of, you know, additional augmentation to
2 the national standards and also it can be used
3 by VA.
4 So VA has agreed to take our open
5 data model and now use it across all of their
6 hospitals, too, so we will end up with a
7 common database for the future.
8 Okay. So in preparation for that,
9 VA will be moving into DoD data centers. So
10 we will sort of co-locate first, so in our
11 Defense Information Systems Agency, DISA, we
12 have a Defense Enterprise Computing Centers
13 and VA will be migrating into those data
14 centers, so that we are physically co-located
15 on the journey to their adopting the common
16 data model, so then, you know, we can stop
17 just being physically co-located and actually
18 be one data model, logically available to you
19 no matter where you are in the world trying to
20 provide care.
21 That is a huge deal. And while
22 it, you know, doesn't sound very sexy, I

1 admit, but the data thing is the heart of all
2 of this. If you have a common open data model
3 that everybody can understand, that anybody
4 can write to and anybody can build to it, then
5 all the rest of this begins to work.
6 And so while, you know, like I
7 said, it doesn't sound like a very sexy topic
8 to talk about, it really was crucially
9 important. Crucially important to be able to
10 move forward in a much more rapid way.
11 If you are a fan of these sort of
12 service-oriented approaches, there is
13 something called Enterprise Service Bus that
14 you have to have in place in order to
15 communicate between databases and applications
16 and we have bought one of those for the two
17 Departments together.
18 And then at the very top is
19 something called a Graphical User Interface.
20 And this is like what does the doctor see when
21 they assess the system. And again, that's
22 sort of really important because, if you will

1 indulge me, because I see a lot of iPhones and
2 Androids at the table, if you think about the
3 model of an iPhone or a Droid that, you know,
4 you have this common platform and then you can
5 pick applications to run on that platform and
6 it works pretty seamlessly.
7 And so if you like this idea, you
8 know, if you're not so sure about service-
9 oriented approaches and do they work, they are
10 how you all live your life today. If you ever
11 buy anything from Amazon or you ever book an
12 airline flight on Travelocity or Expedia or
13 Orbitz, this is all how that world works
14 today.
15 So if you have this common
16 platform that all the architectural standards,
17 the application program interfaces all those
18 kinds of things are all publicly known, then
19 any company could provide you a pharmacy
20 application and they could know how it would
21 plug in and how it would work and they would
22 be able to come to our development and test

1 environment and actually demonstrate how it
2 works.
3 So now, anybody could be in the
4 game, right? You don't have to be only the
5 company that does all of that in one vertical
6 instantiation, right? So we could look for
7 the best laboratory applications, the best
8 pharmacy applications. As a user, there is
9 this common presentation and that common
10 presentation was developed by physicians from
11 both sides, so it reflects the, you know, what
12 do you want to be able to see? What do you
13 want to be able to customize on the screen
14 when you go and do things?
15 All right. So and the beauty of
16 that is that no matter where you go, so if you
17 are a military doc and you are stationed at
18 this hospital today and then you go to another
19 hospital, in two years, right, it's the same.
20 Or you are at the first Joint Facility where
21 we do more than be co-located.
22 At the James A. Lovell Federal

1 Health Care Center in North Chicago, all
2 right, we have VA doctors seeing Navy patients
3 and Navy docs seeing VA patients, right? That
4 there is a common way that you look at the
5 information and see it. So it's very helpful
6 not only the standpoint about making this kind
7 of an approach work, but also to reduce
8 retraining costs and things like that.
9 And then the heart of the matter
10 is this sort of like these applications,
11 right? So it's a much more modular approach
12 and it is sort of a radical departure from the
13 way DoD and VA have traditionally looked at
14 health care systems, but it is something that
15 we see more and more happening in the rest of
16 the world.
17 InterMountain Health, I think I'm
18 going to get that company's name right, is
19 doing this. Singapore, there are other
20 countries that have adopted these kinds of
21 modular approaches. And the beauty of it is
22 because it's all sort of standard space,

1 again, you know, you don't have to get all
2 these applications from the same company.
3 So every time you want to go look,
4 you could pick the best one that's available.
5 And so there is a process working for that
6 that is heavily involving the clinicians. So
7 again, I said patient-focused data approach
8 and provider-focused application work.
9 And so again, I don't want to dive
10 too deeply. I'm going to try to do a quick
11 story and then you guys can ask me questions,
12 so we can get at the heart of what is on your
13 mind.
14 But the way it works is this, so
15 we will take pharmacies as an example. If you
16 want to have a common pharmacy application,
17 you are going to actually have to agree to
18 requirements and business processes, which is
19 something that had never happened before.
20 And so a team is formed that
21 involves pharmacists from both sides coupled
22 with people that are good at documenting

1 requirements, people who are good at Lean Six
2 Sigma continuous process improvement work and
3 for the first time ever, we have actually
4 mapped common processes and agreed to them.
5 So that pharmacy is not done
6 differently in VA than it is done in DoD and
7 what it means to do drug/drug checking and
8 drug allergy checking is not done differently
9 in the two organizations.
10 And so for the first time ever, we
11 are starting to take these functional
12 capabilities and agreeing to a common way
13 ahead. And those agreements are made by the
14 clinicians of both Departments. There is a
15 governance body called the Health Executive
16 Council, the HEC, and that's the venue where
17 these requirements are agreed to, so that the
18 Interagency Program Office, which is, you
19 know, an acquiring organization, could then go
20 buy a pharmacy application that met the needs
21 the doctors had described in this new common
22 operating environment and off we go.

1 And there is sort of a chart here
2 on this page that sort of just digs into that
3 for you. And again, I'm not going to spend a
4 lot of time on each of these, but you have
5 them all and so you are welcome to peruse them
6 at your leisure, but this sort of like lines
7 out for you. There is a lot of functional
8 capabilities that will go into this and they
9 will be built in groups and delivered over the
10 next several years as we move forward.
11 There was a governance chart here.
12 I'll slide back to it now, which is Chart 4 in
13 your presentation. This is how we have
14 organized to do it. It's always -- this is
15 not so much technologically complex. This
16 idea of modular applications that are
17 available anywhere is, again, the way you live
18 your life if you have an iPhone or an Android
19 or an iPad or something like that.
20 But it is a little different for
21 the Government and so, you know, we wanted to
22 make sure we had a strong governance in place

about how you were going to go ahead and do that.

And so the way it works is the IPO, if you will, is the Program Management Office. So we have all the kinds of people you would see if you were looking at the Joint Strike Fighter or any big business system, the kinds of program management people that actually go out and acquire things.

All right. And then there is an IPO Advisory Board that is co-chaired by the two acquisition decision authorities, my boss, Beth McGrath on the DoD side, the Deputy Chief Management Officer, and Roger Baker the VA CIO, but also has membership from all the sort of key communities of each Department.

So I think the leaders in health care, the leaders -- the Comptroller, the acquisition team, so all the folks that were-- if you were a different kind of program, we would call it a Defense Acquisition Board. So the membership of the people that go and help

1 you advise, so your CIO is involved, your
2 Assistant Secretary of Defense for Health
3 Affairs, your Under-Secretary of Defense for
4 Health, on and on to try to help make sure
5 that we're getting it done right.
6 This yellow world is the -- is
7 I'll say sort of like the world of the
8 clinicians, the functional view. And forgive
9 my acronyms, that's the Joint Executive
10 Council, the Health Executive Committee and
11 the Benefits Executive Committee, which are
12 the existing governance bodies between the two
13 Departments that are overseeing the
14 partnership between VA and DoD.
15 So we wanted to leverage them,
16 again, as I said, so that the clinicians are
17 driving the -- this is what I need a
18 laboratory application to be able to do, so
19 that the people over here, who are IT-
20 acquirers, could go get the thing done with
21 the help of the technical folks.
22 The team reports to the -- if you

1 have ever read the statute, the Director
2 reports to the two Secretaries and gets their
3 day-to-day direction from Beth McGrath and
4 Roger Baker. For those of you that are deeply
5 involved in this, there is a lot of OpenSource
6 talk and there is this OpenSource custodial
7 agent.
8 VA and DoD had sort of different
9 needs that they were working on. DoD had done
10 a good job, I will say, of coming together to
11 a common data model. And so we actually have
12 a central data repository for all of our
13 medical treatment facilities.
14 VA was maybe less aligned about
15 data, but had done a much better job, I think,
16 of, you know, the applications being what the
17 clinicians liked. And so we tried to play to
18 people's strength and that's why, you know,
19 heavy DoD involvement and aligned to the
20 common data model, heavy VA and clinician
21 involvement in getting to that common look and
22 feel of it.

1 All right. And so we are moving
2 forward together. VA's system, VistA, was
3 very old. And they felt like it had sort of
4 languished over the years and it wasn't being
5 as innovative as it could be.
6 And so they took the VistA Source
7 Code and put it into the OpenSource, meaning
8 that anybody could now come and look at it and
9 build on it and try to improve it. And so if
10 you have heard that phrasing, there is this
11 idea about how OpenSource software could be
12 beneficial here.
13 And I don't want to dig into that
14 too far, if you are not like an OpenSource,
15 you know, aficionado, but I will say it to you
16 this way, that what we want to be able to do
17 is we are looking for the best and the
18 brightest, to offer the best applications in
19 a way that works.
20 And that work could come from any
21 one of the big current providers of Health IT
22 Solutions, the Epics, the Cerners, the GEs,

1 the Siemens, all the people that are in this
2 business. It could be some new company that
3 is able to take OpenSource software and
4 develop it and so we will look at, you know,
5 sources of supply, if you will.
6 We will look at what are the best
7 applications that are available for each of
8 these needs? And we will put them into place.
9 Some of them may be OpenSource software, some
10 of them may be proprietary software, it won't
11 matter though, because it will have to plug in
12 in that open architecture that we described.
13 So that's the governance structure
14 that we are trying to get ourselves to.
15 James A. Lovell Federal Health
16 Care Center, that's the North Chicago
17 organization, there are several places where
18 DoD and VA sort of live together, but North
19 Chicago is the first place where we actually,
20 you know, opened it as a single integrated
21 facility.
22 And so I have this one slide just

1 to sort of help baseline this all, because
2 people tend to commingle those phrasings. So
3 iEHR, the Integrated Electronic Health Record,
4 is this new system. The system that we will
5 be implementing that will replace AHLTA and
6 VistA. They will be retired.
7 And we will have a new Integrated
8 Electronic Health Record, the new single
9 system for both Departments. All right.
10 That's about building this new thing that we
11 were just talking about.
12 North Chicago is all about gluing
13 together the legacy world of today. And so in
14 North Chicago, we opened up a single facility
15 which was very helpful to both of us. It
16 avoided the Navy having to build a new
17 hospital on the Great Lakes Naval Training
18 Center.
19 So we moved into a common
20 facility. And it's providing a lot of other
21 value, too, because, you know, docs can see
22 different kinds of patients and can get

1 different kinds of experiences and, you know,
2 we can share resources and combine resources.
3 But it's really important from the
4 standpoint of understanding the difference
5 that we recognized that North Chicago is not
6 about iEHR. It's not about this new system.
7 It's about how do you let a physician walk
8 into a room, take their identity card and
9 stick it in the machine and be able to see
10 what is in the VA system and what is in the
11 DoD system.
12 So North Chicago is all about how
13 do you glue together these two legacy systems
14 so that you could provide care today across
15 the two spectrums of patients.
16 So, you know, you get onto a
17 computer or you can be a VA doc senior Navy
18 patient, you stick your card in, your VA card,
19 stick your DoD Common Access Card in, and
20 through this kind of software stuff, you know,
21 you can look back into the existing legacy
22 systems.

1 And so a lot of work has gone on
2 there. There is, you know, a couple of slides
3 here that help you see what they have done so
4 far, what they have implemented, you know, the
5 facility has gone live. They are seeing a lot
6 of people.
7 It is still sometimes cumbersome
8 for them, because, again, they are working in
9 the legacy environment, so there are work
10 arounds that have to be done, you know, some
11 additional pharmacists on duty to help make
12 sure that we're tracking patient drug
13 interactions and things like that.
14 And so what we would like to do in
15 North Chicago is let them be an early adopter
16 of the iEHR. So when we buy the pharmacy
17 application for the big new system, we will
18 put it into place first in North Chicago,
19 because it will help them.
20 And so where it helps North
21 Chicago to do their job better and faster,
22 where we can address, you know, efficacy of

1 care and patient safety issues and things like
2 that with the new capabilities, we will go
3 first to North Chicago. But we may not go
4 first to North Chicago with everything,
5 because they have, you know, some of the
6 capabilities already working fine for them.
7 There are some -- this is a
8 picture of the -- I'm talking about the
9 graphical user interface, this presentation
10 layer, this was the -- just sort of a picture
11 of what the team designed, the team of docs
12 from both teams. I won't bore you with that.
13 There is some interesting stats
14 about North Chicago. It is a great laboratory
15 about, you know, what is it like to try to
16 work across two big organizations, but they --
17 but, you know, I throw them up there for you,
18 just so you can see they actually are doing a
19 lot of work. And so they continue to treat a
20 lot of people, do a lot of prescriptions, do
21 a lot of care instances and we are learning a
22 lot from what they are doing there.

1 MR. CONSTANTINE: But, sir, that
2 took years and years and years to come about,
3 didn't it?
4 MR. WENNERGREN: Well, North
5 Chicago has been in place for a long time,
6 but, frankly, it was, you know, a little over
7 a year ago that people got really serious
8 about how are you going to put the IT stuff
9 into place to glue together. It opened for
10 business like last fall, that's when the new
11 facility finally opened up.
12 And so they have been live now
13 since November or so as a joint facility.
14 Before that, it was a lot of work that was
15 going into building a single building and all
16 this sort of preparatory work that was going
17 on there.
18 MR. CONSTANTINE: I was on -- I
19 worked on Capitol Hill in 2009 and I was going
20 to meetings then and that was very late to the
21 game. There were people who had been there,
22 you know, years working on this issue and

1 trying to judge to see, so I don't know. It
2 just seems like this is a really unique
3 situation what we have in North Chicago.
4 MR. WENNERGREN: Yes. It is a
5 unique situation. And that's why I thought it
6 was important to sort of call it out for a few
7 moments, because it's easy to sort of conflate
8 the two issues together, all right, this idea
9 that, you know, over the last year we have
10 decided to move away from each of us going our
11 own way to this issue about how do you make
12 two very big systems, that are completely
13 separate, actually talk to one another?
14 Right? And so you are right. A
15 lot of effort has gone into North Chicago
16 about how do you make the two existing things
17 talk to one another, right? Which is
18 necessary, but awkward at best and now the way
19 you want to run, you know, as we move from one
20 place to 300 major hospitals, 1,400 major
21 facilities and all that kind of stuff, right?
22 And so that's why I wanted to sort

1 of emphasize that. So North Chicago up and
2 running for about nine months. People working
3 on it for years before that about what would
4 it be like to have this joint thing? And to
5 your point, the demonstration project ends
6 2015 is when they do the report about how did
7 it go.
8 But by that time, our hope is that
9 we will have some of these capabilities in
10 place for the new way ahead that we will not
11 only be able to do like the results of what
12 happened to the demonstration site in North
13 Chicago, but what is happening writ large
14 across the big organizations.
15 We were able to -- at North
16 Chicago so the presentation layer was
17 developed first at Tripler and has now been
18 moved to North Chicago, so now we have a
19 second site doing that new presentation look.
20 And again, we hope North Chicago will be one
21 of the first places to get the pharmacy
22 application at the end of this year, so they

1 can start seeing how it will work when it is
2 not just about talking back and forth between
3 the two legacy systems.
4 All right. So I talked fast. I
5 used a bunch of IT tech words. I'm sorry for
6 that. Right after lunch, you know, I know
7 it's kind of hard. There is so much more I
8 could have said about all of that story, but
9 I didn't want to get in the way of time for
10 your questions.
11 So if you have some questions,
12 like help me and I'll dig into, you know,
13 whatever I talked about quickly that you would
14 like to know more about.
15 MS. CROCKETT-JONES: Yes, I'm
16 wondering what is your timeline for getting
17 these applications selected? I mean, if there
18 are commercially available, I'm wondering how
19 many you are finding are likely to be
20 commercially available?
21 And it's -- the thing that I'm
22 wondering about in my head is that, you know,

1 considering a timeline for getting
2 applications when you have got a pilot GUI,
3 you're going -- it's going to have morphed how
4 many times by the time your applications get
5 in place, which might -- will that -- you
6 know, are you worried that that will then
7 change your applications?
8 MR. WENNERGREN: Yes.
9 MS. CROCKETT-JONES: I mean, you
10 know, some of this has to be happening pretty
11 quickly with a lot of very fragile glass balls
12 in the air, it seems.
13 MR. WENNERGREN: Yes. Although, I
14 will tell you, we can take some encouragement
15 again from my examples about iPhones and
16 Androids that this model about if you
17 understand the standard -- and we commingle
18 terms, because people know about OpenSource
19 software.
20 OpenSource software just means
21 that the software code is known to everybody
22 as opposed to, you know, proprietary software

1 that nobody gets to see. But I would rather
2 focus less on OpenSource software and more on
3 the idea about an open architecture.
4 I mean, that everybody gets to
5 understand what to build to. So APIs,
6 Application Program Interfaces, what do you
7 need to do to plug in that everybody knows?
8 Right? So our idea is that we will publish
9 all of our architectural interfaces. We will
10 have a development test environment for DoD
11 and VA together.
12 So that any company that wants to
13 come in and demonstrate, they have something
14 that works, can come and show us that it
15 works. All those things will help speed the
16 time to market to get capabilities in place.
17 But I want to be really realistic amongst
18 ourselves that this is a huge endeavor.
19 I mean, you know, this is --
20 between the two of us, we are like 18 million
21 patients, right? I mean, so this is like a
22 really big deal. And it's not going to get

1 done overnight. It's going to take, you know,
2 our best guess is 2016, the end of 2016, so
3 four years to get to the place where you are
4 sunsetting the legacy applications.
5 Now, having said all that, there
6 will be application sets and that's what this
7 chart is trying to show you. The capability
8 sets get delivered in waves. And so, you
9 know, long before 2016, people will have new
10 applications like laboratory and scheduling
11 and immunization and pharmacies. There will
12 be capability sets available earlier.
13 But to your question about all the
14 balls in the air, you know, one of the things
15 that I think will help is the presentation
16 layer talks to an Enterprise Service Bus and
17 exchanges information within the application.
18 There is a common data model at the bottom.
19 If you have agreed to the data model, and you
20 have agreed to the Enterprise Service Bus on
21 that chart that I had up before, the
22 applications are really invisible to the day-

1 to-day user.
2 And so the ability to sort of plug
3 in an application, I mean, you know, I don't
4 want to over-simplify, because, of course,
5 we're talking about really significant issues
6 about caring for our people, but, you know, if
7 you go to the iPhone, if you go to the iTunes
8 or you go to the Android marketplace, then you
9 can buy multiple applications that do a
10 stopwatch capability.
11 And as long as it works and plugs
12 in, you, as the user, you know -- I mean, it
13 shouldn't look different to you, because what
14 you are seeing is that common presentation
15 look and feel.
16 So it will take several years. It
17 will be done in waves. There is only so many
18 applications you can be developing and buying
19 at the same time. But because you are going
20 to have this common architecture and common
21 presentation layer all built to standards, you
22 could keep improving the look and feel of the

1 presentation. You could keep adding
2 applications to it. And it should be able to
3 proceed.
4 DR. TURNER: Sir?
5 MR. WENNERGREN: Yes?
6 DR. TURNER: With both DoD and VA
7 being global enterprises, could you comment on
8 bandwidth requirements and issues?
9 MR. WENNERGREN: Yes. Well, it is
10 and it is certainly much broader than health
11 care, right? I mean, because whether or not
12 it's about unmanned aerial vehicles, right?
13 I mean, the proliferation of data flow images
14 is just something that is -- you know,
15 dramatically increases every day.
16 And so I don't want to belittle
17 that point. It is really important. We've
18 got to keep it in mind, but it goes -- spans
19 far beyond. I mean, health care is a player
20 in a much bigger global issue about
21 connectivity to the battle field, connectivity
22 to people and, you know, disadvantaged users

1 and low bandwidth or intermittent
2 environments.
3 There are some things that you can
4 do to help and this kind of an architecture --
5 no, see I'm on the wrong slide. Now, this is
6 the capability set. But the architecture
7 picture slide, this kind of an architecture
8 allows you to cache data where you need it and
9 things like that, so you can do some things to
10 sort of reduce the amount of information that
11 has to flow between point to point at any
12 given time.
13 So there are some things that will
14 be done by doing it this way that will help
15 with that, too. But I mean, overall, we just
16 have the issue of ever increasing demands for
17 bandwidth. And so, you know, sort of more
18 globally than just this, the underlying
19 communications infrastructure of the
20 Department is something that, you know, a lot
21 of people are spending a lot of time on to
22 continue to stay ahead of all the bandwidth

needs that we have.

MSGT MacKENZIE: Let me ask you this question real quick. So I'm trying to get my head around this.

MR. WENNERGREN: Yes.

MSGT MacKENZIE: We're got two separate systems. We are agreeing on a couple of models here, but those models aren't, you know, the presentation, the ESB. WE are agreeing on those. But they don't interface with our current systems.

MR. WENNERGREN: Well, okay.

MSGT MacKENZIE: So the question I have is while these models are coming on over a period of time until 2016, are we using this and that? So is the DoD using AHLTA and this? Is the VA using VistA and this?

MR. WENNERGREN: Yes.

MSGT MacKENZIE: Until some time in the future where they --

MR. WENNERGREN: Here is the --

MSGT MacKENZIE: -- collapse

1 together?

2 MR. WENNERGREN: -- way it kind of

3 works, right? So the Enterprise Service Bus

4 is the thing that allows the information to

5 flow and an Enterprise Service Bus can connect

6 information from application to your new data

7 model or speak to your legacy data models.

8 So you will have AHLTA and VistA

9 are in place today. They are not going to get

10 sunsetted yet. But over the course of the

11 months and years as we go forward, you will

12 have more and more basis that are now using a

13 new pharmacy capability. And they are using

14 a new laboratory capability.

15 And so these capability sets as

16 they come on-line are implemented at the

17 facilities, right? And so old data is still

18 in the old database, the current legacy ones,

19 access to the Enterprise Service Bus and

20 eventually you move into a new data model

21 where the new information will be stored one

22 way, so one continued database goes through.

1 But for today, right, you still
2 have people trying to get their job done,
3 right? And so the legacy systems exist.
4 Eventually all the capabilities of legacy
5 systems are no longer used and the Legacies
6 are sunsetted.
7 There comes an intervening year
8 where some capabilities are still being --
9 some facilities are completely on the legacy,
10 some facilities are using the legacy for some
11 capabilities, right? And so as you go
12 forward, you will have groups of capabilities
13 that get implemented at places.
14 So eventually, you will have
15 everyone on the new pharmacy solution.
16 MSGT MacKENZIE: So --
17 MR. WENNERGREN: You will
18 eventually have everyone on all the new
19 capabilities.
20 MSGT MacKENZIE: So when do these
21 systems --
22 LT GEN GREEN: Mack, if I can --

1 MSGT MacKENZIE: -- start talking
2 to each other?
3 LT GEN GREEN: Mack, if I can
4 help?
5 MSGT MacKENZIE: Yes.
6 LT GEN GREEN: The other thing
7 that he is not talking to North Chicago very
8 much today, but the single sign-on context
9 management that they have put in in North
10 Chicago actually allows you on the same screen
11 to bring up AHLTA and VistA.
12 MR. WENNERGREN: Right.
13 LT GEN GREEN: And when you put a
14 name in, it actually brings up the records in
15 both AHLTA and VistA on a single screen. And
16 so if you think about that, that means that
17 you could leverage some of the work that has
18 already been done to essentially bring a new
19 system on, so that it would show, in our case,
20 AHLTA and now the iEHR.
21 And so you basically would tip
22 over, because you are just deciding where it

1 is pulling data from and so it actually would
2 allow you to just -- essentially at the
3 provider level, they simply would have both
4 screens for a while until the new system is
5 mature enough that you could actually bring it
6 on.
7 MR. WENNERGREN: And then you
8 would have the new screen, which is the new
9 common presentation layer. And behind that
10 presentation layer, it may be getting, you
11 know, old data from the legacy system and new
12 data from the new data model, but to you, you
13 are seeing one common screen that is the
14 screen that you use to provide care.
15 MSGT MacKENZIE: But my point, I
16 guess what I'm getting at, is unless I'm in
17 North Chicago, when I go to the VA in two
18 years, is the VA going to be able to look at
19 my AHLTA stuff or are we still going to be
20 having the same problem?
21 LT GEN GREEN: And so behind the
22 scenes on the legacy systems, there is a lot

of work going on in terms of consolidating the data to get them into common data centers, so that you can, basically, then -- well, I don't want to get into too much of the details, but the reality is as they consolidate the data as they go to a virtualization system, where you are not -- no longer on your computer do you have the software, but now the software is actually run out of a server somewhere.

MR. WENNERGREN: Right.

LT GEN GREEN: And so it gets into a lot of cloud computing type things that are going on all across the country right now.

MR. WENNERGREN: Yes.

LT GEN GREEN: But in the end game, the reality is the magic in the legacy systems is consolidation of the servers and the virtualization that allows you then to make these linkages a lot easier.

MR. WENNERGREN: And one of the things that will be the first things that you see at DoD and VA facilities is that new

1 presentation layer, right? Because that will
2 be the thing that allows you to have a common
3 look and feel and depending upon, you know,
4 whether we are talking about three months from
5 now or three years from now, how it is drawing
6 data and what applications it is actually
7 accessing behind that presentation layer,
8 right, will transition from I'm accessing an
9 AHLTA pharmacy capability to now I'm accessing
10 an iEHR capability.
11 But you will have a common look
12 and feel about how you do -- you as a
13 physician provide through the interaction.
14 MSGT MacKENZIE: For me, it was
15 just in my simple mind, it's like common look
16 and feel means nothing if you are not getting
17 to look and feel information from a different
18 system. So that's what I was just asking how
19 long that transition until that happens is
20 going to take and that's kind of where I was
21 going with that.
22 MR. WENNERGREN: Sir?

1 DR. PHILLIPS: Let me ask a
2 somewhat uncomfortable question and it's not
3 directed at you. You don't have to answer.
4 It's so I can make a statement.
5 MR. WENNERGREN: Okay.
6 DR. PHILLIPS: I want to talk
7 about the forest, not the trees. I mean, we
8 are trying to get maple trees to mate with oak
9 trees and apples and oranges and I'm -- I run
10 an IT Division at the NIH. Has anybody
11 discussed -- well, let me even back up.
12 Someone just mentioned, as we were
13 walking in to this session, we have one
14 monetary system, one monetary system. I know
15 it is perhaps is not, you know, the American
16 way 100 percent, but has anybody discussed we
17 just need to have Congress mandate a single IT
18 system that not only works for the VA and the
19 DoD, but works for everybody in the U.S.?
20 It can be done. And I would
21 suggest, I haven't looked at the numbers, that
22 it could be done for a lot less money and in

a lot shorter time than what we are trying to do.

Again, it's not directed at you.

MR. WENNERGREN: No.

DR. PHILLIPS: But I just kind of want to get something across.

MR. WENNERGREN: Well, I wanted to let you do your statement.

DR. PHILLIPS: My theory on the record.

MR. WENNERGREN: I want to let you do your statement, but I have an opinion, if you want my view on it.

DR. PHILLIPS: I would love it.

MR. WENNERGREN: I would offer to you that I would just adjust your language a little bit, because I think what ends up happening, my experience has been that when we say IT system, we become very enamored with the shiny object syndrome.

So we go well, I want that. I want to implement an SAPERP or, you know, GE

1 such and such and then that's all I care
2 about. And I stop thinking about data
3 standards and I stop thinking about
4 requirements and I start just talking about so
5 where am I with a system named such and such?
6 And I think to the heart of your
7 point is if you could align everyone to a
8 common set of standards about this is the way
9 data is presented and looks and feels and this
10 is how you access it, then again to the point
11 about, you know, the dirty little secret is,
12 I mean, what applications are running in your
13 iPhone? I mean, it really doesn't matter.
14 So you can actually have different
15 applications. I mean, Kaiser Permanente have
16 a different application than, you know, INOVA
17 or somebody, right? But they are able to like
18 talk to each other, because it's the same
19 standards and same thing.
20 So I think you are exactly right.
21 It's our belief and it's one of the reasons
22 why folks like the Federal CTO and others have

1 become excited about what we are doing here is
2 our work -- it's our belief that the work that
3 we are going to do in this regard to flesh out
4 the national standards are things that could
5 be used by the entire nation.
6 This idea about, you know, if I
7 could decouple -- you know, it comes to best
8 of breed. And again, I don't want to talk
9 about some specific company so much, but, you
10 know, so Company A may have like a really cool
11 pharmacy and a mediocre laboratory solution.
12 In the past, you just had to buy
13 it all from them. Right? But now you don't
14 have to. And so, you know, if you have this
15 agreement on common data standards that
16 everyone is going to present their health
17 information the same way, and how does that
18 work, then you are right, you could get to
19 this thing that would be much bigger than just
20 VA and DoD, which is what I'm talking about
21 here, and help us with the national efforts
22 like VLER and things like that.

1 DR. PHILLIPS: Well, thank you. I
2 mean, I'm at the National Library of Medicine.
3 SNOMED and LOINC standards --
4 MR. WENNERGREN: Yes.
5 DR. PHILLIPS: -- are our way of
6 life.
7 MR. WENNERGREN: Absolutely.
8 DR. PHILLIPS: And, you know, I
9 just think it's a slippery slope to hope that
10 APIs and other technologies will get this to
11 be really robust and work at the trench levels
12 for sure.
13 MR. WENNERGREN: Well, I think
14 it's a combination of the open architecture,
15 but the demanding alignment to standards.
16 Right? And so I think that's why, you know,
17 we are working closely with Betty Humphreys
18 and others to talk about, you know, so this
19 stuff that we have could further extend --
20 But then to your point, I think
21 there is the national issue about so you are
22 going to demand conformance to those

1 standards. I mean, for example, identity is
2 like an easy one and it becomes a very touchy
3 subject when you go national, but, you know,
4 I mean, you've got to have a way of
5 identifying -- we have two big identity
6 management issues just for us.
7 The one is that you are a patient
8 and so I know who you are regardless of where
9 you were treated. So we have agreed for the
10 18 million people that we all look after in
11 DoD and Va, we are going to have a common
12 identifier about who is Wennergren?
13 And then the other identity issue
14 is I'm a provider of care. And I need to be
15 able to do the attribute-based access thing
16 that when I stick my card in it says well,
17 Wennergren is allowed to see General Green's
18 record or he is not, right? And he is allowed
19 to see these kind of capabilities.
20 And so those kinds of identity
21 problems we are solving for us, but they beg
22 a broader national conversation about

alignment for identity and things like that, too.

DR. TURNER: Sir, also across both enterprises, there is a wide spectrum of infrastructure differences. What are the infrastructure requirements and will it operate seemlessly on current/existing infrastructure?

MR. WENNERGREN: Well, you know, there is -- this is ubiquitously over-used words like seemless and IT connectivity, right? So I will say this, that, you know, this is like a web services-oriented approach. And so, you know, the computing infrastructure of the two Departments today can handle this, right? And so, you know, is it incumbent upon both Departments to make sure they are not letting their IT connectivity get stale, right?

Because I mean, you know, you are going to need -- you are just going to -- I mean, whether or not it is about radiological

1 images, MRIs and things like that or it's
2 about hand held devices in operating rooms and
3 things like this, this is sort of like
4 advancing the cause about wireless
5 connectivity and broadband connections and
6 stuff is, you know, an important part about
7 what both CIO organizations of DoD and VA have
8 -- are putting into place across their
9 organizations.
10 But I do not view that the
11 movement away from the Legacies to this is
12 going to create a situation where, you know,
13 suddenly the infrastructure that works now for
14 this awkward legacy environment won't work for
15 them.
16 DR. TURNER: Okay. That was what
17 I was getting at. Would this new system
18 require a major infrastructure investment?
19 MR. WENNERGREN: Well, there are
20 certainly infrastructure costs associated with
21 any time that you move to new systems. But I
22 think what will change is so this agreement --

1 I'm very excited about the fact that the VA
2 has agreed to come into the data centers with
3 us, because by moving into this environment
4 along with DoD, you are able to take advantage
5 of the fact that our Defense Information
6 System Agency already has a worldwide
7 presence.
8 And so they are serving up coms to
9 the war fighter in Afghanistan or Iraq, so,
10 you know, they do a lot of work about around
11 the world connectivity. And so if you have
12 all your data being managed by one team, then
13 you can stage your data and do cache and
14 forward and things like that that help, you
15 know, mitigate against some of the issues
16 about, you know, how much information am I
17 trying to throw across a small pipe versus a
18 big pipe and things like that.
19 DR. PHILLIPS: I have to correct
20 one statement I heard.
21 MR. WENNERGREN: Please.
22 DR. PHILLIPS: I didn't want to

1 give the impression I was talking about
2 electronic health records. It was the, you
3 know, health information exchange.
4 MR. WENNERGREN: Yes, sir.
5 DR. PHILLIPS: That I was
6 referring to.
7 MR. WENNERGREN: Yes, I was with
8 you.
9 MS. MALEBRANCHE: And I would like
10 to ask one other question with regards to your
11 office. We have been talking about health
12 records and I know our questions were geared
13 that way, but for recovering warriors, not
14 only is the health information important, but
15 sometimes where they were stationed.
16 I understand this is a little bit
17 awkward to talk about, but in terms of
18 benefits and things for the recovering
19 warriors, sometimes it's more than just the
20 health record.
21 What is your office in
22 relationship to the Virtual Lifetime

1 Electronic Record non-health part?
2 MR. WENNERGREN: Right.
3 MS. MALEBRANCHE: Are you
4 interfaced with them at all?
5 MR. WENNERGREN: Well, so the way
6 we have divided the world is this IPO, so I
7 care a lot about VLER in my life as the, you
8 know, management guide, DoD. The IPO
9 organization is, you know, the Program
10 Management Office, and it's scope of
11 responsibility is to go buy the IT
12 capabilities for the health portfolio of the
13 two Departments.
14 So think like not managing the
15 legacy today, but all the buying of the new.
16 So whether or not it is the health information
17 technology that underlies the VLER health work
18 or it's the health IT technology to replace
19 AHLTA and VistA with this new iEHR, that's the
20 product set that the IPO manages and looks
21 after.
22 Now, having said that, the two

1 Departments are very focused on the broader
2 issue of VLER and everything from the
3 disability evaluation system to, you know, how
4 you are going to get benefits information more
5 rapidly done. So there are still VLER Teams
6 in both Departments that are working together
7 on that.
8 I mean, and so there are, you
9 know, VLER, they call them VCAs, the
10 capability sets for VLER that are focused on
11 benefits and there is a whole re-engineering
12 project about the integrated disability
13 evaluation system and how to move forward with
14 that.
15 So there are a number of other
16 moving parts about how to share benefit
17 information and stuff, too. And I guess like
18 the -- from my lens, the -- having put it all
19 into a standard format and way of doing it,
20 right, can only help.
21 And some of the things I think you
22 have seen initially with VLER that have looked

1 like more sort of gluing things together take
2 place because we haven't adopted this kind of
3 standard approach everywhere yet.
4 So if something happens in iEHR,
5 it will certainly help VLER. But if you were
6 doing a Venn diagram, right, this is like the
7 set of VLER and this whole big screen is the
8 VLER work that goes on.
9 MG STONE: Dave, May of last year
10 we had a discussion of this. NDAA-11 asks for
11 a risk assessment and that report went up end
12 of last year.
13 MR. WENNERGREN: Yes.
14 MG STONE: Tell us about that risk
15 assessment. Tell us about the deliverables
16 that have occurred since May of last year
17 beyond just management architecture.
18 MR. WENNERGREN: Okay. So we have
19 done technical assessments. We had a lot of
20 concerns on the part of, particularly, the
21 Army, concerns about the legacy and would the
22 legacy be able to survive another four years,

1 so we have done technical assessments of the
2 existing infrastructure approach across DoD
3 and have found that with the improvements that
4 they made over the last two years, as they did
5 a lot of AHLTA stabilization and improvement
6 that, yes, indeed, the legacy system some of
7 the duty cycle survived just fine to get us
8 through the 2016 turnover.
9 In terms of deliverables here
10 besides all the, you know, management
11 agreements, charters, documents, things like
12 that, the Enterprise Service Bus contract has
13 been awarded. The GUI has been agreed to. The
14 presentation, look and feel now has been
15 implemented in two places.
16 We have agreed to the common data
17 model. DoD has opened it up and VA begins
18 mapping at Salt Lake City next month. So the
19 first site is mapping to the new data
20 standards. The pharmacy business process re-
21 engineering has been completed and the
22 requirements has been agreed to by the two

1 Departments through the HEC.
2 And the RFI has been issued and
3 the responses received and an RFP will be
4 going out shortly for that. Laboratory and
5 immunization are following, as well as several
6 other applications are in that next capability
7 set.
8 DISA-VA agreement has been reached
9 and signed off in the beginning of the
10 implementation of moving to the common data
11 centers. That's some of the big ones. There
12 is a lot of North Chicago things, too, that
13 probably are too lengthy.
14 But to General Green's point,
15 single sign off with the context management is
16 in place. Some of the order portability,
17 capability are already in place. Patient
18 scheduling and some of the other initial sets
19 of things that they needed have been
20 delivered.
21 MG STONE: Funding then is
22 adequate to implement this program and you are

1 confident that by 2016, we can begin rolling
2 out of the AHLTA/VistA systems?
3 MR. WENNERGREN: Well, I would
4 have liked to have said it differently. I
5 would like to be rolling off of the systems
6 much sooner than that, because I think this
7 modular approach, I mean, you know, my hope is
8 that there are notable number of hospitals,
9 let's say, we'll use a generic phrase, that
10 are using some of these new capabilities
11 within a year.
12 I would like to have transition,
13 would like to have sunset of the legacy
14 systems by the end of 2016, not beginning
15 migration.
16 MG STONE: We all would have liked
17 that. Are we confident that that can occur?
18 MR. WENNERGREN: Um --
19 MG STONE: Do you really have
20 optimism that I am going to be rolling some of
21 my Army MTFs off of AHLTA and VistA and these
22 systems onto a new system in 12 months?

1 MR. WENNERGREN: Do I have
2 confidence? Let me say that a different way.
3 Do I imagine that there are Army Medical
4 Treatment facilities that are using the new
5 presentation layer in 12 months? Yes.
6 Do I imagine that there could be a
7 couple of places that are implementing
8 laboratory in 12 months? Yes.
9 Will they have implemented that
10 entire capability set? No, not in 12 months.
11 Right? Because you saw the other timeline and
12 how they roll out.
13 It's an interesting question you
14 asked me, because, you know, I was -- I got to
15 go to the HIMS Conference, my first HIMS
16 Conference, which is the big health IT
17 conference 30,000 strong, and I had to go do
18 a panel. And, you know, so forgive me for
19 using my straight man for this conversation,
20 but I got a question like this there and I
21 said well, frankly, you know, it's all of our
22 jobs, because I can see two futures.

1 I can see one future where --
2 because it's not about -- there is not a
3 technological barrier to get this done in four
4 years. The only barriers really are about the
5 cultural barriers, about we do it this way,
6 you do it that way and can we all agree and
7 can we stop all going our own way and make
8 ourselves do it together?
9 And so the key determinant about
10 whether or not this can all get done in four
11 years has a whole lot less to do with whether
12 or not you can go by a laboratory application,
13 because we already know what laboratory
14 application we should probably go by, because
15 we already have one that is being worked.
16 And it will be a whole lot more
17 about how well the two organizations can band
18 together to get it done.
19 MG STONE: So if the services
20 would agree, it would all go faster? Is that
21 what you are saying?
22 MR. WENNERGREN: No. I wasn't

1 trying to just pick on the services. But I
2 would say across both of our organizations,
3 DoD and VA, that the alignment of our efforts
4 together and the speed with which we can
5 commit resources will be the key determinant
6 to how fast the implementation of this goes.
7 DR. TURNER: So you don't feel
8 money is --
9 MR. WENNERGREN: You can see --
10 DR. TURNER: Money is not a
11 problem?
12 MR. WENNERGREN: Not at this
13 moment, no.
14 MSGT MacKENZIE: It's not the
15 speed with which we can -- it's the speed that
16 we are willing to commit resources? Commit to
17 committing resources?
18 MR. WENNERGREN: And the resources
19 are more than money. So the program, the iEHR
20 program on the DoD side is funded, right? But
21 then there is a lot of other people that have
22 to be involved. We need, you know, laboratory

1 specialists and pharmacists and others to
2 help.
3 So, you know, there is a lot of
4 people that have to be involved to get it
5 done. I think it can get done. Can I point
6 to you five IT systems that made huge progress
7 and then didn't deliver on time? Absolutely.
8 Can I give you examples about how
9 a service-oriented approach can help really
10 speed up the delivery of IT capabilities and
11 move us away from the sort of big bang thing
12 that we have done in the past? Yes.
13 So, yes, I think we should be all
14 holding ourselves accountable to having this
15 thing done in four years. And if we can get
16 like 80 or 90 percent there, man, we would be
17 a heck of a lot better off than the 10 year
18 implementations of some of the big, you know,
19 ERP systems that we might have done as an
20 alternative.
21 I think you were looking for a
22 different answer than that, but I mean --

because it's easy for me to say sure, we can get this done in four years. But it will require a whole lot of other people to help make that go and I think that's just what we have to remain committed to together.

MG STONE: And you need to know that my skepticism is not a reflection of your effort. You have been refreshing.

MR. WENNERGREN: Well, I appreciate that.

MG STONE: But you have come from an organization that has had very little accountability in the delivery of systems. And I guess we are all a product of our history and there just hasn't been good accountability to move this and we need this moved. We need this as a unified system.

MR. WENNERGREN: I agree.

MG STONE: And we are all in agreement with that. What is concerning is the amount of time it has taken to stand up to management structure and whether we are really

1 moving in the right direction.
2 I happen to think that if you
3 weren't there, we would have made almost no
4 progress whatsoever.
5 MR. WENNERGREN: Well, I
6 appreciate that thought. You know, it takes
7 a strategic leadership team. I think that,
8 you know, I don't know, I'm deeply grateful
9 for both of your and Bruce's participation.
10 I mean, having the Surgeon General involved is
11 hugely important. Having the leadership team
12 on both sides is the way big change issues get
13 worked.
14 And so, you know, the Secretaries
15 are meeting every quarter. The two
16 Secretaries meet again on Monday. This
17 relentless drum beat about what are you
18 delivering, how can you move faster is what
19 has to happen in any large scale initiative
20 like this.
21 I would -- I would only opine
22 that, you know, I actually think once we made

1 the decision to go together, we have actually
2 moved pretty fast. But I agree with you that,
3 collectively, the DoD's sort of health
4 implementation structure, right, in the past
5 has had the problems that you stated.
6 And so I think that's a fair
7 assessment. And so I think that the best
8 thing we could do is shine a big light on
9 this, right? Because the, you know, biggest
10 problem that you have when two big
11 organizations try to work together is the low
12 trust that is inherent whenever you work
13 across organizational boundaries.
14 And one of the best ways to get
15 over that low trust arrangement is to have
16 like outcome-based measures that you are
17 tracking to and that you are very visible
18 with, so that you can see whether or not you
19 are hitting your targets or not.
20 So I think that, you know, the
21 commitment that we need to collectively offer
22 the broad DoD family and VA family is that

when the permanent IPO director takes over in a few more days, that, you know, we hold them accountable to the outcome-based measures that allow us to see, to your point, you know, like you don't want to wait three and a half years to find out that you are only 30 percent there, right?

And so I think that will be part of what will help overcome some of the lack of transparency that may have existed before. I think it was well-said.

LT GEN GREEN: Dave, the one question I have and it's kind of back to Suzanne's, so I know where we are going with the data centers. I know where we are going with the common GUI. And the apps in order for them to be developed to actually work this have to know how to interface between those two.

MR. WENNERGREN: Yes.

LT GEN GREEN: And so the question, I guess, is when do we think we will

1 have, not so much the common GUI out
2 everywhere, but the common GUI at the test
3 centers or where it's available for others to
4 develop software that would interface between
5 the data sets and the common GUI?
6 MR. WENNERGREN: And this, the
7 Enterprise Service Bus, right, having that
8 deployed at the development test center so
9 people can see how you communicate through it,
10 because that's really the way the information
11 flows, it's crucially important.
12 The contract was just awarded in
13 January for the Enterprise Service Bus. And
14 there is a schedule planned to get it put into
15 place at the development test environment in
16 another month or two, so that it's available
17 so that people can begin to bang against it
18 and see how it works.
19 So, yes, you're right. You're
20 absolutely right. Having the presentation
21 layer and the Enterprise Service Bus available
22 so everybody can see it and see how things

1 work against it is one of the important 2012
2 this year jobs to do.
3 DR. TURNER: Could you provide a
4 screen shot of the GUI for us, please?
5 MR. WENNERGREN: Well, this is --
6 I have a mock-up of one here. It was on your
7 thing, you know, I don't want to begin to be
8 the one who tries to explain to you what they
9 go, because, you know, I'm not a physician.
10 But I will say that, you know, it was designed
11 by a bunch of physicians being stuck in a room
12 together for days at a time until they came up
13 with something that they liked.
14 DR. TURNER: That's not
15 necessarily good, but --
16 MR. WENNERGREN: Well, I would say
17 I actually disagree with you. I think it's
18 actually hugely important as long as they are
19 coupled with -- right, and so the partnership
20 that is important is do you have like the web-
21 savvy people that can say, yes, I know what
22 you are interested in seeing to help you do

1 your job and here is how I can translate that
2 into a technical solution. So I don't want to
3 imply that they were driving around.
4 But I'm very sensitive to the past
5 that I think that the biggest beef that you
6 often find with business systems
7 implementations is, you know, a lack of user
8 involvement until like way, way down the road,
9 right?
10 And so I thought -- so I actually
11 give the VA Team, the champion, this is on
12 both of our behalf, a lot of credit for
13 getting it in early to make sure that they
14 were hearing from the users about what it
15 would look like and letting them actually use
16 it, so we have physicians at Tripler in Hawaii
17 and now physicians in North Chicago actually
18 banging against it and offering ideas for
19 improvement.
20 And, of course, you know, the
21 beauty of the web service's kind of approaches
22 is it's really easy to change this to look

1 like this. It's not something that you've got
2 to go back to Company X and award a contract
3 and spend a gazillion bucks to change.
4 MS. MALEBRANCHE: So, Dave, now
5 that this one is -- I know the Tripler folks
6 had done this and it wasn't -- it was intended
7 to be local, I think, and now it's spread.
8 MR. WENNERGREN: Right. We're
9 expanding it.
10 MS. MALEBRANCHE: But it sounds --
11 so it appears that other hospitals have
12 probably maybe done something similar, I don't
13 know, because we haven't scanned across, I
14 mean, where VA and DoD is together. But now
15 that this is out there, is this a pilot of
16 North Chicago or is this available for the
17 other areas that work together to use, so that
18 they don't start creating or in the process of
19 creating --
20 MR. WENNERGREN: Yes.
21 MS. MALEBRANCHE: -- something
22 else?

1 MR. WENNERGREN: It's a really
2 good question. And it's an important point.
3 And one of the conversations that we are
4 having on Monday between the two Secretaries
5 is all right, so how can you -- because there
6 are -- I may get the numbers wrong. Many of
7 you know the numbers better than me. But
8 there is at least 10 or so joint places, they
9 are not quite as joint as North Chicago, but
10 they are physically co-located and things.
11 And so to your point and to the
12 point that you raised earlier, too, right, you
13 want to be able to get capability in people's
14 hands. And there is no reason why, you know,
15 we can't pick like several more sites for this
16 implementation early, start getting more and
17 more people used to using the common look and
18 feel of the future.
19 We have a -- one of the other
20 deliverables this year is the, you know, sort
21 of portal engine and things that live behind
22 this, so it can be more, you know, scaled

1 really big, right?
2 And so, but, you are absolutely
3 right. I mean, there is some things that you
4 can just begin to adopt more and more places
5 and that's what we are looking to do this
6 year.
7 DR. TURNER: Could you comment
8 real quickly about population disease
9 surveillance capabilities on this?
10 MR. WENNERGREN: Probably not.
11 Could you, sir? Could somebody like far more
12 qualified in the field help me out here?
13 LT GEN GREEN: Yes. It's not
14 determined yet, okay. Whether -- so you have
15 to look at this completely differently. Okay?
16 One of the problems with Karen's question is
17 that, yes, you can put the GUI out so it will
18 be on the VistA or it will be on the AHLTA,
19 but then you are working with the VistA or the
20 AHLTA data sets.
21 And the problem is going to be
22 that if the test centers when we actually

1 switch this is going to be on this new data
2 set. Okay. Because the data sets are
3 important in terms of where the ESB drives
4 things to. Yes, you can point them different
5 ways, but some of the work you do now if you
6 do it on VistA, involves programming in mumps,
7 okay, to basically get things to the right
8 place.
9 We are trying real hard not to do
10 that. So now, back to your question, the
11 reason it's not completely determined is so
12 there is two ways to do this. It could simply
13 be an app, remember the data is the data or it
14 could be that you still have a data warehouse
15 that is basically a data mart that is
16 separate.
17 And so those kinds of decisions
18 depend on what the latency times are depending
19 on the number of users and how this stuff
20 scales.
21 So the reality of your question is
22 a lot of the surveillance stuff today is done

1 in the data warehouse, because you don't have
2 the bandwidth to do some of it across the
3 system. And so in the open source stuff, we
4 have released everything like in terms of the
5 CarePoint apps that are doing a lot of that
6 kind of work today to go into the open source.
7 The question being is it going to
8 be an app that basically you can work on the
9 data set or will there be still a data
10 warehouse that allows you to do more of the
11 surveillance and pomp health work? I don't
12 know the answer yet.
13 DR. TURNER: I think the --
14 MR. WENNERGREN: And then the
15 sweet -- excuse me. The sweet spot for both
16 of your questions has to do with this, you
17 know, so where do you invest your time, right?
18 Because, you know, you can optimize one way or
19 the other and we're going to try to do both,
20 right? So I don't want to have, you know, to
21 spend all of our time and energy on 100 places
22 trying to glue together the legacy, if that

1 comes at the expense of how long it takes to
2 get us off the legacy.
3 And so how can you find the right
4 sweet spot about -- is there some other place
5 that could really benefit from having this now
6 where it does nothing but talk to the legacy
7 or are there more places that begin to benefit
8 from it once they get this plus the Enterprise
9 Service Bus and the data capabilities of the
10 new?
11 And so that's sort of the sweet
12 spot that we have to work our way through,
13 right, because otherwise, you know, you are
14 expending all your energy to continue to glue
15 together the legacy stuff as opposed to
16 spending your energy getting the new stuff
17 implemented.
18 So our hope is we could give more
19 people the GUI, the presentation layer, but I
20 also don't want to spend all of our energy
21 trying to customize it for legacy stuff when
22 we could be building it to fit with the new.

1 LT GEN GREEN: And so my answer to
2 Karen would be what you really want is for the
3 open source to know just like other
4 developers, so private companies, to know the
5 GUI and to know the data set and then you
6 would have your people work on programming as
7 part of the open source effort.
8 MR. WENNERGREN: Yes.
9 LT GEN GREEN: Because now, they
10 would be putting things into what could become
11 the new system. So you would put your effort
12 not into trying to change your new system,
13 your old system to look better on this, but to
14 actually try and do programming, so that the
15 new system will actually show them the things
16 they want. That would be my recommendation.
17 And it kind of stops some of the
18 pilot work, because you start -- instead of
19 having 20 places doing pilot independent work,
20 you have 20 places that are working on a
21 common code at the open source.
22 MS. MALEBRANCHE: Right. Because

I was thinking this, I think, grew out of result of the providers being frustrated and they got together and did this. Well, how many other places are doing that, too, and expending a lot of time, energy and money?

And when if it's going to look like this and we know they might not be ready, but to maybe stop that effort --

MR. WENNERGREN: Absolutely.

MS. MALEBRANCHE: -- and go with this, because --

MR. WENNERGREN: Well, this gets back to the collective, you know, good about how fast you can move, right? I mean, every dollar that is spent building the one off, is a dollar and time away from getting us aligned to this to be.

And so we really need to figure out some way that we continue a conversation that prioritizes on what -- you know, I have a near-term need that is just as important I've got to do, versus, don't do that, because

1 that will never become, you know, enterprise
2 grade. And instead, stop spending your effort
3 on that and help get this, right?
4 And I think that goes to the
5 question about the speed with which it can be
6 implemented. How much diversion is there and
7 how much one-off stuff versus, you know, you
8 are roping everything together, which is one
9 of the reasons why, you know, we told the IPO
10 Director they have to have, you know, direct
11 connectivity to both teams in terms of the
12 legacy span, too.
13 So we can sort of keep an eye on
14 how legacy dollars are being spent as well as
15 the new dollars, so we don't, you know, slow
16 things down that way.
17 DR. TURNER: I think while I
18 appreciate your comment about data mining and
19 data repositories, I just want to be sure to
20 make the point we would be missing a very
21 great opportunity in modern medicine as the
22 first Gulf War has shown and as several -- as

1 our folks come back with different disease
2 processes, as well as scenarios on national
3 security not to have a robust ability to do
4 large population disease surveillance.
5 MR. WENNERGREN: Absolutely.
6 MS. MALEBRANCHE: I'm just going
7 to say that I think it would be very unlikely
8 with open source architecture, which I now
9 understand. When I first saw that open
10 source, I did not understand that you meant
11 that is how the architecture of the data --
12 MR. WENNERGREN: Yes.
13 MS. MALEBRANCHE: -- transferring
14 processing was being presented. I think it's
15 going to be really unlikely for someone not
16 to, for enterprising reasons, create an app
17 for that.
18 MR. WENNERGREN: Yes. I didn't
19 want to give short shrift to your answer. I
20 was hoping from a technical standpoint others
21 might weigh in, but clearly, that's a
22 functional capability can only be improved if

1 you have a common data model then trying to
2 look across legacy disparate databases that
3 don't, you know, map well to each other,
4 right?
5 So I mean, so it's got to help the
6 speed with which you can assimilate
7 information and do business intelligence and
8 things like that.
9 DR. TURNER: Right.
10 LT GEN GREEN: And --
11 MR. WENNERGREN: I'm sure there
12 is --
13 LT GEN GREEN: -- it will
14 absolutely be there. I mean, that's not --
15 MR. WENNERGREN: Yes.
16 LT GEN GREEN: -- a question. It
17 will absolutely be there.
18 MR. WENNERGREN: Yes.
19 LT GEN GREEN: I just don't know
20 whether it is going to be an app that pulls
21 that data from the main data source or if it's
22 going to be a data warehouse. Again, it's

1 just because there are some things that are --
2 MR. WENNERGREN: Part of the --
3 LT GEN GREEN: -- not necessarily
4 today considered iEHR.
5 MR. WENNERGREN: It's part of the
6 continuing --
7 LT GEN GREEN: Yes.
8 MR. WENNERGREN: -- international
9 debate about things like semantic web versus
10 the one big database, right?
11 LT GEN GREEN: Right.
12 MR. WENNERGREN: And so how easy
13 can you pull information from disparate
14 sources, yes.
15 MR. REHBEIN: We talk about two
16 databases, but I think there is actually a
17 third. And that is that one that is
18 distributed out there in the offices of all
19 the TRICARE providers.
20 MR. WENNERGREN: Oh, yes. Yes,
21 well, at least if there is --
22 MR. REHBEIN: Is there going to be

1 a way to capture that, capture all that data
2 or are we going to depend on the United States
3 Post Office staying in business?
4 MR. WENNERGREN: Well --
5 MS. MALEBRANCHE: Well, Dave, not
6 to --
7 MR. WENNERGREN: -- I would like
8 to make sure that we are moving away from a
9 paper-based world, but, you know, there is
10 like a lot of nuances, so the question is yes.
11 So let me start with the things I can control
12 and then the things that groups like you can
13 help with, right?
14 So things I can control is if I
15 have a common data model and I take the
16 national -- and I tell all my partners if you
17 align to SNOMED and RxNorm and LOINC, then we
18 will be able to have a seamless exchange of
19 information.
20 There is implicit in there a need
21 for private providers to move from paper to
22 plastic, if you will, right? So I mean, so I

1 need private sector providers to be able to
2 have electronic record systems, too, but if I
3 publish the common data model that we will be
4 using, it's all standard-based and it's all
5 aligned to the national standards, then it
6 should certainly be able to accelerate the
7 ability of my private sector partners through
8 TRICARE to be able to share information better
9 with me than currently happens today.
10 MR. REHBEIN: Can we convince the
11 IT security people to allow private providers
12 into that system?
13 MR. WENNERGREN: Well, you know,
14 so that's a great question and it's one that
15 I would only give short shrift to, because
16 there are so many competing things. But I
17 think maybe the way to serve that up is they
18 don't necessarily -- there are ways to
19 exchange information that people have access
20 to information in more real-time that is
21 different than the way we might have thought
22 about this in the recent past, which is always

about like I need network access.

And if I can't get network access, right, because you are always going to have the issue about -- to the question that was asked over here. The DoD infrastructure is doing a whole lot of stuff and so how deeply do you want to let, you know, people that you don't know who they are and things like that deeply into your network is problematic.

But having said all that, data can be served up in ways that don't ever let people actually get into your network, but have access to the information if they have the right kind of credentials. But what has to be in place to make that happen?

They are going to have to have an electronic capability. They are going to have to adopt some kind of identity approach, so you could ascertain the veracity of the identity of the individual. So there are some sort of common building blocks that have to be put into place that, you know, I'll sort of

1 defer to the Office of the National
2 Coordinator and others that are trying to work
3 this on a national scale.
4 But, yes, for our partners, I
5 mean, there are -- you know, there is the
6 ability to get a credential just like we have.
7 You know, there is a PIV is the phrase for the
8 SmartCard that DoD and the Federal Government
9 uses. But there is an opportunity for people
10 to have credentials.
11 And so I got to think this is
12 going to help and I've got to think in the
13 meantime the VLER work about, you know,
14 network connectivity and interim information
15 interchange can help with that, too.
16 MR. REHBEIN: I just think that's
17 too big an opportunity to pass up.
18 MR. WENNERGREN: Yes.
19 MR. REHBEIN: And I agree with
20 General Stone, you have taken some really big
21 steps here.
22 MR. WENNERGREN: Well --

1 MR. REHBEIN: Just those two
2 Departments, both making the decision to give
3 up their legacy system and go to something
4 new, that was a -- that's a giant step.
5 MR. WENNERGREN: Yes.
6 MS. MALEBRANCHE: One other thing
7 though, when you said there is a third, there
8 is a fourth, because remember, whenever there
9 is a DoD, there is a VA.
10 MR. WENNERGREN: I think you all
11 are being kind, because I think there is
12 thousands actually.
13 MS. MALEBRANCHE: We will call it
14 -- but our fee-base is the same sort of thing.
15 MR. WENNERGREN: Yes.
16 MS. MALEBRANCHE: And there are, I
17 think, programs. I know when you go overseas,
18 if a patient allows a certain access, you can,
19 I mean, pay for the service and allow that.
20 MR. WENNERGREN: Yes.
21 MS. MALEBRANCHE: But I just --
22 every time that comes up about the network, I

always think well, we have also got the same thing, because I used to think it was only DoD, but it's the same issue -

MR. WENNERGREN: Yes.

MS. MALEBRANCHE: -- that you don't get that information back commonly.

MR. WENNERGREN: Yes. And I would hate for like my optimistic personality to -- I don't want to like oversell anything, because, I mean, these are like complex issues, right? But again, you know, the more you are aligned to standards that are open and understood by everyone, the more everybody can get and look at everybody's information together.

And so you can move away from the sort of kind of less than elegant way that we have like bonded stuff together in the past to a world where information can be seen by many, shared by many if they have the right attributes and, you know, access to the information.

1 LT GEN GREEN: Yes, one final
2 thing on in terms of other people coming into
3 the network and things. The reality is once
4 you have your data standards and your GUI,
5 then, essentially, Dave, if somebody is not
6 electronic yet, I mean, the more open source
7 users the better, because then people should
8 be able to get to it and actually be able to
9 interface.
10 But even if they don't, it's just
11 an application that brings in an e-fax or
12 brings in a scanned document that says I'm
13 going to store those here. And so then you
14 can decide whether you are going to try and
15 make them computable or not later.
16 MR. WENNERGREN: Yes.
17 LT GEN GREEN: But, I mean, if you
18 see what I'm saying, once you get to this
19 point, you basically have -- it's just an app.
20 I need the referrals from the private sector
21 to come in and so I'm going to accept e-faxes
22 or I'm going to accept adjacent -- JPEGs or

1 I'm going to accept whatever.
2 I mean, that's just an app and it
3 tells us where it is going to be stored and
4 links it to a patient.
5 MR. REHBEIN: And I agree it is.
6 It can be a very simple thing. But what I'm
7 scared -- well, what I'm worried will happen
8 is we have trouble now in places where we
9 can't find TRICARE providers. And if this
10 becomes an extra challenge for them, then we
11 have less TRICARE providers and our people
12 have less opportunity for health care that
13 way.
14 MR. WENNERGREN: All right. Well,
15 you have been real patient with me while I
16 talked about a really technical subject right
17 after lunch, but I think we are like almost
18 out of time. Did I do everything that you
19 needed me to do today? Are there any other --
20 MS. CROCKETT-JONES: As far as I
21 can tell, I think we have exhausted our
22 questions.

1 MR. WENNERGREN: All right.
2 MS. CROCKETT-JONES: So thank you.
3 MR. WENNERGREN: Well, thank you
4 for taking on the task that you all have done.
5 MS. CROCKETT-JONES: At least at
6 this -- you know --
7 MR. WENNERGREN: Invite the team
8 back next year, so you can keep tracking with
9 them, because, you know, shine a spotlight on
10 accomplishments is what gets things done. And
11 finding the problems early lets you fix them.
12 MS. CROCKETT-JONES: Well, it was
13 very thorough and thank you very much, Mr.
14 Wennergren.
15 MR. WENNERGREN: All right.
16 Thanks for having me.
17 MS. CROCKETT-JONES: We have got a
18 15 minute break, guys.
19 (Whereupon, at 2:12 p.m. a recess
20 until 2:27 p.m.)
21 LT GEN GREEN: Welcome back.
22 Is that correct, Mayer?

1 COL MAYER: Oh, Mayer.
2 LT GEN GREEN: Mayer, I'm sorry,
3 sir. Commanding Officer of the United States
4 Marine Corps Wounded Warrior Regiment. Last
5 March we received a briefing on the status of
6 the Wounded Warrior Regiment and we will now
7 be receiving an update on their Recovering
8 Warrior Programs, IDES, other briefers who may
9 be briefing are listed in your agenda and will
10 introduce themselves or be introduced as they
11 appear.
12 Please, look at your agenda for
13 the specific questions that they are
14 addressing and their information is in Tab R.
15 And, Colonel Mayer, over to you.
16 COL MAYER: Thank you, General. I
17 was going to introduce my team, but I guess I
18 can't now, but those three gals there, guys,
19 watch out. They are dynamic and they are
20 ready. We have been prepping for this for a
21 month now, I think.
22 And it's good to be back. You

1 guys always put me after lunch and so I
2 promise to be enthusiastic and passionate
3 about what I feel is by far the greatest
4 program in the way that General Amos, our
5 Commandant in the Marine Corps, says semper
6 fidelis and shows it daily by taking care of
7 our wounded, ill and injured Marines.
8 Last year, I gave you an overview
9 of the program and I'm not going to do that.
10 What I would like to do though is give you an
11 update. And I asked to dim the lights and I
12 think they are dim. Are they dimmed?
13 It doesn't seem dimmed, but either
14 way, what I would like to do is just talk
15 briefly about our program as an overview, if
16 you will, and then we will go into the
17 specifics of the Task Force. And if I get too
18 long, ma'am, just give me the hook and I will
19 move on.
20 MS. CROCKETT-JONES: Okay.
21 COL MAYER: I love this picture
22 here. See this Devil Dog here, this triple

1 amputee corporal, Tyler Southern. He is very
2 well-known in National Capital Region. He is
3 at Walter Reed.
4 But what I'm proud of in this
5 film, picture is Corporal Southern is
6 graduating from our Corporal Corps up there.
7 He was one of 15 of his buddies at Walter Reed
8 graduating through a professional military
9 education, a corporal's course, the same
10 corporal's course that every Marine Corporal
11 must go through and is taught at the bases and
12 stations around the Marine Corps.
13 This one was put on by the one
14 here at Quantico and they came up to Walter
15 Reed to give it. And there is Corporal Tyler
16 Southern. If you could see him there, like I
17 saw it that day, very much a United States
18 Marine. Not once has he focused on that he is
19 missing an arm and two legs.
20 Down there -- oops, see you get
21 moving parts from a Marine here and I just
22 probably skipped too far. There we go.

1 Down in the lower corner, there is
2 a beautiful Hollywood-looking family. The key
3 thing here is that our programs have gotten
4 better to support our families and the
5 recovery of the Marines and the families. We
6 say mind, body, spirit and family.
7 And I will talk to you throughout
8 the afternoon about our success in making our
9 programs better.
10 This is Corporal Todd Love. You
11 notice he is very high up, by-leg amputee. He
12 is also missing his left arm. And there he is
13 in Hawaii surfing on his hand and prosthetic
14 hand. Absolutely an amazing athlete that is
15 going to win. And we have programs to help
16 him win always.
17 This picture here I'm very proud
18 of. You know, our motto is "Still in the
19 Fight." And we constantly are proud and are
20 constantly talking to Marines that if they are
21 combat wounded, they can return to the fight
22 and stay in the Marine Corps for an entire

1 career.

2 And Corporal Paccheco there is a

3 scout sniper that lost his leg in Afghanistan

4 on his first tour. He came back, recovery at

5 Balboa and then as part of our Return to Work

6 Program, he went back up to Sniper School at

7 Camp Pendleton and taught other Marines how to

8 be snipers.

9 In this particular photo here, and

10 it's hard to see because of the lighting, he

11 has taken off this prosthetic, is balancing

12 his weapon and he is telling the students you

13 can get a better shot if you stabilize the

14 weapon and you can use almost anything to

15 stabilize it, including my leg, and it takes

16 it off and uses it. Ain't that cool?

17 And the neat thing is he went

18 through the, you know, disability evaluation

19 system and he was found fit and he is now back

20 in Afghanistan as a scout sniper, not as an

21 admin clerk or something like that, as a scout

22 sniper.

1 I'm very proud of that Marine
2 there. And he is one of our focus of ability,
3 I don't know, models or stars and it's on
4 posters across where you find Marines
5 recovering.
6 Take a look at this picture here.
7 Now, if that doesn't bring pride to you, you
8 can't get the full effect, hopefully it is
9 better in your books, but I know that when you
10 look at that picture, what you see is a
11 platoon of Marines. Right? And then only
12 after you study it for a few moments do you
13 say, hey, wait a minute, the whole front row
14 is in wheelchairs.
15 Hey, they are missing their legs.
16 Hey, wow, they could be maybe wounded Marines.
17 But the first thing you always see when you
18 look at that photo is United States Marines.
19 And don't they look exactly what they are,
20 like Marines?
21 In dressed blues, that is Charlie
22 Company at Walter Reed there and that is the

ceremony, the opening of the Walter Reed.

Hey, you want to hear something funny? I know I'm trying to get you all lively here. Is if you could see even better back there is General Chiarelli, he is in the third row and they stuck him right behind all of our Marines. And he is looking at the wave of blue and he is looking for, of course, the Army there and they are not even in the crowd.

So that was a glory day for us and we wave that flag proudly.

This picture here is one of my favorites, those that know me know that I'm a huge horse person. I know that the best thing for the inside of a person is the outside of a horse. And I do my utmost to get Marines on horses.

This is a Navy Corpsman that is recovering with us out of Camp Pendleton. And she is at our second cutting horse classic that we hold down in Oaksville. Our next one, write this down now and I got it for public

record, is 14 April and it has a barn dance afterwards. So I'm looking to all the cute gals there taking notes, bring your hats and your boots and come down and watch the Marines do a cutting horse classic and barn dance.

And, of course, we will feed you well, so I know that's a particular. The best way through to a Marine is through his stomach. So, yes, so come on down to that. But there she is. It takes absolute great self-esteem, renewal of confidence for a wounded warrior, especially a wounded warrior with PTS or with TBI, to get on a 1,000 pound animal and go against cows.

And I am absolutely proud of those that we have in this program and are doing what we do.

That's kind of the I love picture version of this. You guys want more words and facts and all that, so I will -- that's what I'm best at talking about.

I would like to just emphasize a

1 few more points. Just now, I listened to the
2 last five minutes of the gentleman telling you
3 about an application between DoD and VA and
4 all that stuff.
5 I'm telling you now, that I would
6 like you to take your iPhone that's sitting
7 right there and I know you all got iPhones and
8 you go to your app store, and usually I make
9 people do this, I can't make you all do this,
10 but I'm telling you, you need to do it,
11 because at your app store on your iPhone or
12 your Android, you will be able to download in
13 under a minute, and I know because myself and
14 my Sergeant Major have done this, even though
15 my wife won't let me have an iPhone, you can
16 download our app.
17 And that app gives the ability for
18 our section leaders, our RCCs, our Marine
19 patients to immediately reach into a library
20 of wounded warrior knowledge and be able to
21 find the specific questions they need.
22 We just launched it last week. It

1 was developed in-house and it is absolutely
2 fabulous. If you -- I'm telling you folks,
3 just go to your app store and write wounded
4 warrior in your search engine and it will come
5 right up and you will have all the knowledge
6 you all are looking for on this panel.
7 We are very proud of it. And we
8 will -- of course, it needs probably some
9 improvement as we go, but it's there. It's
10 available. Did you get it? Yes, if you type
11 in wounded warrior, it will bring up ours. We
12 are the only one in there, mind you, only one.
13 It's the Wounded Warrior Regiment.
14 It has our symbol. It works better with the
15 iPhone than the Droid, but the Droid does
16 work.
17 Let me tell you something cool
18 while you guys are doing it. I was talking to
19 three wives and their families at Camp
20 Pendleton last week and every single question
21 they asked me, my Sergeant Major who is an old
22 fuddy-duddy, too, he found on our app and he

1 was able to show the gals right there. And
2 they pulled out their iPhones and they
3 downloaded it.
4 I got all of you guys doing this.
5 Wounded warrior, there it is, that one there.
6 You found it.
7 MSGT MacKENZIE: Sir? Sir?
8 COL MAYER: Question?
9 MSGT MacKENZIE: Yes. Did you
10 guys do that through Apple creating that app?
11 And how was -- how did -- what was the
12 relationship in that interface, if so?
13 COL MAYER: Tim?
14 MR. CLUBB: Hi, I'm Tim Clubb.
15 I'm the Program Manager for the Recovery Care
16 Program for the Marine Corps and the Wounded
17 Warrior Call Center. We developed the app
18 under the Wounded Warrior Call Center. We
19 went under that contract. We subbed to
20 another company that develops apps
21 specifically.
22 It was developed through them for

1 us with input from Wounded Warrior Regiment on
2 what they desired to be on that page. All the
3 licensing and coordination with Apple was done
4 through them. So is that what you are looking
5 for?
6 MSGT MacKENZIE: It does, because
7 it's -- you know, we have seen it through not
8 only our site visits, but from my position
9 within SOCOM looking at that same concept
10 going, you know, how do you break into that
11 world. How you get that thing created. And
12 seeing that you guys have done that, that was
13 why I was curious as to how you went about
14 that.
15 DR. PHILLIPS: Mack, I can help
16 you with that. You could become an app
17 developer if you follow the standards of
18 Apple. And you need some technical folks to
19 do that. We do that.
20 COL MAYER: Yes. And I encourage
21 you all to look at it. What it is is it's
22 basically just fact sheets. Well, it's a lot

1 more, but what is in there is digestible
2 information that is written for the families,
3 for the section leaders that are implementing
4 our policies and for the Marines out there.
5 And so it is a great, great
6 resource and it's even cool because old guys
7 like me can do it. So I encourage you to look
8 at it.
9 MR. WILLIAMSON: The benefit to
10 that is that one of the challenges that all
11 the warrior programs face is getting a
12 consistent message to the population
13 regardless of their location. So this
14 diminishes that luck and location factor that
15 often times is the difference between one
16 service member getting the support that they
17 need and another not.
18 Every product that you will find
19 on that site, every slide that you see that we
20 develop provides across the bottom access to
21 us through our call center or through our
22 Wounded Warrior Regiment website.

1 The intent there is to whet the
2 appetite with the information contained in the
3 spread sheet or the fact sheet, but to get
4 them to call into the call center or deeper
5 dive into our Wounded Warrior Regiment site to
6 get a digestible and compliant with regulation
7 response to very common issues.
8 COL MAYER: We gave it to
9 Secretary Campbell and boy, he just loved it.
10 He was playing with it and everything. So I'm
11 just telling you it's addictive. So it's a
12 good thing to be addicted on.
13 All right. The next thing is I
14 wanted to tell you that I just got back from
15 Camp Pendleton where we were running our
16 Marine Corps trials. And the trials and
17 preparation for the Wounded Warrior Olympics
18 or the games that comes up here in May.
19 But I want to tell you there was
20 175 active duty warriors there. There were 50
21 veteran wounded warriors there. There were 50
22 foreign or international allied countries with

1 their athletes there, from eight different
2 countries, representing them. And we
3 participated in a week long game in eight
4 sports.
5 And if you talk about just
6 absolutely a monumental camaraderie,
7 competitive team spirit and just bonding
8 amongst warriors, that was there. And that
9 was done by a handful of Marines and a few
10 others and it was put in place and that is an
11 international level event.
12 And I just left it two nights ago
13 and the French, the Germans, the Brits, the
14 Aussies, the Netherlands, the Mexicans, the
15 Colombians, every single one of their
16 representatives came up to me and said we, our
17 countries, cannot replicate the goodness of
18 this event. We just don't have the
19 capability.
20 And to come here and do that is
21 absolutely huge for us. And I just wanted to
22 tell you all that. And if I get a chance, if

1 I get a chance, I'll be able to show you a
2 five minute clip that kind of highlights all
3 of that. It's very neat.
4 The regiment has put out new
5 orders and policies. You have those in your
6 huge binders. Try to read them. If you can't
7 read them, go to our app and all that
8 information is there. But we put out quite a
9 few new orders and I'll try to talk to them.
10 We just opened our Hope and Care
11 Center at Camp Pendleton. If you haven't been
12 there, I know some of you all went out there,
13 I think you will agree with me it's an
14 absolutely amazing, amazing capability. It's
15 far more than a facility. It is a capability
16 for the Marine and the families. And it
17 enables, it enables so much goodness.
18 Our next one will open in Camp
19 Lejeune this summer in June and I encourage
20 you all to come down and do the opening with
21 us.
22 We have made great strides in

transition. You know that's a hot topic right now with everybody and we have gained now 11 transition coordinators and we have also implemented new guidelines and procedures to ensure that there is a seamless transition. And I look forward to talking to you all about that later on.

Marines have led the way. I talked about the app, but we also have what we call the Megalink. And the Megalink links -- it is specifically designed for the IDES, but what is neat about it and what gave us so much difficulty early on in my time here with the wounded warriors is the whole where is the Marine in this DoD system? I mean, in the Integrated Disability Evaluation system.

How do I know where his paper package is? How do I track a Marine? You know, what is incredible to me is that I can track a machine gun or a Humvee that is moving through the maintenance system, but we couldn't even track one of our Marines,

1 because of this antiquated paper system as it
2 bounces from DoD over to VA and back.
3 We have now, through some very
4 smart people, but in-house, once again like
5 the app is saying, here is a need, let's get
6 it together and now I can track exactly where,
7 once he starts the medical evaluation board
8 process, the package all the way through the
9 findings.
10 And we do it daily. And we have
11 monthly meetings with the VA, with BUMED and
12 the Marine Corps, with all the different
13 facilities or the regional directors and we
14 talk through how we are doing.
15 I can give to a commander, like a
16 Commander 1 MEB, a by-name list of all the
17 Marines that are beyond 100 days in the MEB
18 process or beyond 120 in the PEB process.
19 It's an absolute fabulous database, if you
20 will, that we developed and we use all the
21 time.
22 Erica in the middle there is our,

1 I don't know, genius or our brains. So I will
2 take no credit for it, but it's absolutely a
3 great tool that we are sharing across the
4 Marine Corps.
5 Computer-based training. Okay.
6 So as Paul just said, a huge thing in this
7 business is how do you train a wounded warrior
8 leader or somebody who is going to be a non-
9 medical caregiver or an RCC, how do you make
10 it all standard?
11 You all know this is a complex
12 business. Hence, we wouldn't have all of us
13 here, right? And there is nothing in my
14 career, I didn't grow up as a Lieutenant
15 Captain Major or Lieutenant Colonel doing
16 wounded warrior stuff. I was just cast upon
17 it a year and a half ago. So you've got to
18 have standardized training.
19 We just started what we call
20 computer-based training modules. Everybody
21 that comes to me in 30 days of joining the
22 regiment will go through computer-based

1 training modules, so that we all are speaking
2 a common language, that we have a common
3 database in which we start up on.
4 That is huge. That is huge for us
5 in that we only approve it with an approved
6 mobile training team and our inspection team
7 that goes forth and looks at each of our
8 detachments and battalions and provides the
9 top down guidance that is so needed in this
10 business. So we will be glad to talk about
11 that.
12 The RCCs, and that's April and Tim
13 here, have developed a RCC Integrated
14 Disability Evaluation System Handbook. And I
15 don't know, did we provide them the handbook?
16 Okay. So if ever you wanted to
17 see what are the individual steps in the IDES
18 process and try to understand what my role is
19 and what's the role of the, you know, rating
20 board or whoever, it's in that process. It's
21 easy to follow, digestible steps designed for
22 an RCC to better be able to understand and

also help out, support the Marine.

But we just put that one out. We are very proud of that. Facebook now, remember I told you last year to become my friends, we had just launched Facebook, over 6,000 fans. If you were to go on our Facebook site today, you would be overwhelmed by our good news of the Marine Corps Trials, that's the hot thing that we just did.

Soon it will be my Cutting Horse Classic III going when, ladies?

PARTICIPANT: April 14th.

COL MAYER: 14 April. All right, all right. Remember, I'm going to feed you and give you a barbecue. We have a focus on the -- focus on ability exhibit at the Marine Corps Museum.

So you want to talk about just a neat thing on the -- in the Marine Corps Museum and you know how fabulous that place is, go up to the second deck on your way to Tun Tavern and Food and all along the bulkhead

there are pictures of our warriors. And it's absolutely magical to see that.

On the left hand side or the port side as you are moving, you are going to see art work and art done by the Marines. Some of the -- some of it is absolutely exquisite. There is one Marine makes tables and other things with his hands that is just fabulous. Absolutely fabulous.

There is a purse there that is just incredible. But I encourage you to try to get there and see it. It closes here 10 May, so it's a six month thing. And then we will ship it out by site out there. And we are going to have a wine and cheese thing on 3 April.

3 April, we are -- you know, how you see in the movies, you know, you look at the art work and you sip your champagne and eat cheese? Well, we are going to do that. Marines, 3 April, 16:30. Please come. I'm very proud of that one.

1 And I have one more of this and
2 then we will cover some more as we go. Mary
3 said you've got to keep this under five
4 minutes. I don't know if I'm doing well. No,
5 I'm not. All right.
6 The other thing we saw a need for
7 is that when a Marine transitions out of the
8 Marine Corps and goes over to the right side
9 of the DD 214, that there is a period of time,
10 a gap so to speak, and our defense is that we
11 need to help the Marine.
12 So what we have done is we created
13 a process and a better way of tracking and
14 supporting the Marine and family as they
15 transition over to the VA.
16 And in that critical 90 day
17 period, our RCCs, our district injured support
18 coordinators and our support staff at the call
19 center are all working together
20 collaboratively in an integrated manner to
21 enable the Marine a smoother transition to the
22 VA.

1 Okay. And so that's kind of my
2 overall hey, here is where we have come. I
3 have tried to show you some great pictures and
4 tried to instill in you the absolute passion
5 that our program has for these Marines.
6 And at the trials last week, I had
7 three Marines come up to me at the closing
8 dinner and their wives were with them and the
9 wives, each one of them, was in tears. And
10 what they said to me was this, they said your
11 program, your Wounded Warrior Athletic
12 Reconditioning Program has literally saved my
13 and the wife said, my husband's and our
14 marriage, it has saved our lives.
15 Because it got us from a funk that
16 we were in, it got us back involved, back part
17 of a team, back lifting the self-esteem and
18 brought us so we know that there is no
19 boundaries to our future. And I'm just
20 absolutely, absolutely thrilled to spend the
21 rest of the afternoon answering your questions
22 and talking about the program.

1 CAPT EVANS: Hey, Jim?
2 COL MAYER: Okay.
3 CAPT EVANS: Jim, this is Connie,
4 right here. I have a question regarding --
5 well, let me just kind of clarify on the
6 picture up above where we have to spend a week
7 to explain why we had so many Marines at the
8 ribbon cutting, we have now standardized our
9 processes and we have -- we kind of divide the
10 numbers between all of the services when we
11 have a high visibility event. So let me just
12 speak to that.
13 Second, the Marines --
14 COL MAYER: Sorry, Connie, I
15 didn't know you were here. Oh, my goodness.
16 CAPT EVANS: When we transition a
17 Marine, so we know that they are in the
18 process or they are going to the right of the
19 DD 214, I noticed that we hold them -- we may
20 keep them here in this area, although they
21 want to transfer to another area.
22 So my question is why can't we get

1 them to that final destination before they
2 receive that 214? Do we have to keep them
3 here? Can they start, can they be setup in an
4 -- you know, already in school, already
5 working that job just awaiting to sign the
6 paperwork? Can we do that? Is that not
7 allowed?
8 COL MAYER: Yes, what the Marine
9 Corps does, and her question, as I understood
10 it, is why do we have to keep the Marine, in
11 this case, here until assigning the 214.
12 So we have done a couple things.
13 First off, we won't let a Marine leave here or
14 leave any hospital or MTF where he is
15 recovering until he has physically the DD 214.
16 We found that there is a lot of challenges
17 with if you let them go home before receiving
18 that, of getting that -- of course, he needs
19 it for a variety of things.
20 So once a Marine has received
21 their findings from the VA and has accepted
22 the findings, he is then in a kind of a

1 waiting pattern while it is all being
2 processed. We can assign a Marine, at that
3 point, home awaiting orders.
4 And what we will do is give him a
5 paper copy of his orders and send him home or
6 send him where he wants to go to start his
7 career. So it might seem like they are
8 holding longer than they can, but we try to
9 get them out of here as soon as possible.
10 MR. WILLIAMSON: The DD 214 can be
11 issued to the Marine far in advance of their
12 actual separation or retirement date. So if
13 the Headquarters Marine Corps sets a Marine's
14 retirement date as 30 June, that DD 214 can be
15 cut this early and issued to the Marine and
16 then he can proceed to permissive TDY,
17 terminal leave or perhaps if he is a local
18 area, conduct an internship or an
19 apprenticeship.
20 COL MAYER: Did that answer your
21 question? Okay. Fabulous. What I propose we
22 do now is go to the Marine Corps' response to

1 the Task Force's recommendations from your
2 report that was just released last -- for last
3 year's survey, I guess.
4 And so I have been asked to just
5 bring them up and not brief them, but just say
6 are there any questions in each one and I'll
7 go through.
8 You have been provided kind of our
9 answers up front, but I'll be glad, or my
10 team, to elaborate on any of them. See, we
11 are already losing people, so I know that I
12 spoke too long already.
13 LT GEN GREEN: So on the IDES, we
14 were very impressed at Lejeune with the
15 process that has been put in place there, in
16 terms of how efficient it is to get people
17 through the system, as well as the way that
18 they manage paper. And now I understand the
19 pilot with regard to doing the summaries in
20 AHLTA.
21 What are you folks doing or, I
22 guess this is almost a Navy question on the

1 IDES, since you don't own it, are you taking
2 the processes that have been so successful at
3 Lejeune and taking them to the other centers?
4 MR. WILLIAMSON: As you said,
5 General, that is a Bureau of Medicine and
6 Surgery issue. But on the Marine Corps side
7 of the house, even though we don't own the MEB
8 phase nor do we own the PEB phase, we do own
9 the Marines. We strongly advocate for
10 improvements in the process.
11 And we are certainly engaged with
12 the Bureau of Medicine and Surgery and the VA.
13 As the colonel pointed out in his earlier
14 comments, we do a monthly VTC with the
15 Regional Medical Commanders hosted by the
16 Bureau of Medicine and Surgery in concert with
17 the Regional Medical Commanders, our Marine
18 Corps Line Commanders are participating in
19 those teleconferences.
20 So what we have there is a
21 conjoining of the line leadership and the
22 medical community, which was a piece that was

1 candidly missing in the past, in all the
2 services. Anybody that was referred in the
3 PEB or the MEB process, that was considered to
4 be a medical issue and the line community kind
5 of stepped back and let that process proceed.
6 Well, the medical community does
7 an outstanding job of treating patients, but
8 they don't have as great a concern over the
9 administration of that case as it moves
10 through the process. And that's where the
11 Marine Corps said we need to step into this
12 process.
13 The colonel talked about the
14 innovations that we have come up with at the
15 regiment level to extract the VTA data that
16 tracks the case as it goes through. One of
17 the capabilities that is lacking currently in
18 the VTA application is a report-generating
19 capability.
20 If you will, you are a medical
21 board supervisor at any particular medical
22 treatment facility, you have got six PEBLOs

1 that work for you and the only way you know
2 what their case load is, is if you walk over
3 and do a desk audit. And literally, if you
4 don't see it on their desk, you don't know
5 that they have got it, because there is no
6 management information system that will
7 provide that to you.
8 We have taken that VTA data. We
9 have merged it with our own Marine Corps total
10 force personnel system, our recovery care
11 coordination tracking system and our Marine
12 Corps Wounded, Ill and Injured tracking
13 system.
14 Every Monday morning, our recovery
15 care coordinators generate for their
16 individual recovery care coordinators a
17 listing of every Marine that is assigned to
18 them and that report provides them visibility
19 on where that Marine is currently in the
20 process.
21 The colonel spoke to the recovery
22 care coordinator handbook, that RCC then

1 identifies a problem on that report and can
2 now go to that recovery care coordinator
3 handbook and knows exactly what to do in terms
4 of getting that case moving forward.
5 That transparency did not exist in
6 the early days of the IDES process. What is
7 the effect of that? We started tracking the
8 MEB phase back in June. At that time, there
9 were 610 cases that were currently exceeding
10 the 100 day processing goal. And of those
11 610, many of them were 190 days and older.
12 Now, that number is down to 144,
13 but more importantly, the numbers of days
14 above 100 has gone down significantly.
15 Now, there is the improvements in
16 the MEB phase that has been spawned by the
17 interaction between the line community and the
18 medical community. There has been a greater,
19 if you will, production level of the MEB cases
20 going forward to the PEB.
21 In response to that, in
22 anticipation of that, our Headquarters

1 Personnel Command, General Milstead, directed
2 that the PEB, unlike all other Marine Corps
3 elements that have only a percentage of their
4 authorized personnel allowance, he stated that
5 they will have 100 percent of their personnel
6 allowance. And we have also put an additional
7 five administrative clerks into the PEB to
8 help with that case processing and we have, at
9 the larger installations where Marines are
10 going through it, added additional staffing at
11 that level to present the findings to the
12 Marine.
13 And I think the Recovering Warrior
14 Task Force was probably the first body that
15 ever heard a Marine say that the IDES process
16 is too fast. That's -- you know, everybody
17 had to do a double take on that, but that's
18 what is going on.
19 Down at Camp Lejeune what they
20 were successful in doing is having a study
21 done by John Hopkins. They came down and did
22 an industrial engineering study and the best

1 example for you in that is they had a car
2 assembly program down there that looked like
3 Rolls Royce where a team of six people built
4 a car.
5 And Henry Ford came along and
6 revolutionized the industry by putting it on
7 assembly line. That's what they have done
8 down at Camp Lejeune. That industrial
9 engineering team identified key steps in the
10 process that could be gunned by non-technical
11 people.
12 In other words, you don't have to
13 have a doctor Xeroxing copies of a medical
14 record when you can hire a GS-3 to do that.
15 And so they have created that assembly line
16 process. That is being exported outside of
17 the Camp Lejeune area. There is dramatic
18 improvements in the MEB phase. But the
19 challenge now comes with those cases showing
20 up at the PEB.
21 On our side, we continue to inform
22 the Marine and family of how the process

1 works. You have seen our pocket guide on how
2 that process works. We have got a fact sheet
3 that you can find on that app that hopefully
4 provides some degree of visibility.
5 Most of the angst that service
6 members experience in this process is not
7 knowing where their case is at or how they can
8 influence it moving forward. We hope that we
9 are now better able to support that Marine,
10 develop their expectations, which would then
11 allow them to do a better job of planning
12 their transition out of the service.
13 We have also placed in key
14 locations DES attorneys who are there to
15 counsel the member in the MEB phase to ensure
16 that the quality of the information going
17 forward to the PEB is complete, that all the
18 conditions that they are afflicted with are
19 properly referred or they have the opportunity
20 to claim those conditions before they go
21 forward.
22 Anything else?

1 CSM DeJONG: I'm going to ask the
2 same question I asked yesterday about the
3 attorneys. Are they -- do the Marines have to
4 seek them out and ask for their help or are
5 they coming to them offering help?
6 MR. WILLIAMSON: Here is another
7 thing that we are doing with the Megalink
8 capability. We are actually providing to our
9 wounded warrior attorneys a by-name roster of
10 every Marine, by medical treatment facility,
11 of those who are going into the process at the
12 MEB referral point.
13 So those wounded warrior attorneys
14 have the ability to contact those Marines.
15 But we also have, in our pocket guide and in
16 our fact sheet, the telephone number for the
17 wounded warrior attorneys and encourage those
18 Marines to seek them out.
19 Now, those Marines who are joined
20 to one of our detachment or battalion
21 elements, who are the most seriously wounded,
22 or ill, have probably better access or at

1 least a greater awareness, because they have
2 got people around them who are going into this
3 process.
4 And in the barracks, you know, one
5 soldier talking to another is sometimes the
6 best communication system.
7 But to answer your question
8 directly, no, there is a mechanism for them to
9 be sought out by the attorneys, and there is
10 the ability for them to find the attorneys.
11 COL MAYER: I'm going to move to
12 the next one, everybody's favorite, IDES.
13 I'll pass that one. Did I go the right way?
14 No? Oh, I'm holding it backwards. All right.
15 Here we go.
16 Four is the CRP Standards. Any
17 questions on this one?
18 MS. CROCKETT-JONES: Yes, I have a
19 question. It says that there is -- you are
20 ensuring CRP standardization. Do you consider
21 the paper document the standard CRP? Is the
22 CRP intended to be a dual use tool, both, you

1 know, cadre and recovering service member or
2 is this sort of a paper document?
3 MS. PETERSON: Hi. I'm the Deputy
4 Program Manager for the RCC Program. It
5 should be a document for both. And really the
6 word document -- using the word documentation
7 or document, we are trying to get away from
8 that, because it's really a planning tool. A
9 planning tool not only for the Marine, but
10 it's a planning tool for the recovery team.
11 And one of the things that we are
12 doing is the Marine, you know, since it's the
13 Marine's plan, the Marine has a part in the
14 development of the plan. But now, we have got
15 viewing rights into RCP-SS, so that the
16 section leaders of the recovery team members
17 can get in an see the CRP at any point.
18 That way, there is not duplication
19 in effort. So what the RCC should be doing
20 and they are trained to do this through our
21 policy and our robust training program is to
22 really develop a plan with clear action steps

1 that guide a Marine through a particular
2 stage. And then a section leader can come in
3 and look and see what actions are due. And
4 then they can ensure through daily interaction
5 with the Marine that those actions are taken
6 care of.
7 MS. CROCKETT-JONES: Does the
8 Marine have access to his CRP?
9 MS. PETERSON: He does not have
10 access to RCP-SS, but he has access to his
11 CRP. When RCCs are required by our policy
12 that every interaction with a Marine, and at
13 a minimum, that has to occur at least once
14 every two weeks, but they must be -- they must
15 receive a new copy of their CRP that is
16 updated with what the additional action steps
17 are for that Marine at the time.
18 And they go through it and that's
19 literally a discussion item each time that the
20 RCC sits down with a Marine.
21 Additionally, what is really more
22 important is that WWCTP just released

1 something called a quick view where instead of
2 that cumbersome document, now, it prints a
3 one-page what are the goals and what actions
4 are due for that Marine. And it is just a
5 one-pager.
6 And now section leaders can go in
7 and get that quick view. And when they see
8 that Marine on a daily basis, they can hand
9 them that quick view and say this is what you
10 need to do today.
11 So I think the effort of the RCC
12 providing the CRP, the section leaders and the
13 other recovery team members using it as a true
14 planning document, I think, that is what is
15 going to make the CRP a useful tool.
16 MR. WILLIAMSON: The CRP is built
17 in concert with the Marine Corps' lines of
18 operation: mind, body, spirit and family.
19 Each Marine is required to be participating in
20 activities in each of those lines of
21 operation, and that comports to the CRPs
22 intent for that lifeplan.

1 And the section leader is the
2 individual who is immediately responsible for
3 assisting the Marine in executing that plan.
4 MSGT MacKENZIE: On one of our
5 site visits, the information that you are
6 briefing is not what we were shown. Okay?
7 And the Marines that were working with -- the
8 Marines and the Wounded Warrior Battalion were
9 still using the six part folder; which me
10 being a liaison working with Marines, I was
11 always impressed by, because it was always
12 very thorough and complete.
13 And when I asked what is the
14 correlation between the two items, they were
15 still sticking with the six part folder
16 because that other item wasn't being used. At
17 which point in time, I was shown six CRPs of
18 Marines who had already completed through
19 their recovery and left the Wounded Warrior
20 Battalion. Not a single one of them was
21 complete.
22 So I wonder where the disconnect

1 is here, because the -- what you have written
2 on paper, and I believe in this, but what we
3 saw was not this.
4 CSM DeJONG: Across the forces,
5 this CRP is -- it briefs very well. It
6 executes very poorly when you start talking to
7 families, when you start talking to service
8 members, it doesn't matter which service we
9 talk to, it -- what the service members want
10 is it to be used as a counseling tool.
11 They hate this computer stuff.
12 They hate -- they want interaction between a
13 non-medical case manager, whether that be a
14 squad leader or a case manager, with that
15 document, with their families into: this is
16 how we are going to get you from Point A to
17 where you want to be.
18 Notoriously, across all forces,
19 this briefs very well; it is executed very
20 poorly. So it's something that we challenge
21 you to look into, do some follow-up, do some
22 audits and figure out exactly what the

1 families feel of this and exactly what your
2 Marines are feeling of this.
3 MS. CROCKETT-JONES: And I just
4 wanted to throw in a word of caution when you
5 are dealing with the population. A lot of
6 them have TBI and PTS, a piece of paper that--
7 I mean, it's gone. It's already gone. If you
8 gave it to them, it's already gone.
9 And so their lack of view
10 electronically, might be something you want to
11 seriously look at. The other thing is that
12 when it becomes more dynamic, we saw
13 leadership using it for risk assessment in a
14 way that a less dynamic plan just doesn't
15 touch.
16 So I'm just -- what we are saying
17 is your intention would be great for reaching
18 a better level of making it a really good
19 tool, but we have -- our installation visits
20 have not seen it happening that way.
21 MS. PETERSON: And we actually
22 agree with you. And I want to answer two

1 separate questions. I'm going to answer
2 your's first.
3 One of the reasons why we did this
4 app is because one of the things that we are
5 getting for our Marines is iPads at all
6 locations. And so one of the things that the
7 RCCs are doing for those Marines is not only
8 uploading the Wounded Warrior Regiment App,
9 they are also uploading some of the other TBI
10 apps, and PTSD apps that are out there
11 approved by DoD.
12 And additionally, what they are
13 doing is PDFing the plan, emailing it to the
14 Marine, and the Marine can pull it up on their
15 iPad and look at it. So we are working
16 towards that. Maybe one day we can get that
17 as part of our app. Those are the things that
18 we are looking at now, so we do agree with you
19 there.
20 In terms of audits, what I'm
21 really excited to tell you, we did not have
22 this the last time we were talking to you, in

1 fact, we have just put it in in the last
2 quarter, is we now do quarterly audits. One
3 of the things that we did on our program is
4 developed an auditing tool that is a really
5 robust auditing tool.
6 I think we are the only ones that
7 actually have it where we go in and I go in
8 every single quarter on RCCs and I audit at
9 least 10 percent of their case load, sometimes
10 more, depending on location and depending on
11 RCC.
12 And we go down each of the
13 columns. We have criteria, questions that we
14 look at when we are looking at the CRP and how
15 are RCCs actually developing it. And I'm
16 telling you, when we first started the audits,
17 I agree with you, you know, some of the things
18 that we thought were happening in the plan, it
19 was happening on-site, face-to-face, via post-
20 it notes and sometimes emails, but actually
21 getting it into that document, so that the
22 documents used as a planning tool, it wasn't

1 there.
2 We found that in the audits. We
3 have instituted a training program since then
4 that we have put into place with the RCCs to
5 teach them skills like interviewing skills.
6 So how do you pull out of a Marine who
7 sometimes doesn't even know what he wants to
8 do at transition, these guys don't know. 19,
9 20 year-old Marine, it's difficult to pull
10 that out of them.
11 How do you do that? What
12 techniques do you use? Then how do you
13 capture that into a plan? And then how do you
14 start developing even more robust goals? So
15 it's not just about the short-term needs. So
16 what is going to -- you know, what is the --
17 getting the Marine an iPad, you know, that's
18 a short-term need. It is easy to fix. We can
19 do it right now. You get it in CRP, but
20 really, so what?
21 What are the long-term goals?
22 Education, employment, what is going to set

1 this Marine up for success? That's what we
2 are training the RCCs to do. How do develop
3 the plan and then how to use the plan. And
4 I'm telling you, honestly, we are seeing big
5 improvements, but what is really important is
6 that beyond just putting it into the plan, the
7 other recovery team members have to believe in
8 it.
9 And that's our -- that's kind of
10 our next step, because what we need them to do
11 is also talk to the plan. It can't just be
12 the RCC. It has got to be the section leader,
13 every single day using it. They may also have
14 other methods that they use to keep track of
15 the Marine on a daily basis, fitness scores
16 and stuff like that that would never be in a
17 CRP.
18 But that CRP needs to be part of
19 whatever folder that the section leader is
20 using to keep that -- to hold that Marine
21 accountable to his goals and actions.
22 MSGT MacKENZIE: And that is what

1 I was getting to was, you know, this is just
2 stuff that was observed.
3 MS. PETERSON: Yes.
4 MSGT MacKENZIE: Okay. And when
5 you look at a CRP and you say okay, the
6 Marine's statement of I want to get a job,
7 there is no action steps after that.
8 MS. PETERSON: Absolutely.
9 MSGT MacKENZIE: I want to get an
10 education. There is no action steps in the
11 CRP that -- in the CRPs that we were shown.
12 MS. PETERSON: Yes.
13 MSGT MacKENZIE: You know, and it
14 was a very small sample. Okay. But it's
15 just, you know, the positiveness of your
16 efforts to do all this stuff, we just -- you
17 know, you don't want to -- I just want to let
18 you know, that it is not what we are seeing,
19 because it's -- you know, and you look at that
20 and go okay, if it is a good plan, if it is a
21 good tool, let's make sure we can recommend it
22 and help getting that tool working, but every

1 time we look at the tool, it's not working or
2 we talk to the guys and they are not -- it's
3 not working well for them.
4 And we talk to the folks that are trying
5 to -- that are working with them directly and
6 they are using something else, because it
7 still works better than what the new one is,
8 that's why we bring that to your attention.
9 MS. PETERSON: I really look --
10 CSM DeJONG: But --
11 MS. PETERSON: -- forward to you
12 guys following it, too.
13 CSM DeJONG: --and nothing beats -
14 - across the services, there is electronic
15 audits. Nothing beats on the ground talking
16 to a service member. And across the focus
17 groups that we have, it doesn't matter what
18 service, you can choose, one of the questions
19 we asked the family member focus groups is --
20 MS. PETERSON: Yes.
21 CSM DeJONG: -- what is a CRP?
22 MS. PETERSON: Yes.

1 CSM DeJONG: And they all look at
2 us like we are speaking a different language.
3 MS. PETERSON: Yes.
4 CSM DeJONG: They feel very
5 disconnected from the recovery plan for the
6 warrior because they are not brought into the
7 process, which we feel is a very important
8 part of the process of getting them involved
9 in it, too, because they are as much, if not
10 more, motivation than their peer groups.
11 MS. PETERSON: Absolutely. I feel
12 a little like I might have -- like I didn't
13 shove you questions to ask me, but you are
14 asking me things that I'm really excited to
15 tell you about.
16 Family: major concern. As we
17 start to get this right for the Marine, and
18 the Marine starts believing in the plan and we
19 start to use the plan, we are marketing it out
20 there, we are doing some initiatives like we
21 have developed some posters that talk about,
22 you know, it's like the Got Milk? ads where it

1 says Got a Plan?
2 You know, Got a Plan For Your
3 Future? that sort of thing. It has got a
4 really interesting picture on it and they are
5 going to be hung up all over the barracks
6 rooms to really start.
7 It's an issue with awareness of
8 what the acronym CRP means. But the more time
9 we can get it out there, the more people that
10 start to use it, start to talk about it, I
11 think there is going to be awareness there.
12 But another thing that we are
13 doing now, is that I talked to you guys last
14 time in my family readiness role when I talked
15 to you guys last year, about the Keeping It
16 All Together Handbook. That was traditionally
17 a FRO or family support coordinator
18 responsibility.
19 They would pass it out, but there
20 was a true disconnect between who was walking
21 that family through it, and when were they
22 receiving it, early in the process. RCCs are

1 going to start taking on this role. So it
2 gives them an opportunity to walk families
3 through and invite them in earlier in the
4 process than we were before.
5 The other piece, though, is
6 convincing a Marine of the importance of
7 bringing in that spouse. So another part of
8 our SOP is we have a family contact
9 authorization form where an RCC is now trained
10 to talk to Marines at the very first interview
11 and they talk to them about the benefits of
12 the RCC, the benefits of having a family
13 member involved early.
14 It gives them the opportunity to
15 put in the contact information for the family
16 members that the Marine wants to contact and
17 invite in to meet with. Also, the family
18 members that they don't want us to.
19 But they get a counseling session
20 now that says this is why you want to do this.
21 Whereas, maybe before, they questioned it.
22 At the MTFs where the families are

1 there, resident, you won't find this as big of
2 a problem there, because the families are
3 already at bedside. They are working with the
4 RCCs. It's really more of a problem with the
5 battalions where the family is not always a
6 resident with the Marine and it's difficult
7 bringing them in.
8 So we are looking at ways to
9 invite the family into this process more. But
10 I do invite you guys really truly with these
11 audits, the first quarter just went out, the
12 training plan went out, this marketing effort
13 is going out to address a lot of these
14 recommendations you will be entrusting over
15 the next year.
16 I look forward to you guys taking
17 a look and you will see a change.
18 DR. PHILLIPS: Let me just add
19 something technical that might be an
20 impediment for usage. And we have heard this
21 on many occasions from both sides, from the
22 reviewers and the submitters that they are

1 having a lot of technical difficulties,
2 bandwidth, downloading the pages, crashing and
3 that's something you might be able to address.
4 MS. PETERSON: Absolutely.
5 LT COL KEANE: Dr. Phillips, I
6 believe that specifically for the Army, I
7 haven't heard any problems about -- with the
8 Marine Corps it's not -- it's a piece of
9 paper.
10 DR. PHILLIPS: Okay. No, I know.
11 LT COL KEANE: Right, sir?
12 COL MAYER: Well-said. But it is
13 a computer system and bandwidth and all of
14 that is always a challenge. But everything
15 you all said is absolutely true. And as a
16 commander, I feel the passion of the team and
17 I know all these great products read-well and
18 they sure as heck brief-well, the devil, of
19 course, is in getting it implemented all the
20 way down.
21 And as a -- you know, that's a
22 complicated task. You know, if you are a

1 drill instructor, you go through a three month
2 school that teaches how to be a drill
3 instructor. You know, we have, what I said
4 before, computer-based training and a few
5 weeks classes and the RCC. I mean, so this is
6 a tough business.
7 Getting that implemented, I still
8 use this. How many years is there a Mark I
9 day timer out there, you know? So I have an
10 electronic calendar and I have it written
11 down. Why do I do that? Just because I don't
12 know, I've always done it that way.
13 And so you saw section leaders
14 with the old platoon commander notebooks,
15 that's -- as Marines, that's what we are
16 taught from day one is to have a platoon
17 commander notebook.
18 But I am encouraged that we are
19 getting better each day and that our process
20 and the electronic process will get better
21 each day, especially, and I can talk all day
22 to you folks, about integrating the line, as

1 the Navy says, with the medical side, so that
2 it's integrated.
3 So scheduling and all of that is
4 seamless. I hate using that word, but it's so
5 that both sides can see it, so it's not a
6 mystery from the medical to the non-medical.
7 We can talk about that perhaps later.
8 Any others on that one? Okay.
9 The next is command climate. You
10 know, I will say that we have a great command
11 climate. We encourage a total recovery, mind,
12 body, spirit, family. I just got back from
13 Camp Pendleton and the spirit at that event
14 was incredible.
15 I talked to numerous families out
16 there who, at least from what they told me,
17 and I know they never tell colonels anything
18 but the truth, were absolutely abundantly
19 happy. And I realize there might be some that
20 are disgruntled, that's what Marines are.
21 They are always complaining, that's the way
22 our nature is, but by and large, I think we

1 have a great command climate out there and we
2 always work to make it better.
3 You can see it at Walter Reed or
4 at BAMC or Camp Lejeune. Sir?
5 MR. REHBEIN: Colonel, one thing
6 you should be aware of, I have, during our
7 visits and I can't go very far with this for
8 privacy reasons, spoken to two Marines that
9 fall into the ill and injured category. And
10 they wonder, they both expressed to me,
11 whether they should be in the Wounded Warrior
12 Regiment, because they are not wounded.
13 And so there may be a little bit
14 of extra morale building that needs to go on
15 there, because I'm sure you have a number of
16 those folks in the battalions. You might take
17 a look at that just to make sure that that's
18 not a place where morale starts to go down.
19 COL MAYER: Yes, sir. I think
20 that's a great point.
21 MR. REHBEIN: I would add --
22 COL MAYER: I will tell you though

1 for -- there may be isolated cases, but boy,
2 there sure isn't discrimination on the staff.
3 MR. REHBEIN: No, and don't get me
4 wrong. They were not at all dissatisfied with
5 the care or with the way they were being -- or
6 with the way they were treated by any of the
7 cadre. It was simply an internal feeling of:
8 I'm not a wounded Marine.
9 COL MAYER: Yes, right.
10 MR. REHBEIN: And being in the
11 Wounded Warrior Regiment, I just don't feel
12 like maybe I don't fit.
13 COL MAYER: Right, yes. I fully
14 understand.
15 LT GEN GREEN: I would add that
16 your athletic reconditioning program and the
17 family events, the things that your chaplains
18 are doing with these folks is a role model.
19 I mean, I was very impressed when we went down
20 and talked with your guys to a person in our
21 breakout groups. They were all very impressed
22 with the athletic reconditioning program.

1 The one area that I think you
2 might still -- just from talking with several
3 of these folks and granted we had relatively
4 small samples, but they are still looking for
5 that employment, that -- whether it is a
6 vocational rehabilitation or getting back into
7 a unit where they actually could do some parts
8 of the job that they have been trained to do.
9 But that kind of activity for the
10 mind, that gives them value based on their
11 occupation, not saying that just the fact of
12 being a Marine isn't a great reason to have
13 pride, don't misunderstand me.
14 COL MAYER: Right.
15 LT GEN GREEN: But I think that
16 you might be able to get some of these folks
17 gainfully back to some level of occupational
18 enjoyment. And I don't know how to help you
19 get there. And I -- as I told the people at
20 Lejeune, it is a problem everywhere where we
21 aggregate folks who are wounded, ill and
22 injured.

1 And so when we were running
2 patient squadrons, we couldn't solve this,
3 because finding something that is
4 occupationally rewarding is tough. But it is
5 an area that I think that came up fairly
6 routinely that they came in for the sessions,
7 they felt very tied to the unit, they had
8 great support from their squad leaders, but
9 they still felt that they, you know, were
10 looking for that gainful how can I contribute.
11 COL MAYER: Yes. I mean, sir,
12 from the man at Quantico's perspective, one,
13 it's mandatory that when they are medically
14 able that they participate in education,
15 internship or a return to work type program.
16 So, to me, it's clear I want them
17 doing that. The commandant wants them
18 involved. But why it's not happening across
19 the board is something that I spent a lot of
20 my time going out and asking Marines and
21 getting them gainfully in a productive thing.
22 And you have heard me speak before

1 and the last thing I want is for a Marine to
2 leave my program and all this great support
3 and then be out on his own and say now, what
4 do I do? You know, that's why define your
5 goal early and we will help you achieve it.
6 There are lots of Marines that are
7 doing just that now and we will talk about
8 internships with -- and education. I've got,
9 you know, Marines up at Georgetown right now
10 and all that. We are starting -- the Marine
11 Corps University, is we are going to start a
12 Marine Corps University pre-college prep
13 course that we are going to start at Walter
14 Reed. We are going to have seminars to see
15 how it goes, take our lessons, reading,
16 writing, public speaking and critical
17 thinking. It's going to be a great course put
18 together by Marine Corps University.
19 And then we hope to beam it out
20 via the VTC across all the different stations,
21 so that others can benefit from it. So I'll--
22 so I agree with you 100 percent in that we --

1 our charge is to find the 20 percent that are
2 not going to win on their own that we need to
3 get out and father-to-son-type mentorship.
4 Absolutely.
5 MR. CONSTANTINE: Sir, the reason
6 -- one of the reasons we had this command
7 comment in our recommendation was, well, due
8 to a number of -- basically, some issues. And
9 one of which was Twentynine Palms. Are you in
10 a way to influence the line commanders have on
11 determinations over medical?
12 And how a number of the wounded
13 warriors there felt regarding the care they
14 are getting, how they are treated by that
15 command and the long distances they are having
16 to travel to Balboa for counseling?
17 Do you know was that -- were those
18 issues addressed with you or I guess, what's
19 your feeling about how things are at
20 Twentynine Palms now?
21 COL MAYER: I just returned from
22 the trials. 80 percent of their people were

1 down there participating in the trials. The
2 Marines were extremely motivated. I think
3 they have got great section leaders and RCCs
4 out there.
5 From what I have seen, it's a
6 great program. And I'm not sure exactly what
7 you said. Sometimes -- I'm just telling you
8 folks is this is a leadership business. These
9 are young guys that you need to help them find
10 a meaning in life.
11 A lot of times young Marines want
12 to be on liberty or they want to go to their
13 room and do Gameboys and so folks with
14 traumatic brain injury, with PTS or some type
15 of injury, you have got to encourage them to
16 get out and do things.
17 And it's not always an easy task.
18 You all are parents yourselves. You know that
19 every single kid is not always inspired and is
20 not outside playing or whatever. They would
21 rather stay inside and watch TV and eat the
22 wrong food or go to, you know, their friend's

house.

If only -- it's not all that simple. So for every person you say I have a negative story on, I bet I can show you five that there is a positive story and that they are going to win because of the programs in place.

MG STONE: Colonel, we chose Twentynine Palms because of its remoteness from the flag and what we found, and this is all in our report as well as our engagement with Marine Corps leadership, was that the vast majority of injured Marines were still in the line and expressed great problems accessing health care.

Those within your regiment were doing great. And so you had over 300 Marines on limited duty profiles with substantial health care problems. You had 22 at the time we were there last year within your regiment. There was no cohesive manner in which that decision of those 22 was made to put them

within the regiment, but they were doing great.

And you are right, you're running a great program with well-trained people. But what about the other 280? What will we find next week when we go out there? What difference is there?

LT GEN GREEN: Why don't we move to the next slide, because that's I think exactly what we are talking about here.

COL MAYER: Well, that's the entrance criteria. Okay. Well, I can answer this in a number of ways. So first off, right now, there is 43 total patients at Twentynine Palms, so it has grown or almost doubled in size.

There is a well-defined entrance criteria to Wounded Warrior Regiment and it is through the battalion commanders through a known process and a board made up of multiple people, not just one, so it has got to be a, you know, it is a consensus that is based on

1 a lot of different considerations on whether
2 or not to accept a Marine into the command.
3 The commanders at the Battalion
4 level can say yes. The only one that can say
5 no is me. It has to come up to me to say no.
6 And we constantly are reviewing cases, adding
7 people, double questioning, reaching out and
8 saying hey, have you thought about this
9 particular person.
10 What probably isn't as well-known
11 is for the line commanders, or those
12 operational force commanders, on knowing about
13 the detachment out there and about how to get
14 a Marine over into Wounded Warrior Regiment.
15 And so that is something we are
16 improving on. I talked to the -- every
17 commander's course, we talk to all the
18 enlisted, senior enlisted professional
19 military education courses we have. I talked
20 to many of the -- all of the commander
21 spouses, but also many of the -- when I go
22 local like at Camp Pendleton, I just did a

town hall meeting, if you will, for those that wanted to come and listen.

We have about 1,200 in our program right now. We have grown. Every month we grow. And I think that it is the right size. Of course, it could be a lot larger. The Army, I think, is at 14,000, a little bit different criteria.

But the thing that sticks in my mind is that it is the Marine spirit of being with their unit. And a lot of the Marines would rather be with their unit and their buddies and those who they fight for. What we don't want is a system that leaves it up to the Marine to decide how best to cure himself, right, or give him help.

And so we need to be interdictors, where we will, and that's constantly something we work at. I'll tell you this, if we know that there is a problem, we get them help.

Not all the time is it best to bring the Marine to the wounded warrior debt

1 or battalion, sometimes it's better to leave
2 them in place and provide RCCs to provide the
3 advice and the support as necessary.
4 And then we work through the Navy
5 Medical System as well. So Twentynine Palms
6 is remote. It is away from Balboa. There is
7 a transportation requirement there. And
8 that's the nature of it. It would be better,
9 do you think, to move them all down and
10 displace them away from their families?
11 That's possible.
12 DR. TURNER: Colonel? Sir?
13 COL MAYER: Sir?
14 DR. TURNER: You just mentioned
15 that you were the final say on admission into
16 your regiment.
17 COL MAYER: Yes.
18 DR. TURNER: Of all the young
19 Marines that are recommended by the battalion
20 commanders and their board for admission into
21 your regiment, what's your acceptance rate?
22 COL MAYER: Well --

1 DR. TURNER: I mean, how many do
2 you turn down for acceptance into the
3 regiment?
4 PARTICIPANT: We will have to take
5 that for the record.
6 COL MAYER: Well, yes, we will
7 take that for the record, sir, and get back to
8 you.
9 DR. TURNER: Thank you.
10 LT GEN GREEN: I think that one of
11 the things, and this may be outside of your
12 purview, but one of the questions that came
13 from the Twentynine Palms visit last year that
14 we tried to deal with was whether or not there
15 was a medical voice at the -- in the decision
16 process for some of these folks who are not
17 able to keep appointments.
18 And so at Twentynine Palms in
19 particular, I think, when they talked with the
20 case managers, we found that in several cases
21 they felt they didn't have the voice to
22 basically influence people getting to

1 appointments. And I know that's a little bit
2 outside of the regiment, but the question is
3 if your goal is to keep them in the unit, then
4 you have to have a mechanism to make certain
5 that they are getting the medical care
6 necessary.
7 And so where do the medics fit
8 into that decision process?
9 COL MAYER: Yes. So, sir, as I
10 say, we have a Recovery Team that consists of
11 the section leader, leadership, the nurse case
12 manager, which is medical approval and medical
13 process, and the RCC, which is the expertise,
14 the goal setter and kind of the tracker on the
15 professional development of the Marine as the
16 Marine family navigate through the system.
17 But in my mind, a Marine only
18 misses one appointment and then after that, he
19 doesn't miss any more, because the section
20 leader is ensuring that he will be at his
21 appointed place at an appointed time.
22 And so, I mean, the mechanism

1 either it is not well-known or we have a
2 breakdown in the process, but it shouldn't be
3 because we just didn't have the Marine in the
4 right place at the right time.
5 LT GEN GREEN: But is that true
6 only within the regiment or within the unit?
7 See, the problem wasn't within the regiment.
8 It was a problem with the Marines that were
9 maintained in the unit.
10 COL MAYER: Well.
11 LT GEN GREEN: And so the real
12 question is what's the case manager's role in
13 the decision process if a Marine is missing
14 multiple appointments? Because I think we
15 actually found several that had missed
16 multiple appointments.
17 COL MAYER: Right.
18 LT GEN GREEN: Which was
19 problematic. Coming from the unit, not within
20 the regiment.
21 COL MAYER: Right. I understand,
22 sir. And I would have to defer that to the

1 operational commander who is responsible for
2 the Marine. So as a -- when I was a commander
3 out in the Fleet Marine Force Operating
4 Forces, I tried to ensure, you do a formation
5 and the Marines go down there if you are light
6 duty, limited duty cadre.
7 DR. PHILLIPS: Just to be
8 specific, I was a military physician, but we
9 were told again in the line command, platoon
10 sergeant or whatever, often and I can't give
11 you numbers, but we heard this, that something
12 else would supersede a medical appointment or
13 an order. A dignitary visiting, even the
14 warrior games and I'll just pass that on to
15 augment what General Green had said.
16 COL MAYER: Yes, sir. Okay.
17 Great--great dialogue. This is care for
18 Reserve. Now, any questions on care for the
19 Reserve?
20 MS. DAILEY: You have a unique
21 cell in the Wounded Warrior Regiment staff
22 that links wounded Marine Reserves with their

1 orders with their treatment. We have just got
2 a touch of it in Lejeune. I think some of the
3 other services are struggling with how to
4 bring together that Reserve component and
5 injured process.
6 Can you talk a little bit about
7 your Reserve cell in your Wounded Warrior
8 Regiment?
9 COL MAYER: Absolutely, ma'am. We
10 have -- at Wounded Warrior Regiment, our
11 Reserve medical staff, which consists of a
12 surgeon, who just happens to be a
13 neurosurgeon, and then we have a -- and he is
14 a rotating Navy doctor.
15 We have a GS-15, who is the
16 continuity, so to speak, or retired sergeant
17 major and then a staff of Marines and Navy
18 Corpsman that monitor all the Reserve cases.
19 So Reserve Marines that are on
20 activated orders when they are looking at
21 transitioning back to their civilian careers,
22 if they have a medical condition, their

1 packages are done up at the local unit level
2 and then they are sent to our guys for review.
3 And that way, we have got
4 consistency and continuity across the force.
5 Our team represents Headquarters Marine Corps
6 and is the final say in lots of different
7 things concerning whether a Marine stays on
8 medical hold orders or does a line of duty
9 type of recovery and benefits.
10 It is a lot of hard work. Those
11 folks roll up their sleeves every single day
12 and a lot of the packages are contested to the
13 Congressional level or to my level in which we
14 review them and work with Manpower and Reserve
15 Affairs to come up with the fair answer.
16 As you know, in this business, it
17 is a lengthy and sometimes complex process and
18 there is quite a few issues that are
19 constantly being worked on that. Quite a few
20 cases and for a variety of different reasons.
21 I don't know if that answered your
22 question? Paul, is there anything you want to

1 add about Army?

2 MR. WILLIAMSON: No, sir. I think

3 you have covered the majority of it. As the

4 Colonel mentioned, the Reservist, if they are

5 on active duty when they incur a line of duty

6 injury, we will retain them in the medical

7 hold status until that condition is resolved

8 or they have been referred into the Disability

9 Evaluation System process.

10 If a Reservist, while on a period

11 of training or ADT, incurs an in the line of

12 duty type injury, they can be held in what we

13 call a line of duty benefits status where they

14 are provided medical care for the condition

15 that they incurred the injury for. Not all

16 conditions that they have, but specifically

17 that condition that they incurred in the line

18 of duty. And in some cases, they will be

19 accorded line -- I'm sorry, incapacitation

20 pay, if that line of duty injury prevents them

21 from returning to what their civilian

22 occupation would be.

1 COL MAYER: Okay. PTS Care and
2 Access. While you are reviewing that one, I
3 just want to say that those that know the
4 assistant commandant of the Marine Corps
5 General Dunford, I would tell you that this is
6 his number one issue. He has many, but this
7 is huge for him. And he is constantly
8 challenging myself and our medical advocates,
9 the Marine Surgeon from the Navy to find --
10 and all the commanders out there, to ensure
11 that we are finding the Marines with PTS and
12 getting them the treatment they need.
13 You know that the NICUs he is
14 looking at are -- he is talking to the Navy
15 right now and the Army about forming centers
16 that look at traumatic brain injury and PTS
17 and any other cognitive type injury altogether
18 in the same center simultaneously.
19 The NICUs are going up in three
20 more location satellite type sites. We will
21 get one of them at Camp Lejeune. And there is
22 a confidence -- he is constantly pressing for

with the NICUs and the CFI down at BAMC to be doing more than we are doing for not only the analysis, but the treatment of our Marines with PTS.

So I like to think we are at the forefront of pushing for the better treatment and the care for PTS Marines.

Here is a picture of our Hope and Care Center, absolutely beautiful. What we should have shown though is our Marines that we have helped and that have gotten better. And I can think of numerous examples of those that we have helped and returned to their careers or out into new careers in the civilian world.

Okay. I'll move to personnel.

LT GEN GREEN: I think you can press on. We're impressed.

COL MAYER: We talked about this. Good, good. I can talk about the app again. The next one is resources. And we talked already about the Keeping It All Together

1 Handbook, the apps, the computer-based
2 training, our fabulous RCCs, our Army of One,
3 if you will, in April right there.
4 LT GEN GREEN: I think you can
5 keep going.
6 COL MAYER: Okay. The next one is
7 on caregiver support. We talked already about
8 much of this.
9 LT GEN GREEN: Agreed. Go ahead.
10 COL MAYER: This is VA and Voc
11 Rehab. We gave you some numbers. And I'll
12 tell you, one of the two things or two things
13 that I have been pushing lately with my
14 commanders is Voc Rehab and getting the
15 counseling out there to everybody.
16 You can see that we have some
17 improvement to be made. I'm a huge believer
18 in the Voc Rehab Program. There is a lot of
19 great benefits to it that I want to make sure
20 the Marines know and understand. And I'm also
21 convinced that many of this population of
22 wounded warriors aren't interested in your

1 traditional type jobs.
2 And so we -- as a matter of fact,
3 I meet next week with the Small Business
4 Administration and the head of Voc Rehab and
5 this entrepreneur boot camp, I just think that
6 thing is great. And so you are going to see
7 a sharp rise in Marines starting companies and
8 at least getting the training and
9 understanding how to go about doing that. So
10 I'm a big believer in that. We can do better
11 on this and we will.
12 And we'll go to the next one.
13 MR. DRACH: Colonel, Colonel,
14 excuse me, before you go to the next one.
15 COL MAYER: Oh, I'm sorry, sir.
16 MR. DRACH: How do you account for
17 your requirement that all of your Wounded, Ill
18 and Injured meet with a BR&E counselor prior
19 to separation, yet 28 percent said they were
20 unaware of the program?
21 COL MAYER: Absolutely, sir. And
22 I would say there is no excuse, quite

1 honestly, and, you know, I just think of lots
2 of things I'm required to know as a Marine
3 Colonel and I bet you there is lots I don't
4 know that I'm supposed to know by standards.
5 There's just an overwhelming amount.
6 We will do better on this. I'm a
7 huge believer in the Voc Rehab and we will get
8 better.
9 MS. CROCKETT-JONES: Could this be
10 a timing issue? Could -- if -- you may need
11 to push the requirement earlier in their
12 transition or before, you know, to a certain
13 number -- a certain amount of time before
14 their separation in order for it to be -- have
15 more impact on getting them into a program.
16 MR. WILLIAMSON: And you are
17 correct on that, ma'am. That DoD and VA
18 entered into an agreement where Voc Rehab
19 counselors would be provided well enough in
20 advance of the Marine separating that. In
21 fact, our desire is that any Marine that is
22 referred in the IDES process, we know how long

1 that process takes, that they begin that
2 engagement on the counseling, so that number
3 on awareness is an historical number. But
4 that will significantly go up as time passes.
5 MSGT MacKENZIE: Sir, one of the
6 things about awareness that seems to -- we ask
7 in all of our site visits and it seems to trip
8 a lot of people up is actually awareness of
9 how and when it is available.
10 MR. WILLIAMSON: Right.
11 MSGT MacKENZIE: And the reality
12 to it is is that if you are going to provide
13 education and training to your Marines, part
14 of that education should be the process then
15 to getting into it.
16 And how do you request it if it is
17 not readily available?
18 MR. WILLIAMSON: Right. And
19 that's --
20 MSGT MacKENZIE: And with a --
21 MR. WILLIAMSON: -- one of our
22 fact sheets that we have just --

1 MSGT MacKENZIE: Right.
2 MR. WILLIAMSON: -- developed.
3 MSGT MacKENZIE: Because with a
4 memorandum rating, I mean, you can begin to
5 address BR&E options as much as 365 days prior
6 to separation.
7 MR. WILLIAMSON: Absolutely.
8 MSGT MacKENZIE: So but, you know,
9 nobody seems to recognize that and this is
10 numbers that have been in place since 2009,
11 that I know for a fact, because I did that
12 prior to deciding I wasn't going to separate
13 or retire, rather. But so it has been around
14 for well over two and a half years since I did
15 it, so I just encourage those facts to be
16 placed out there.
17 MR. WILLIAMSON: Right.
18 COL MAYER: PEBLOs. Any questions
19 on this recommendation, response?
20 PARTICIPANT: We're good.
21 LT GEN GREEN: Yes, we're good.
22 Go ahead.

1 COL MAYER: Okay. And I think
2 that completes our questions specifically from
3 the report. I don't know if anyone wants to
4 take a break? That might be a good time,
5 ma'am. Rock on?
6 LT GEN GREEN: I think we are --
7 yes, we are actually approaching a break and
8 so we need to move through things fairly
9 quickly. So let's let you go ahead and we
10 will see if we can't finish up.
11 We really, by our timing, should
12 finish with you folks in about 10 or 15
13 minutes.
14 COL MAYER: Woo hoo.
15 LT GEN GREEN: And so if you could
16 walk us through the things you think are
17 really important here and the Members can stop
18 you anywhere along the line. Okay?
19 COL MAYER: I would love for you
20 to see the tape, if you think we have time.
21 All right, sir, I have covered almost all of
22 this already in training, probably in my

1 opening remarks.
2 LT GEN GREEN: I agree.
3 COL MAYER: We can always get
4 better at training and I'm constantly focused
5 on how do we do this.
6 Regional limited duty liaisons.
7 Paul?
8 MR. WILLIAMSON: As it points out
9 here in this slide, we are moving away from
10 the actual body that is identified as the
11 Regional Limited Duty Coordinator. That
12 capability was put into place because we did
13 not have a very good IT-IM solution for that.
14 The Marine Corps Headquarters is
15 developing the capability where they will now
16 be able to identify and then send out
17 individual messages to the commander of any
18 Marine that is on a period of limited duty and
19 to the Marine themselves to make them aware
20 that a re-evaluation of their condition is
21 required, at this point in time.
22 And there will be action taken

1 administratively to remove them from that
2 limited duty status, unless the medical
3 community validates that requirement to stay
4 in that status.
5 LT GEN GREEN: So basically, the
6 LIMDU NCO is going to cease to exist because
7 you are going to track it centrally?
8 MR. WILLIAMSON: That's correct.
9 LT GEN GREEN: Okay. Thanks.
10 MS. DAILEY: That individual
11 provides guidance through the system for those
12 Marines also.
13 MR. WILLIAMSON: The primary role
14 of the regional limited duty coordinator,
15 every command that has a Marine that is on a
16 period of limited duty is required by
17 regulation to have an internal limited duty
18 coordinator.
19 The role of the regional limited
20 duty coordinator was to identify units that
21 did not appear to have a very effective
22 program than to engage that command, provide

1 training to that commander and his staff on
2 how better to make that program work.
3 But again, the unit commander will
4 now receive an individual notification that
5 you have got a Marine that requires re-
6 evaluation.
7 COL MAYER: All right. Meaningful
8 work is the next topic. Work opportunities.
9 I think there is no surprises on the slide.
10 What I would like to say is that the Wounded
11 Warrior Regiment is a huge fan of the new --
12 the National Defense Authorization Act that
13 was just released and of the -- that allows --
14 the law change that allows now active duty
15 service members in recovery process to go out
16 and work for civilians.
17 What we are waiting on is the DoD
18 instruction. So once that comes, we can write
19 our service instruction and hopefully get
20 marines, especially down in Camp Lejeune,
21 Twentynine Palms out there doing meaningful
22 work in the civilian sector.

1 And that would provide us greater
2 latitude to address your earlier question.
3 CAPT EVANS: Right. Only because
4 -- and I asked that question, I hear from the
5 Marines or hear from some of the guys back
6 over at campus, why do I have to stay here so
7 long when I know I want to go back to North
8 Carolina or somewhere? I would like to go
9 back now and then I can come back and sign my
10 paperwork. But I'm already setup to where I
11 would like to be. So we hear that frequently.
12 And the second part to that, we
13 get them setup in this area, then they don't
14 want to transfer to that next location. They
15 want to stay, because now they have already
16 started school. They have started employment.
17 So they kind of get setup in this area, so
18 they kind of defer leaving, because we do such
19 a good job in this area.
20 So I think it's just two parts to
21 it when you hear from the Marines out in the -
22 - on campus.

1 COL MAYER: Right. So just real
2 quick, I'll answer that as from a commanding
3 control, a leadership perspective, until a
4 Marine signs his findings, it is not a good
5 idea to let them all go across the United
6 States. It makes it very hard to get them
7 back from medical and all that.
8 So we tried that before in the
9 early phases of the One Warrior Regiment and
10 we already know that that doesn't work. The
11 reason many of them like to stay here and, you
12 know, Marine Corps policy is to move them
13 closer to home station.
14 What happens is whether it is
15 perceived or not, there is a -- they love
16 Walter Reed. And a lot of that is due to your
17 hard work and so the Marines and their
18 families hear that this is the place to be and
19 they want to stay at Walter Reed.
20 And so the doctors allow them to
21 stay. So it's a mixture. We would just as
22 soon move them to Camp Pendleton and Camp

Lejeune. So a lot of it is a product of being good at what you do.

MR. DRACH: Colonel, could you talk on the work? Could you talk a little bit about your employment tool kit that you all developed about a year or so ago?

COL MAYER: Absolutely. I'll let the girls that developed it talk about it. It's all yours.

MS. FLORES: Good afternoon, everyone, Erica Flores. I am a Research Analyst on our Future Initiatives and Transformation Team. And we work closely with you as we develop the employment tool box.

It is up on our website and currently I know the RCCs are using it to assist their Marines as they go through their employment initiatives seeking out work and I don't know if you can talk to that any more, April?

MR. DRACH: Talk about some of the elements that are in it.

1 MS. FLORES: Sure. Gosh, it has
2 bene quite a while since I have reviewed it.
3 MS. PETERSON: MOS translator.
4 MS. FLORES: Yes, it's a step-by-
5 step process. The first process was actually
6 to offer the Marine the opportunity to almost
7 connect back to the Wounded Warrior Regiment,
8 so there was a page that allowed them to fill
9 out their information and that information
10 would be sent directly to our transition.
11 So once they filled that out, they
12 could go to the next step, which was to
13 identify almost like a needs assessment. What
14 are their current capabilities? And all of --
15 the reason why it was built was because we
16 heard from our Employment Advisory Board
17 Members that many of these individuals were
18 jut inundated with the resources that are out
19 there.
20 So we wanted to create pages that
21 took them directly to the kind of gold star
22 websites that we knew provided them with the

capabilities and information that they needed.

Right, everything within three clicks. So the first step was the needs assessment. The second thing was to help them identify what their MOS was and how that related to real-world experience.

O*NET, I believe, was the resource that we used. I have heard that there are other capabilities that are coming into place now that might be a little more efficient as far as there was a disconnect between what some of those MOSes were and what real-world experience might be.

We also had resume building in there with several different templates that provided the individual to go in and either create a federal resume or other types of resumes, civilian resumes.

And then also the last page had just a tab that allowed the individual to click into whether it would be a monster or a job, jobs.net, whatever it might be to allow

1 them to search for additional work.
2 I know in the meantime, the
3 transition cell is working on developing a
4 capability that will allow them to click on
5 that jobs tab and go in directly to employment
6 that is available for just specifically
7 wounded warriors.
8 COL MAYER: All right. And that's
9 the pipeline. If you are not familiar with
10 that program, you need to be, because that's
11 going to just make us the best site in DoD.
12 I said that for these gals' benefit, because
13 they will now explain it to you whenever we
14 get it developed. But it's coming and then
15 I'll be glad to come back and tell you.
16 So we are really -- it's in
17 partnership with Cisco and I think only the
18 National Guard are the other ones using the
19 Pipeline Program.
20 MS. DAILEY: Sir?
21 COL MAYER: Sir? Ma'am?
22 MS. DAILEY: Are you actually

1 going to wait on a DoDI before you move
2 forward with the new legislation? That takes
3 a very long time.
4 MR. WILLIAMSON: You must.
5 MS. DAILEY: You must.
6 MR. WILLIAMSON: Yes. We had that
7 same issue with special compensation for
8 assistance with activities of daily living.
9 The NDAA authorized that back in '09. It was
10 not released as a DoD program until August of
11 this year.
12 As soon as it was released in
13 August, on the 15th of September, we paid our
14 first Marines and continued to, but we do have
15 to wait for DoD implementing direct.
16 MS. DAILEY: Okay. I am under the
17 impression that that might not be in the plan
18 to do a DoDI. But I will leave that up to the
19 services to sort out.
20 COL MAYER: There are really cool
21 legal ones that we are doing though. Navy
22 facilities, you all know Admiral McCoy and we

are -- as best we can to participate with him and working with Marine Corps type things.

So diesel mechanics and all that, operation war fighters is a big one.

I'll go to the next slide. And here is just some of our Marines out there on different internships. It's Operation War Fighter. This young lieutenant was my cowboy setting up my horse program and he got snatched by the, I think, Congress. But there is neat things out there.

Elevate is -- I'm a huge believer in the University of Pittsburgh's Elevate Program, which is a college preprep college school. If you don't know about it, I encourage you to check into it.

Rory Cooper is the director and they teach computer assisted design, a 10 week program. They pay for everything, everything to including your housing and all of that. And it's an Operation War Fighter program and it's also designed for veterans. And we are

1 taking advantage of that.
2 You can see some of the various
3 things we do up there.
4 I know that we are the leaders in
5 transition and that transition assistance to
6 Marines. We work very closely with the other
7 services here at the policy level in getting
8 the word out and with OSD, Mr. Bob Carrington
9 and his office up there.
10 So I think the transition side at
11 the top level is very well-integrated in
12 talking and it's now getting implemented at
13 the section leader, RCC level and inspiring
14 the Marines to pursue a career. The
15 opportunities are absolutely there.
16 And so anyway, we are excited
17 about this and everybody is leaning into this
18 very much.
19 Next is Paul's favorite.
20 LT GEN GREEN: If I could
21 interrupt you, Colonel?
22 COL MAYER: Go back.

1 LT GEN GREEN: When we come back,
2 I think I misread the agenda and so we do have
3 more time after the break and so let's go
4 ahead and take a break and come back. And
5 then we have asked a lot of questions on the
6 IDES already, but we will let you fill us in
7 on some of the numbers and then so we will
8 just come back and start on the IDES.
9 So let's take a 15 minute break
10 and come back at 4:15.
11 (Whereupon, at 3:59 p.m. a recess
12 until 4:14 p.m.)
13 LT GEN GREEN: Okay. I just lost
14 my partner, so let me --
15 COL MAYER: I think she said go to
16 the last slide and show your movie.
17 LT GEN GREEN: I thought I had
18 done pretty good getting you through some of
19 those slides pretty quick there, Colonel.
20 COL MAYER: Okay.
21 LT GEN GREEN: Suzanne?
22 COL MAYER: Are there any other

1 questions on work opportunities?
2 MSGT MacKENZIE: Yes, sir.
3 COL MAYER: Fire away.
4 MSGT MacKENZIE: Right here, sir.
5 One of the things that we were in this
6 discussion at, I believe it was, Camp Lejeune,
7 we were down there talking about these
8 internship opportunities and the limits posed
9 by the Marine Corps on distance, you know,
10 which makes me --
11 COL MAYER: On distance?
12 MSGT MacKENZIE: Each time you
13 learn -- distance from, you know, central hub.
14 And, you know, although we didn't ask this
15 question when we were at Twentynine Palms the
16 last time, it just flashes up in my head.
17 You know, the opportunities we,
18 even as the SOCOM Care Coalition, look at this
19 and go, you know, how do we provide the
20 opportunities to these individuals without
21 them being in the National Capital area where
22 the resources are available?

I mean, we can all promote how great things are when the resources are available, the key or the challenge that we are tasked with is providing the opportunities to our warriors that don't have access to this.

And when opportunities come up, it's just automatic going well, we can't send them that far. We have a distance limit. We have limits on how we do orders or simply, you know, we don't have the commanding control capability to do that.

How do you address those situations or have those even been brought up to you, sir?

COL MAYER: All right. Before -- Paul is itching to answer that. I will tell you what you all can help me with. I talked to three wives and I was just saying this, but I want to tell you all, because this is huge.

In talking to the wives, I sat there with them for an hour. And I've got a

1 lot of energy and passion and these were young
2 energetic wives married to wounded warriors
3 and you could see that they just didn't know
4 about all the opportunity that is available to
5 them out there.
6 And in talking to them, it pretty
7 much came down to they want to start small
8 businesses. And then at the same time, at the
9 -- I mean, talking to wounded warriors at the
10 trials, what they are interested in is not
11 necessarily your traditional type internships
12 and jobs out there, especially the ones with
13 defense contractors and what have you.
14 And then almost immediately after
15 talking to these Marines, I had this rich guy
16 approach me and he said hey, I want to give
17 the Marines, you know, golf trips and all that
18 stuff and I just said no, they don't need any
19 more golf trips. They don't need painted
20 jeeps. They don't need all that stuff. They
21 don't need any more charity.
22 What they need is for you to take

1 all your rich donors that have made bazillions
2 out there on the stock market or putting
3 businesses together and be their mentors to
4 advise them and help these guys that have, you
5 know, bled together, have sweated together,
6 now form as a team and keep them together, but
7 have them start a company.
8 You know, down in Texas I have
9 marines that are playing the stock market and
10 making beaucoup money and they are all self-
11 taught. They did that in their spare time.
12 And the one guy, he is teaching other Marines.
13 Think how powerful that would be
14 if we -- instead of we just giving stuff, we
15 start teaching, because these guys are great.
16 They are innovative. They got great minds.
17 I have a Staff Sergeant Lyons at Balboa, he
18 has done four patents and started his own
19 company in the last six months, all through
20 really his own devices and a little bit of
21 mentorship.
22 And anyway, I'm just very, very

1 excited about the possibilities about bringing
2 real opportunity out there to these young
3 Marines. That's what I would like to see
4 instead of a lot of the gifts. Take that same
5 level of knowledge that is able to -- you
6 know, take the Anna Bell Teams, heck, you
7 know, the dang Indianapolis Colts, God bless
8 them, they hired Josh Bliel and he is their
9 public spokesman, you know, multiple amputee.
10 Wouldn't it be great if the NFL,
11 each team, adopted one of these guys and they
12 made him director of security or something?
13 I mean, there is all ways of rallying America
14 behind and giving meaningful things to set his
15 goals.
16 The Marines don't know what they
17 don't know. They are young kids. Heck, I'm
18 51 and I still don't know what I want to do
19 when I grow up, you know what I'm saying? How
20 do we expect a 20 year-old with no legs or
21 with a TBI to know, all right, here is my
22 goals I want to go do.

1 That's why it's important to get
2 the right mentors with -- I don't know if I
3 answered anybody's question, but I had to get
4 that off my chest. Paul?
5 MR. DRACH: Colonel, just a quick
6 response. Over here. Over here. You talked
7 about the spouses and entrepreneurship and you
8 mentioned earlier boot camp, are you aware of
9 the Ernst & Young working with University of
10 Syracuse to offer spouses internships or
11 scholarships at Syracuse for entrepreneurship?
12 COL MAYER: Sir, am I ever. And
13 that is exactly what I look these guy -- I
14 mean, there is one gal there and I wish you
15 all were me, but you know exactly what it is
16 like. Here is this young, beautiful girl with
17 eyes that just struck my heart, and I'm like
18 looking at my daughter, and she said I really
19 want to open a bakery and make cakes and
20 fudge.
21 And I said that's easy. Heck, I
22 know we can do that one. And the first place

we are going to go is the spouse's entrepreneur workshop. Right? I got it working and we're going to send her there. Absolutely, sir.

MR. DRACH: And some of your warriors that are doing day trading, they might be interested in the VOWS Program, Veterans on Wall Street. I can send you some information on that.

COL MAYER: They know about it. I talked to them about it and they said no. It's too -- we like what we are doing. You know, we have already got a method. We don't want it so structured. And then we have to go work for some bank. We are making our own money. You see what I'm saying?

I love these guys. As a matter of fact, I want to have them teach VTC-wise across the force, because I think what they are doing is cool. And now, they have got a growing number down there. They are all playing the stock market. I hope they all

1 keep winning. You know what I'm saying?
2 Paul?
3 MR. WILLIAMSON: The problem with
4 allowing a Marine to travel away from their
5 permanent duty station to participate in an
6 internship is encumbered by the JFTR and it is
7 also by Marine Corps policy.
8 In order to go to a location away
9 from the base, they have to go most often in
10 a permissive TDY status. The Marine Corps
11 policy is it's 30 days and then you have to
12 return back to your parent unit. You are
13 responsible for your travel there and your
14 return from.
15 As the Colonel mentioned earlier,
16 if you have got a young man who is in the IDES
17 process and you say okay, we are going to
18 allow you permanent permissive TDY to go back
19 to Sweat Socks in South Dakota to learn how to
20 punch cattle, if something happens in the IDES
21 process that requires him to come back for a
22 VA examination, that's on him, you know.

1 We, unfortunately, cannot issue
2 him cost orders to go do that. So that's the
3 first limitation. So, obviously, we are
4 trying to tie them to some local capability
5 that will most likely address their desire to
6 participate in an internship or some other
7 internship or apprenticeship.
8 MSGT MacKENZIE: Which leads me to
9 my next thing. Obviously, that 30 day
10 limitation is a factor in the Marine Corps
11 that is what I was directly tying this to.
12 But also, sir, I encourage you with your
13 motivation, because we are looking at this
14 ourselves, is those rich guys, those Fortune
15 500 companies that are looking to provide
16 opportunities of mentorship when you can
17 provide permissive, even if it is permissive
18 orders, because these guys want to take them,
19 make them executive assistants, give them that
20 period of time of mentorship.
21 Not just here is a couple of ideas
22 and my business card, call me. But a

1 consistent mentorship of people with that
2 level of thought process that are making, you
3 know, eight or nine figures a year, that's
4 where the unfortunate -- the 30 day order
5 problem comes into play when these gentlemen
6 are trying to provide this opportunity or to
7 encourage that opportunity in working with
8 perhaps the restrictions of the Marine Corps
9 order system.
10 It's just one of those things that
11 we are looking at it. I encourage that as
12 well, because that's an opportunity.
13 MR. WILLIAMSON: Well, we are
14 working with our policy branch to develop an
15 exception for our wounded warrior population.
16 It kind of ties with the authorization that is
17 contained in the legislation that allows for
18 internships and apprenticeships with other
19 entities.
20 But we do have marines, we had one
21 young man that was stationed at Camp Lejeune
22 who is with the National Park Service. In

1 fact, he was on CNN one night with all the
2 firemen, etcetera, who has been allowed to
3 stay in this area beyond that 30 day period.
4 We kind of look the other way, if
5 you will, the mikes are off, I hope. But, you
6 know, there are times when the good deals are
7 too good to let pass. But we are encumbered
8 by current policy.
9 MSGT MacKENZIE: And the success
10 of that helps to drive the policy change, so -
11 -
12 COL MAYER: Yes, absolutely.
13 MG STONE: Sir, can you recommend
14 to us potential policy change and where it
15 might be most effective? We had heard this at
16 a number of visits. In fact, we had marines
17 quantifying how much out of pocket expense
18 they had. You would do the Committee a great
19 service by suggesting us potential -- to us
20 potential policy changes to do out.
21 MR. WILLIAMSON: Well, we probably
22 have trouble getting that through the Marine

1 Corps, but we can certainly propose it.
2 MG STONE: Just consider it a
3 question we would ask of where policy needs to
4 be changed affecting what area and we will put
5 the words together.
6 COL MAYER: Well, I think, right
7 now what we are looking for is the DoD
8 instruction that provides implementing
9 guidance for the NDAA-12 authorization. So
10 and we are already working with our policy
11 branch, so we are very much for that, which
12 would then open up, like you said, a
13 mentorship with like Ross Perot.
14 Ross Perot is currently mentoring
15 one of our lieutenants, who is trying to start
16 an oil company down in Texas. He is a veteran
17 now, but, yes, absolutely. We would love to
18 see that with like my guys down in BAMC that
19 are currently, you know, playing the stock
20 market.
21 Wouldn't it be great if you were
22 also getting mentored by somebody that has

been successful over a long-term. You know, they might just be lucky right now.

MSGT MacKENZIE: Yes, sir, and that's -- when we look at the remote locations --

COL MAYER: Right, Camp Lejeune.

MSGT MacKENZIE: -- that ability to travel --

COL MAYER: Good one.

MSGT MacKENZIE: -- I mean, there is more opportunities at Camp Lejeune than there is in Twentynine Palms.

COL MAYER: Right.

MSGT MacKENZIE: I mean, we drove through the town to get there, so we did have good visibility on that challenge. But having those opportunities will give those marines the same opportunities and they are not sitting there going man, if I was just in D.C., I would --

COL MAYER: Right.

MSGT MacKENZIE: -- have a better

1 shot.

2 COL MAYER: Right. Absolutely

3 true. Okay. All right. Everybody's

4 favorite, IDES.

5 MR. WILLIAMSON: I think we

6 covered most of the efforts that we have

7 ongoing right now with Navy Medicine and

8 Marine Corps leadership.

9 You can see modest increases or at

10 least decreases, if you will, in the

11 processing times for the MEB phase. On the

12 PEB side of the house, there is very minimal

13 activity there.

14 The principal concern of the

15 future of the IDES process is when you look at

16 the statistics, the intended goal time frame

17 for an individual to process through is 295

18 days. I think that's achievable. I really do

19 think that's an achievable number.

20 The problem is that we have to

21 understand that the IDES clock starts when the

22 marine is referred into the IDES system and it

1 stops when the VA issues a benefits letter.
2 There is a lot that goes on in
3 between. Let's say that the PEB and the MEB
4 phase meet their timelines of 100 or 120 days.
5 If we allow a marine to transition out for a
6 length of time after they have accepted their
7 findings, there is intended to be 45 days
8 there, but very few of them ever transition
9 out in 45 days.
10 The question is why does the
11 process -- why is the process penalized for us
12 allowing for a marine to execute a longer
13 transition?
14 In other words, we could very
15 simply say, "Marine, as soon as you find or
16 you accept your findings, you have 30 days to
17 get out," and we would very easily be able to
18 meet that 295 timeline, but that's not what we
19 do.
20 When that marine gets his
21 findings, he is offered the opportunity to
22 stay, to leave at his convenience. You want

1 to use all that 90 days leave that you have
2 accumulated and take permissive TDY of 20
3 days? Yes, I do.
4 Well, that quickly busts that 45
5 days. Worst case yet, if the marine says,
6 "Okay, I accept my findings on the 1st of
7 October, but I have got a son that is going to
8 graduate from Quantico High School next June,
9 can I stay until next June?" Absolutely.
10 Guess where that time counts? On
11 the IDES clock. That doesn't make any sense.
12 But that's one of the encumbrances. And so
13 when you see these numbers of 404 days to get
14 through the process, it is impacted by that.
15 Now, we are aggressively looking
16 at and advocating for each of these phases to
17 accomplish what they are intended to
18 accomplish in 120 days or 100 days and we will
19 continue to do so. And I think we will drive
20 those numbers down.
21 Any questions on that slide?
22 MR. REHBEIN: Those extra nine

1 marines that are at the Physical Evaluation
2 Board, are you going to be able to keep those
3 particularly with authorized strength levels
4 being cut?
5 MR. WILLIAMSON: Yes. The Deputy
6 Commandant for Manpower and Reserve Affairs
7 has committed to ensuring that the PEB has
8 what it needs from the Marine Corps to process
9 those cases in a timely manner.
10 In addition to providing those
11 marines, we have gone to ASN M&RA and asked
12 them to have an internal efficiency study
13 accomplished, not unlike that which was
14 accomplished at Camp Lejeune, that they can
15 look at them from an industrial engineering
16 process to see if they are most efficiently
17 processing cases through.
18 I served as the President of the
19 PEB, the Department of Navy Physical
20 Evaluation Board for five years. I walked out
21 the door in May of 2007 and, at that time, a
22 legacy case from the time it came into our

1 mailroom until the findings went out to the
2 field level PEBLO was being done in 11 days.
3 It quickly jumped to 99 days as
4 the PEB wrestled with the IDES process coming
5 to fruition still managing the legacy process,
6 still doing TDRL cases, now doing the SABO
7 cases from the Physical Disability Review
8 Board and processing combat-related special
9 compensation cases.
10 But there is still something that
11 is hampering their ability to process their
12 cases in a timely manner. And it's not just
13 the Department of the Navy. The Army as well.
14 And we have had several meetings
15 on that topic. Under the legacy system, the
16 service is required, first, to determine the
17 disability and then to apply a disability
18 rating. They are only required now to
19 determine fitness for continued military
20 service.
21 I'm confounded by it needing to be
22 50 days to make that decision. Really, if you

1 have got a young man who is missing both legs
2 and he has a traumatic brain injury, it should
3 not take that long to figure out that he is
4 not going to be fit for continued military
5 service.
6 Next slide, please. The question
7 was why does it appear to take longer for a
8 recovery care -- I'm sorry, a marine supported
9 by a recovery care coordinator to go through
10 the process than it does for one who does not
11 have?
12 Well, a lot of that has to do with
13 the complexity of the medical conditions that
14 are being referred on that marine that we have
15 joined to us and his being supported by a
16 recovery care coordinator.
17 There is also the impact of that
18 transition piece that I was telling you about
19 that we allow those in the Wounded Warrior
20 Regiment to stay longer than most other
21 marines who have an illness or injury want to
22 stay in the Marine Corps. They want to move

on. A recovering marine typically wants to stay with us longer than that.

Any questions on that? Next slide.

COL MAYER: Okay. As you know, we put out surveys that seek to gain information and you asked us well, what have we done with all that knowledge we have gained from our surveys? And we have covered a lot of it.

I'll just quickly go over we have developed our computer-based training to get a base line standardized training program across the regiment.

We developed the app specifically to bring the Library of Resources and Information to those that need it the most.

We have increased our staffing and we have added active duty, mainly section leaders to the tune of, I think, 69 is what we have added or will add as the many manpower process works to the Wounded Warrior Regiment.

We have added 11 transition

1 coordinators to better enable successful
2 transition of the marines and their families.
3 The FRCs and the RCCs, we believe,
4 are better integrated now due to the numerous
5 meetings and conversations and we provide
6 information to the FRCs early on and so that
7 we may continue to work to improve the support
8 we give to the marines, both in the Marine
9 Corps and with the federal processes.
10 Paul just talked about all the
11 IDES gains. And I'm telling you, folks, this
12 man here, Dean Trujillo, that lady in the
13 middle, Erica, and some hard working folks at
14 Camp Lejeune in the form of Doc Zinder and his
15 team have done more to improve the performance
16 of IDES across all the services than a
17 mountain of surveyists and all the other folks
18 out there.
19 And there has been tremendous
20 improvements in the IDES system, but it is
21 through a few people rolling up their sleeve
22 and doing some hard work.

1 What Paul just briefed was
2 monumental, monumental and it is getting
3 better every day.
4 CAPT EVANS: Colonel Mayer?
5 COL MAYER: Yes, ma'am?
6 CAPT EVANS: I still don't hear --
7 so what is the connection with the nurse case
8 manager, the clinical case manager? I hear a
9 lot with the RCC. You have worked hard to
10 make sure the communication between RCC and
11 FRC, but the nurse case manager still seems to
12 be a little bit of a -- not clear that role
13 that the nurse case manager provides to the
14 marine.
15 COL MAYER: Well, you know the
16 role of the nurse case manager. And the key
17 thing, I mean, I go to almost every medical
18 conference that takes place. San Antonio, I
19 was just down in San Diego, there was another
20 one. They love to have me come and talk. And
21 I blast those dang doctors and nurses and all
22 them, because I'm telling you, folks, the

1 medical world doesn't understand the
2 importance of all these non-medical programs
3 out there.
4 And we, as an institution, have to
5 do a better job of integrating medical with
6 non-medical requirements. And so the role of
7 the nurse case manager, you know exactly what
8 it is, but she has got to share it. We need
9 ways to share scheduling.
10 How many here would even imagine
11 having a schedule you are not sharing with
12 anybody? Well, right now, the person that is
13 the one that is responsible that looks at his
14 schedule for medical stuff is the medical side
15 and the marine.
16 It's not shared with the non-
17 medical section leaders and those responsible
18 for his care. How can I set up dynamic
19 educational-type programs that are six months
20 out to get a marine through his training and
21 all that if we don't share a common schedule?
22 It's still passed between, you know, people in

1 multi-disciplinary team meetings.
2 Why can't we all look at the same
3 schedule and pull the information we need?
4 So that's really the disconnect.
5 It's not us not wanting to share with the
6 medical. It's more of, you know, HIPAA rights
7 and not sharing information that has still not
8 been fixed, I think, across the Department of
9 Defense. I think that's where it is.
10 We don't share well with the VA
11 right now. And that's from a grunts
12 perspective of all this, but that, I think, is
13 the real issue is sharing medical information
14 with the non-medical folks.
15 There is just a history of not
16 willing to do that and I don't know if there
17 is any doctors out there, but that, to me, is
18 the issue or the big issue right now.
19 MR. WILLIAMSON: Yes.
20 COL MAYER: And it's just
21 training, you know. We have only been doing
22 wounded warrior -- we get five years in April.

1 Remember, if you go to my wine and cheese
2 thing, we are going to celebrate that at the
3 museum on April 3rd. I'll even feed you,
4 ladies. Yes, yes.
5 All right. So does that answer
6 your question? I know I threw it right back
7 at you.
8 Social media improvements. Hey,
9 folks, I mean, I am not a social media animal,
10 but the key thing is this, we provide dang
11 near real-time updates on Facebook and Twitter
12 and all the other ones immediately. And so
13 the marines can literally see that night what
14 they are doing that day.
15 And the families are involved and
16 you can update. And it is constant messaging.
17 When news comes out from the VA or from DoD,
18 when policies change or there is something I,
19 as the commander, want to get out, there isn't
20 this long process that we have had that all of
21 us here have grown up with. It's out
22 immediately and you can see it. I'm breaking

1 your devices.
2 You can see it immediately on
3 Facebook. I mean, really it's cool. And we
4 are using it in a big way out there. We are
5 even texting instruction, you know, because
6 the marines won't answer their phones, so we
7 text it out there. I think it's cool.
8 Anyway, the key thing is not
9 getting old white guys to write your social
10 media program. You've got to get young
11 college kids with long hair and they get it.
12 All right. And then improvements
13 in the RCP-SS and GALS. Absolute. You know,
14 you're right. The CTP isn't perfect, but by
15 golly, it's a heck of a lot better and it's in
16 there.
17 That tool is a good tool and I'm
18 convinced and trust me, I'm still using my
19 daytimer, but I'm convinced that is the tool
20 that we need to use, because in the future, it
21 will be integrated with medical scheduling.
22 It will be integrated and we are already

1 starting to do it to integrate it with our
2 MCWIITS and it will be an integrated platform
3 for information sharing with everybody.
4 And so it is getting better, but
5 by golly, I think that's the way to go. And
6 if it isn't filled out, if it just says wants
7 to get a job, then we have failed the marine,
8 quite honestly.
9 Any questions on that slide there?
10 And there is maybe a bunch of other stuff.
11 MS. DAILEY: Sir, if you would
12 like to show your tape, I think we can do
13 that. These slides here, the survey results
14 were mostly backup slides from my staff, from
15 my research staff to catchup on their
16 information.
17 I think we have time to let
18 everyone kind of look through. Go to Tab T.
19 Excuse me, we can go to Tab S, yes.
20 COL MAYER: Yes, while we are
21 bringing up the film, we are able to do this?
22 MS. DAILEY: While we are doing

1 that, in Tab S is their update to training.
2 We did have the Army come in and brief us in
3 San Antonio on their training of their cadre
4 and their personnel, so the Marine Corps in
5 Tab S did provide us an update to their
6 training.
7 Colonel Mayer covered that earlier
8 with the update for the on-line training and
9 the training modules on-line and that is the
10 update they wanted to provide us. And the
11 rest of the updates are in Tab S.
12 COL MAYER: Okay. So this is a
13 tape that we made really quickly and we showed
14 it at the Marine Corps trials at the final
15 dinner. And this is a five minute tape to a
16 loud rock and roll song, but it shows a great
17 example of the dynamic programs that are
18 happening every day, mind, body and spirit.
19 And I think you will enjoy it. I
20 really do. I think it will move you and
21 you'll see that for every negative perhaps
22 example, I can show you five positive out

1 there.
2 So let's enjoy.
3 (Whereupon, video played.)
4 (Whereupon, video ends.)
5 COL MAYER: So a great, great
6 example of stuff that is happening across the
7 country with our marines. And so that ought
8 to inspire you just by watching it.
9 And anyways, I guess that's our
10 message out there. All right guys, we will
11 take any more questions if you have them.
12 LT GEN GREEN: It is a great
13 message. It is a great message. Thanks for
14 sharing the video. Thanks for bringing the
15 whole team up to talk with us. I appreciate
16 the book, okay, thank you for that. And I
17 appreciate the app, thank you for that, okay.
18 I think if no one else has any
19 other questions, then we will let you folks
20 go. Well done. Thank you.
21 COL MAYER: Oorah.
22 MS. DAILEY: Our next meeting is

in the middle of May and I will get word out to you. We will solidify who is going to Norfolk and out to Iowa. We will bring those plans together.

And we are going to Twentynine Palms next week, so I will see the Twentynine Palms team on Tuesday, Monday evening probably. So good.

LT GEN GREEN: A special thanks to everybody. I know this was a little bit longer than usual in terms of doing three days, but we got through a lot of information, and so we will finish off the visits and let the research team do a little work.

And so it will be a few months before we get back together, but we will sit down the next time to do the hard work, which is to narrow things down in terms of what our recommendations will be.

Be thinking about how we are going to deal with some of the things that are repeats, okay. In other words, are we going

1 to emphasize some of the things from the
2 previous report?
3 And so I would like for you -- the
4 one piece of homework for the group is I would
5 like for you to be thinking about, from the
6 previous report, based on what we have learned
7 this year, is there anything we want to
8 emphasize?
9 And then we need to think about
10 how we will do that.
11 So with that, anything, Suzanne?
12 MS. CROCKETT-JONES: I just know
13 that all the civilian members are glad to be
14 back and working again.
15 LT GEN GREEN: Military members as
16 well, by-the-by.
17 MS. CROCKETT-JONES: And now, I
18 think that we will be -- I think we have got
19 a lot of information even though we did have
20 some truncated work effort. I think we have
21 got a lot of information to move forward on
22 those recommendations. I think we will be

ready.

LT GEN GREEN: Have a great couple of months. We will see you in May. Thank you, everybody.

This concludes our session.

MS. CROCKETT-JONES: Thanks.

(Whereupon, the meeting was concluded at 4:50 p.m.)

A

abet 147:8
ability 106:18 185:4 193:3 253:21 308:2 354:3 358:7 360:6 371:2 374:17 386:16 401:14 402:10 474:7 479:11
able 22:11 30:16 39:5,9 43:7 49:22 89:3,3 91:17 116:21 132:22 133:9 156:18 179:1 181:8,13,14 181:15 184:7,8 185:2,13 187:14 191:7,19 192:2,21 197:13 199:1 202:11 213:17 214:21 227:9,10 228:4 233:20 234:2,4 252:14 274:2 278:10 285:9 286:22 287:12,13 293:18 295:16 296:3 298:9 303:11,15 309:2 315:18 320:17 323:15 326:4 330:22 346:13 357:18 358:1,6,8 363:8,8 374:12,20 376:1 381:1 385:22 400:9 419:3 424:16 425:14 434:17 449:16 466:5 476:17 478:2 488:21
absence 253:21
absolute 150:9,11 373:10 383:19 389:4 487:13
absolutely 25:13,15 86:19 145:4 166:21 181:4,22 193:21 322:7 337:7 342:20 347:2 352:9 354:5 355:14,17 369:14 373:15 375:1 380:6,21 381:14 384:2 387:2,6,9 389:20,20 413:8 415:11 419:4,15 421:18 427:4 438:9 442:9 444:21 447:7 454:7 460:15 468:4 472:12 473:17 475:2 477:9
abundantly 421:18
academic 56:15 58:7 87:21
accelerate 55:14 358:6
accept 16:6,18 36:8 363:21,22 364:1 431:2 476:16 477:6
acceptable 153:20 174:3
acceptance 433:21 434:2
accepted 15:16,20 16:2 200:3 235:17 391:21 476:6
accepting 10:22
accepts 19:11
access 24:4 27:1 53:17 91:6 92:4 107:1 108:16 109:21 187:13 189:9 219:11 298:19 312:19 320:10 323:15 358:19 359:1,2,13 361:18 362:21 378:20 401:22 404:8,10,10 441:2 463:5
accessing 317:7,8,9 429:15
accident 124:11
accidents 203:3
accompany 7:13
accomplish 19:12 59:1 84:10 477:17 477:18
accomplished 51:3 161:4 478:13,14
accomplishments 50:15 365:10
accorded 440:19
account 444:16
accountability 338:13,16
accountable 67:9 279:13 337:14 341:3 412:21
accounting 60:6
accumulated 477:2
accurate 50:1
accurately 90:8
achievable 192:8 475:18,19
achieve 6:3 192:7 426:5
acquire 292:9
acquirers 293:20
acquiring 290:19
acquisition 111:10 280:4 292:12,19 292:21
acronym 416:8
acronyms 293:9
Act 70:1 279:22 451:12
action 192:6 198:5 198:10 403:22 404:16 413:7,10 449:22
actionable 57:10
actions 52:4 99:2 104:1 106:12 404:3,5 405:3 412:21
activated 438:20
active 11:1 13:13 20:12,15,17 28:12 28:16 104:9 116:19 129:17 150:1 186:6 190:6 257:22 262:13 276:3 277:15 379:20 440:5 451:14 481:18
actively 105:16
activities 104:12 405:20 458:8
activity 9:5 424:9 475:13
actual 26:14 96:2 144:14 225:13,14 392:12 449:10
acute 93:7 179:10
adaptive 132:17,20 133:12
add 31:16 133:20 162:7 165:18 208:9 217:19 238:10 263:1 418:18 422:21 423:15 440:1 481:20
added 107:2 164:17 175:17 261:10 278:3 398:10 481:18,20 481:22
addicted 379:12
addictive 379:11
adding 217:11 309:1 431:6
addition 78:1,14 89:20 90:9 155:18 214:2 478:10
additional 18:20 90:16 155:19 264:4 273:19 284:1 299:11 398:6,10 404:16 457:1
additionally 404:21 409:12
address 55:4 60:22 104:16 146:6 148:20 149:1 174:11 177:20 195:6 204:15 209:7 210:2 214:12 216:15 249:8 299:22 418:13 419:3 447:5 452:2 463:13 470:5
addressed 94:16 110:20 154:19 427:18
addressing 111:18 129:5 366:14
adequate 246:6,7 269:5 332:22
adequately 208:5
adherence 100:14
adhering 170:14
adjacent 363:22
ADJOURN 3:25
adjust 195:9 319:16
adjusting 246:20 246:21
adjustment 159:16 213:12
admin 42:8 370:21
administration 395:9 444:4
administrative 3:4 4:5,17 398:7
administratively 450:1
Admiral 458:22
admission 433:15 433:20
admit 260:9 285:1
adopt 347:4 359:18
adopted 288:20 330:2 466:11
adopter 299:15
adopting 284:15
Adovan 270:22
adrenalin 133:2

ads 415:22
ADT 440:11
adult 177:12 214:13
advance 264:16 392:11 445:20
advanced 234:14 234:18 265:18
advancing 54:12 120:1 325:4
advantage 326:4 460:1
adversarial 177:14
advice 274:4 433:3
advise 293:1 465:4
advisement 237:6
Advisory 103:19 104:5 292:11 455:16
advocate 50:3 54:16 86:12 394:9
advocates 441:8
advocating 477:16
aerial 309:12
affairs 99:7 274:9 293:3 439:15 478:6
affect 26:8 57:11 210:17
afflicted 400:18
afforded 176:4 177:5
Afghanistan 79:10 79:15 118:11 232:16 326:9 370:3,20
AFI 230:3
aficionado 295:15
AFMOA 252:6
AFSCs 235:7 240:6
AFSOC 243:21 244:10,11
aftermath 154:10
afternoon 41:14 273:15 369:8 389:21 454:10
age 253:8,9
agencies 56:16 84:7 207:13
agency 2:6 60:15 111:15,15 129:2 234:22 284:11 326:6
agenda 47:21 129:4 366:9,12 461:2
agent 70:5 104:17 104:22 294:7
aggregate 424:21
aggregation 260:21
aggressive 89:17 104:18 170:20
aggressively 40:10 264:5 477:15
ago 4:11 17:9 116:5 129:18 154:3 159:2 174:16 230:22 244:9 252:2 274:12 301:7 380:12 384:17 454:6
agree 14:19 23:18 25:13,15 34:7 152:7,7 211:7,15 220:10 289:17 335:6,20 338:18 340:2 360:19 364:5 381:13 408:22 409:18 410:17 426:22 449:2
agreed 19:12 273:18 279:14 280:15 284:4 290:4,17 307:19 307:20 323:9 326:2 331:13,16 331:22 443:9
agreeing 290:12 311:7,10
agreement 321:15 325:22 332:8 338:20 445:18
agreements 281:4 282:22 290:13 331:11
aha 92:21
ahead 25:14 35:5 47:15 92:8 178:22 199:14 220:14 244:1,1 246:17 290:13 292:1 303:10 310:22 443:9 447:22 448:9 461:4
AHLTA 159:20 190:14,18 225:13 228:13 237:9 275:5 280:17 297:5 311:16 312:8 314:11,15 314:20 315:19 317:9 328:19 331:5 333:21 347:18,20 393:20
AHLTA/VistA 333:2
aid 154:4,7,8,9 155:7 234:10
aiding 239:13
ailment 14:8
Ain't 370:16
air 2:5 3:11 58:16 74:9 79:7 80:10 129:1 213:19 223:18 224:5,7,16 225:7 226:16,18 226:20 228:21 229:19 230:7 231:8,15 234:21 235:9,15 239:7,18 240:6 250:20 252:21 256:9 257:2 258:4 305:12 307:14
aircraft 241:5
airline 286:12
Airman 102:6
airmen 234:9 236:19
alcohol 87:11 123:17 131:15 254:11,12 255:7
alcoholic 88:13
Alexandria 1:10
algebra 125:15
algorithms 79:11 93:14
align 6:17 104:16 320:7 357:17
aligned 104:22 105:17 106:20 108:19 294:14,19 352:16 358:5 362:12
alignment 322:15 324:1 336:3
alleged 202:9
allergy 290:8
allied 379:22
allow 183:22 194:11 315:2 341:4 358:11 361:19 400:11 453:20 456:22 457:4 469:18 476:5 480:19
allowance 398:4,6
allowed 160:2 164:7 323:17,18 391:7 455:8 456:20 472:2
allowing 469:4 476:12
allows 90:22 310:8 312:4 314:10 316:18 317:2 349:10 361:18 451:13,14 471:17
alluded 93:22
alma 187:7
alternative 11:12 337:20
altogether 441:17
AMA 53:13
amazing 369:14 381:14,14
Amazon 286:11
AMEDD 150:19
America 466:13
American 124:6 207:14,15 318:15
Amos 367:4
amount 11:13 27:21 60:21 112:3 123:8 269:8 310:10 338:21 445:5,13
Amputation 47:2
amputee 117:9 368:1 369:11 466:9
amputees 116:20
analysis 50:3 212:1 442:3
Analyst 454:12
analytics 68:14
analyze 57:6 97:17 98:9
anatomy 205:18
Andrews 231:17
Android 291:18 308:8 374:12
Androids 286:2 305:16
and/or 136:12 193:6 195:20 196:3
anecdotal 146:22
anecdotally 245:2
anger 123:18 132:22 133:5 271:19
angry 88:13
angst 400:5
animal 125:3 373:14 486:9
Anna 466:6
Anne 20:6 23:18 43:14
announcing 274:1
annual 52:11 70:20
anonymous 160:1
answer 41:11 48:3 59:9,16,19 78:5 82:9 85:11 98:16

98:20 111:4 114:11 123:3,4 171:5 172:3 189:22 191:22 202:11 217:3 318:3 337:22 349:12 351:1 354:19 392:20 402:7 408:22 409:1 430:12 439:15 453:2 463:17 486:5 487:6
answered 41:5 103:8 222:19 439:21 467:3
answering 72:11 389:21
answers 48:5 191:7 199:2 393:9
anticipate 214:3
anticipated 71:3
anticipating 70:22
anticipation 397:22
antidepressant 137:7 160:19 162:3
antidepressants 75:13 157:17
antiquated 383:1
Antonio 483:18 489:3
anxiety 123:19 131:15 185:12 196:6,7 200:12,18 207:6 271:2,8,10
anxiousness 8:14
anybody 8:2 37:18 55:6 56:18 285:3 285:4 287:3 295:8 318:10,16 395:2 484:12
anybody's 467:3
anyway 186:22 230:6 460:16 465:22 487:8
anyways 490:9
apart 8:10
APIs 306:5 322:10
apologize 8:4 177:8 185:17 224:22 256:22
app 114:1 348:13 349:8 354:16 355:20 363:19 364:2 374:8,11,16 374:17 375:3,22 376:10,17 377:16 381:7 382:9 383:5 400:3 409:4,8,17 442:20 481:14 490:17
apparently 274:11
appear 366:11 450:21 480:7
appears 124:10 345:11
appetite 379:2
Apple 114:2 376:10 377:3,18
apples 318:9
application 115:12 213:4 278:21 286:17,20 289:8 289:16 290:20 293:18 299:17 303:22 306:6 307:6,17 308:3 312:6 320:16 335:12,14 363:11 374:3 395:18
applications 51:8 112:15 282:16 285:15 286:5 287:7,8 288:10 289:2 291:16 294:16 295:18 296:7 304:17 305:2,4,7 307:4 307:10,22 308:9 308:18 309:2 317:6 320:12,15 332:6
apply 479:17
appointed 435:21 435:21
appointment 10:13 25:7 27:10 87:17 226:4 435:18 437:12
appointments 13:15 24:16,16,17 110:3 171:8 434:17 435:1 436:14,16
appreciate 178:1 219:21 223:6 272:14 338:10 339:6 353:18 490:15,17
apprenticeship 392:19 470:7
apprenticeships 471:18
approach 198:20 205:11 206:21 227:2 235:16 243:15 282:9 288:7,11 289:7 324:13 330:3 331:2 333:7 337:9 359:18 464:16
approaches 196:5 285:12 286:9 288:21 344:21
approaching 448:7
appropriate 7:14 18:7 43:10 224:20 240:7,7
approval 435:12
approve 177:6 385:5
approved 385:5 409:11
approximately 186:6 223:19
apps 113:5,14,16 341:16 349:5 376:20 409:10,10 443:1
April 5:7,9 32:17 105:15 257:1 267:20 373:1 385:12 386:12,13 387:16,17,21 443:3 454:20 485:22 486:3
architectural 286:16 306:9
architecture 282:3 296:12 306:3 308:20 310:4,6,7 322:14 330:17 354:8,11
area 30:21 50:17 64:13 93:21 109:10 129:13 155:7 172:2,17 199:6 208:10 209:12 390:20,21 392:18 399:17 424:1 425:5 452:13,17,19 462:21 472:3 473:4
areas 15:16 43:4 79:1 84:3 109:21 148:12 209:21 345:17
argument 254:18
arises 20:19
arising 27:22
arm 368:19 369:12
Armed 1:4 71:12
Army 2:13 3:9 17:14 20:2 28:9 34:15 39:13 57:19 58:16 66:20 79:4 80:7 90:4 105:9 106:13 107:9 108:19 128:15 129:10,12,19 131:7,8 137:9 145:12 147:13 148:3 150:1,17 155:3 159:6 161:3 172:20 186:20 191:9 210:19 224:9,18 226:19 261:17,19 263:14 265:19,20 266:4 330:21 333:21 334:3 372:9 419:6 432:7 440:1 441:15 443:2 479:13 489:2
Army's 74:5 104:17,21
arounds 299:10
arousal 180:11 181:7
arrangement 340:15
arrive 219:20
art 81:6 82:2 387:5 387:5,19
artificial 34:10
artificially 28:1 34:9
ascertain 359:19
aside 65:4
asked 7:9,13 12:11 50:13 81:9 116:1 135:11 149:17 162:18 163:12,19 178:7 220:4 221:7 221:12 235:11 256:16 334:14 359:5 367:11 375:21 393:4 401:2 406:13 414:19 452:4 461:5 478:11 481:7
asking 71:13 126:15 219:18 240:15 244:18 317:18 415:14 425:20
asks 330:10
ASN 478:11
aspects 60:6 95:19 194:9
Assault 202:20
assaults 202:9,9

assembly 399:2,7 399:15
assess 100:5 276:1 285:21
assessment 61:7 68:4 72:1 80:3 197:8 206:21 212:1 221:4 261:11 330:11,15 340:7 408:13 455:13 456:4
assessments 330:19 331:1
assets 81:1 241:20 242:4 244:10
assign 392:2
assigned 396:17
assigning 18:9 391:11
assimilate 355:6
assist 61:10 103:21 110:6,19 112:20 193:3 454:17
assistance 458:8 460:5
assistant 2:21 273:7 293:2 441:4
assistants 470:19
assisted 459:18
assisting 406:3
assists 109:12
associated 9:21 34:16 42:15 116:6 131:14 138:13 178:19 202:21 213:7 229:14 325:20
Association 124:6 207:15,16
assume 6:4 245:4 250:20
assuming 66:11 68:22 220:19
assured 7:21,22
athlete 369:14
athletes 380:1
athletic 389:11 423:16,22
attached 2:6 129:2
attacks 123:20
attend 231:2,11 236:19
attendance 246:2
attended 185:19
attending 234:18
attention 96:14 149:21 175:5 229:5 238:21 414:8
attorneys 400:14 401:3,9,13,17 402:9,10
attractive 187:15
attributes 362:21
attribute-based 323:15
attributing 208:21
audit 59:21 60:3,4 396:3 410:8
auditing 410:4,5
audits 407:22 409:20 410:2,16 411:2 414:15 418:11
augment 437:15
augmentation 284:1
August 198:18 458:10,13
Aussies 380:14
authorities 292:12
authority 55:11 103:8,9,13 108:10
authorization 70:1 279:22 417:9 451:12 471:16 473:9
authorized 398:4 458:9 478:3
automatic 463:8
automatically 135:8
automobile 203:2
availability 72:8,11 77:10 78:15,20 98:16 107:5 149:16,17 154:22 192:16 230:10 257:7 262:18
available 7:18 52:16 53:5,7,20 69:11 70:11 71:11 78:18 83:10 96:2 96:21 113:8 187:10,12 188:19 192:14 232:15 283:22 284:18 289:4 291:17 296:7 304:18,20 307:12 342:3,16 342:21 345:16 375:10 446:9,17 457:6 462:22 463:3 464:4
avatars 115:15
average 252:18
aviation 243:4 251:21
aviator 86:3
avoidance 180:8
avoided 244:19 297:16
awaiting 112:6 391:5 392:3
award 345:2
awarded 331:13 342:12
aware 83:21 158:20 181:11 240:19 253:3 422:6 449:19 467:8
awareness 402:1 416:7,11 446:3,6 446:8
awkward 275:3 276:22 302:18 325:14 327:17
aye 47:11,11
A-F-T-E-R-N-O-... 273:1
A-2 200:7
a.m 1:11 4:2 128:5 128:6

B

B 138:4 180:2 240:3 254:1 256:20
back 5:19 9:12 11:13 12:14 13:22 14:6 16:21 17:3 19:7 24:21 27:11 28:12,16 29:14 32:7 34:8,13 38:17 57:7 60:18 65:14,17 77:7 91:4 110:12 119:2 119:3,3 123:13 126:9 128:8 129:18 132:9 134:20 135:6 145:6 149:12 151:3 152:21 168:1 174:12,13 174:14 179:1 182:7 190:5 194:17,18 202:6 203:16 208:14 210:11 230:15 232:2 234:4 235:6 235:20 236:1,9 237:21 240:12 245:5 246:21 249:2,6 250:10 251:11,13 253:17 260:1 262:4,15 264:8,15 266:8 267:1,3 272:18 274:3 279:20 281:6 291:12 298:21 304:2 318:11 341:13 345:2 348:10 352:13 354:1 362:6 365:8,21 366:22 370:4,6,19 372:5 379:14 383:2 389:16,16 389:17 395:5 397:8 421:12 424:6,17 434:7 438:21 452:5,7,9 452:9 453:7 455:7 457:15 458:9 460:22 461:1,4,8 461:10 469:12,18 469:21 486:6 491:16 492:14
background 44:13 48:1 129:12 130:5
backup 47:17 66:6 488:14
backwards 402:14
bad 30:7 61:4 170:8 236:5
Baker 292:14 294:4
bakery 467:19
balancing 370:11
Balboa 370:5 427:16 433:6 465:17
Ballroom 1:10
balls 305:11 307:14
BAMC 422:4 442:1 473:18
band 335:17
bandages 95:11
bandwidth 309:8 310:1,17,22 349:2 419:2,13
bang 337:11 342:17
banging 344:18
bank 468:15
barbecue 386:15
barely 93:15
barn 373:1,5
barracks 402:4 416:5
barrier 166:17 167:12 335:3
barriers 101:16 167:2,11 193:20 335:4,5

base 25:21 49:8 115:3 225:8 226:8 228:16,21 231:20 232:3 234:5 240:17 469:9 481:12
based 8:1 17:11 36:15 38:17 75:17 80:17 84:4 96:15 99:11 112:2 144:2 159:16 173:6 184:5 193:13 194:18 198:22 199:3 202:3 214:5 220:12 221:21 228:13 231:3 244:13,15 246:16 268:13 424:10 430:22 492:6
baseline 130:7 297:1
bases 80:12 368:11
basic 16:13 34:14 35:1 76:5
basically 13:1,7 14:16 117:12 151:21 178:9 185:18 187:9,13 192:22 193:7 199:9 215:7 229:20 245:16 247:5 257:17 314:21 316:3 348:7,15 349:8 363:19 377:22 427:8 434:22 450:5
basics 208:7
basis 27:16 29:2 93:11 115:18,19 212:22 213:2 232:3 233:7 312:12 405:8 412:15
battalion 108:21 155:14 401:20 406:8,20 430:19 431:3 433:1,19
battalions 385:8 418:5 422:16
battle 264:22 265:9 265:18,19 309:21
battle-mind 246:17
bazillions 465:1
beam 426:19
beat 85:19 87:13 339:17
beats 414:13,15
beaucoup 465:10
beautiful 369:2 442:9 467:16
beauty 287:15 288:21 344:21
becoming 91:10
bedside 418:3
beef 344:5
beg 323:21
began 283:11
beginning 37:2 90:19 145:10,13 204:20 220:6 230:22 264:7 332:9 333:14
begins 277:17 285:5 331:17
begun 198:18
behalf 344:12
behavior 173:21 189:1
behavioral 73:9 107:2,9 108:1 110:3 122:13 148:2 149:10,22 150:15 152:4 155:17 157:19 158:22 159:11 160:9 162:17 172:20 176:16 189:5 196:2 208:17 221:4 223:17 226:4 239:10
behaviors 131:16
belaboring 59:5
belief 320:21 321:2
believe 4:4 23:3 34:22 36:17 37:11 55:13 67:6 70:8 73:8 102:17 128:16 157:5 166:20 186:16 194:21 205:12 214:8 216:8 243:13 266:18,18 267:7 407:2 412:7 419:6 456:7 462:6 482:3
believer 443:17 444:10 445:7 459:12
believing 415:18
belittle 309:16
Bell 466:6
Belvoir 90:18
bene 455:2
beneficial 132:17 132:20 133:4,6,7 133:12 138:21 234:1,3 295:12
benefit 20:11 27:18 28:2 34:5 38:6 136:8 137:15 138:9 196:9 329:16 350:5,7 378:9 426:21 457:12
benefits 13:3,14 14:16 20:11 36:19 37:2,9 108:14 136:20 223:3 271:5 293:11 327:18 329:4,11 417:11,12 439:9 440:13 443:19 476:1
benevolent 110:18
benzodiazepines 270:22 272:4
best 15:6 28:8 60:12 62:10 70:18 96:19 111:1 194:11 200:21 225:22 254:1 277:1 287:7,7 289:4 295:17,18 296:6 302:18 307:2 321:7 340:7 340:14 372:14 373:7,21 398:22 402:6 432:15,21 457:11 459:1
bet 429:4 445:3
Beth 292:13 294:3
Bethesda 90:10 129:14
better 49:1 57:20 58:18,21 92:13 93:14 120:5 125:7 135:5 137:17 143:8 144:10 149:8 169:5 172:17 173:12 174:5,7 183:9,13 186:22 195:4 197:9 199:2,7,10 202:13 211:9 213:8,12 237:11 242:13 257:3 260:18 268:7 277:5 294:15 299:21 337:17 346:7 351:13 358:8 363:7 369:4 369:9 370:13 371:9 372:4 375:14 385:22 388:13 400:9,11 401:22 408:18 414:7 420:19,20 422:2 433:1,8 442:6,11 444:10 445:6,8 449:4 451:2 474:22 482:1,4 483:3 484:5 487:15 488:4
Betty 322:17
beyond 39:13 91:16 116:2 283:18 309:19 330:17 383:17,18 412:6 472:3
bidirectional 283:7
big 5:12 57:15 59:2 84:14,16,17,20 88:17 96:17 111:16 151:2 219:10 258:19 279:4,19 281:21 282:14,14 292:7 295:21 299:17 300:16 302:12 303:14 306:22 323:5 326:18 330:7 332:11 334:16 337:11,18 339:12 340:8,10 347:1 356:10 360:17,20 412:4 418:1 444:10 459:4 485:18 487:4
bigger 309:20 321:19
biggest 83:2 103:7 340:9 344:5
bill 24:19
bills 16:6,10
binary 221:16
binders 381:6
biomarker 118:22
biomarkers 121:2
bit 26:7 33:13 34:6 48:1,13 54:5 111:11 130:3 139:1 142:6 153:8 177:7 208:10,11 227:7 247:2 249:20 264:12,14 319:17 327:16 422:13 432:7 435:1 438:6 454:4 465:20 483:12 491:10
Black 262:22 263:2

263:12
Blackberry 186:12
blast 81:12 182:4 483:21
bled 465:5
bless 466:7
Bliel 466:8
blob 96:17
blocks 359:21
blood 91:18 93:2 118:18,21 138:8 138:18 183:20
blow 117:11
blowing 241:9
blue 226:13 278:14 372:8
blues 371:21
board 42:16,18,20 43:14,22 48:7,11 48:16 104:5 122:8 258:6 259:6 292:11,21 383:7 385:20 395:21 425:19 430:20 433:20 455:16 478:2,20 479:8
Board-certified 188:14
Bob 460:8
bode 47:14
bodies 174:16 222:21 293:12
body 134:21 207:22 290:15 369:6 398:14 405:18 421:12 449:10 489:18
bolus 60:21
bomb 226:14 236:16
bonded 362:18
bonding 380:7
book 200:15 286:11 490:16
books 371:9
Boolean 125:14
boom 31:5
boot 444:5 467:8
Booten 176:2
boots 373:4
bore 160:2 300:12
boss 292:12
bother 279:7
bothers 33:12
bottom 225:5 307:18 378:20
bought 285:16
bounces 383:2
boundaries 340:13 389:19
box 47:13 454:14
boy 379:9 423:1
Bragg 120:14
brain 2:9 47:4 49:14 50:21 54:14 56:9 76:5 81:2 89:18 90:7,11,22 91:8,9,14,19 93:9 95:21,22 175:20 428:14 441:16 480:2
brains 90:2 384:1
branch 230:13 257:6 471:14 473:11
brand 183:10
bread 88:17
break 72:14 127:20 178:13,14 365:18 377:10 448:4,7 461:3,4,9
breakdown 436:2
breaking 486:22
breakout 423:21
breathe 113:18
breather 113:19
breathing 164:16
breed 321:8
brief 21:17 47:21 48:10,12 59:4 177:3,6 231:19 393:5 489:2
briefed 23:4 29:12 29:16 70:7 109:5 280:10 483:1
briefers 366:8
briefing 8:5 45:8 109:2 273:5 274:11,12 366:5,9 406:6
briefings 17:11 111:14 172:5,6
briefly 59:3 367:15
briefs 407:5,19
brief-well 419:18
brigade 108:22 109:9 115:6,6,7 130:13 151:1,2 155:10,17
brigades 108:21
brightest 295:18
bring 6:7 13:17,22 19:21 20:5 28:11 39:14 42:10,19 57:7 94:13 115:11 118:12 120:17 171:12 181:19 194:16 223:1 314:11,18 315:5 371:7 373:3 375:11 393:5 414:8 432:22 438:4 481:15 491:3
bringing 45:15 417:7 418:7 466:1 488:21 490:14
brings 95:3 314:14 363:11,12
Brits 380:13
Britts 236:4
broad 136:1 340:22
broadband 325:5
broaden 130:2
broader 166:15 309:10 323:22 329:1
broadly 61:9 70:16 74:7 251:3
broke 29:15
broken 72:15
brought 11:20 27:7 150:20 155:8 223:16 261:17 389:18 415:6 463:14
Bruce's 339:9
BR&E 444:18 447:5
bucks 345:3
buddies 368:7 432:13
buddy 234:10,12
budget 55:7
budgeting 63:5
BUDS 121:1
build 63:1 101:17 282:13 285:4 295:9 297:16 306:5
building 74:21 75:4 90:18 276:11 297:10 301:15,15 350:22 352:15 359:21 422:14 456:14
built 31:7 114:1 147:2,6 149:5 291:9 308:21 399:3 405:16 455:15
built-in 266:4
bulkhead 386:22
bullet 95:3 162:12
BUMED 3:10 177:8 187:2 383:11
bunch 95:18 115:9 118:22 137:5 304:5 343:11 488:10
bundle 96:17
burden 18:15
Bureau 175:8,12 187:2,19 212:2,13 394:5,12,16
Bus 285:13 307:16 307:20 312:3,5,19 331:12 342:7,13 342:21 350:9
business 273:17 289:18 292:7 296:2 301:10 331:20 344:6 355:7 357:3 384:7 384:12 385:10 420:6 428:8 439:16 444:3 470:22
businesses 464:8 465:3
busts 477:4
busy 224:22
button 25:18 278:14
buy 282:14 286:11 290:20 299:16 308:9 321:12 328:11
buying 308:18 328:15
buys 13:10
by-leg 369:11
by-name 383:16 401:9
by-the-by 492:16

C

C 136:17 138:5 155:1
cache 310:8 326:13
cadre 25:19,22 403:1 423:7 437:6 489:3
cakes 467:19
calculation 180:20
calendar 420:10
California 40:16 65:8 116:9 199:6
call 23:20 114:14 125:3 179:5 200:12 206:7 207:8 226:3 227:2 292:21 302:6 329:9 361:13

376:17,18 378:21 379:4,4 382:9 384:19 388:18 440:13 470:22
called 65:7 68:7 102:16 107:14 203:19 236:2 247:8 265:18,19 265:20 277:20 280:18 283:10,12 285:13,19 290:15 405:1
calls 104:7,11
camaraderie 380:6
camp 65:8 67:1 74:19 79:14,18 82:14 118:15 120:12,13 186:3,3 370:7 372:19 375:19 379:15 381:11,18 398:19 399:8,17 421:13 422:4 431:22 441:21 444:5 451:20 453:22,22 462:6 467:8 471:21 474:6,11 478:14 482:14
campaign 89:17 102:2 148:1
campaigns 147:11 147:12
Campbell 379:9
campus 90:10,18 452:6,22
Canadians 235:22 236:4
cancer 125:17,18
candidate 274:2
candidly 395:1
CAP 111:21
capabilities 81:21 233:21 274:7 277:10 278:4,17 278:20 280:4,6 290:12 291:8 300:2,6 303:9 306:16 313:4,8,11 313:12,19 323:19 328:12 333:10 337:10 347:9 350:9 395:17 455:14 456:1,9
capability 9:14 105:2,3 106:3,10 106:17 193:3 307:7,12 308:10 310:6 312:13,14 312:15 317:9,10 329:10 332:6,17 334:10 346:13 354:22 359:17 380:19 381:14,15 395:19 401:8 449:12,15 457:4 463:12 470:4
capable 274:2
capacity 262:21
CAPE 61:7 63:4
CAPE-1 62:22
Capital 368:2 462:21
Capitol 301:19
CAPT 1:16 2:7 47:11 52:14 53:2 53:6 64:11,16,22 65:3 66:1,5,8,16 68:2,10,19 69:3 69:13 73:21 74:2 79:21 80:5 81:8 81:15 82:21 83:5 83:15,22 84:8 86:6,11 89:6,10 89:14 92:5,18,22 93:1,6,12,15,19 94:18 106:2 108:22 109:4,6 110:11 111:3 112:21 113:3,6,9 116:7,10,13,16,18 117:1,4,8,11,22 121:3,6,21 122:6 122:16,21 123:2 126:20 127:3,12 127:15,19 182:9 182:11 227:8 228:2,4,8 390:1,3 390:16 452:3 483:4,6
captain 41:1,1 47:3 47:7 64:8 73:17 79:21 92:12 108:17 115:22 175:15 176:4,9 178:7 179:13 198:12 384:15
capture 200:20 357:1,1 411:13
capturing 191:5
car 247:16 399:1,4
card 298:8,18,18 298:19 323:16 470:22
care 1:3 11:22 12:3 12:6 13:19,20 15:14 16:4 19:3,6 19:8 23:8,9 28:12 31:4 33:15,20 34:18 38:16,18 40:17 42:3 50:6,9 52:1,12 54:14,18 55:16 56:21,21 57:12 58:14 61:1 77:1,14 79:12,16 79:19 81:6 84:11 84:19 86:13 97:13 97:17 98:10 100:13 102:13 107:3,5,8 108:2,8 108:16 109:21 126:13 130:4 134:9 141:12 142:22 143:4,15 143:21 144:2,21 145:18 148:4,6 149:9 151:22 156:2 158:6,11 164:2 166:10 168:19 169:11,20 169:21 170:21 173:17,19 174:10 174:20,21 176:18 184:9,10 188:7,22 189:3,8,9 202:8 216:4,6,9,11 217:18 219:11,16 229:12,16 230:4,5 234:10,12,17 262:13 263:3 271:14 275:22 276:5,10,19 278:2 278:12 283:6 284:20 288:1,14 292:18 296:16 298:14 300:1,21 309:11,19 315:14 320:1 323:14 328:7 364:12 367:6 376:15 381:10 396:10,15 396:16,22 397:2 404:6 423:5 427:13 429:15,19 435:5 437:17,18 440:14 441:1 442:7,9 462:18 480:8,9,16 484:18
career 226:9 235:14 236:14 237:2 238:3,10 241:7 243:4 245:22 246:9,11 247:2 248:9 249:1 252:16 259:5 370:1 384:14 392:7 460:14
careers 438:21 442:14,14
caregiver 384:9 443:7
CarePoint 349:5
caring 308:6
Carolina 187:6 452:8
CARR 2:18
carried 283:2
carriers 107:18
Carrington 460:8
carry 233:12
Carson 107:11 109:6 120:14
Carsons 126:6
case 19:9 20:22 159:14,16 179:20 219:5 232:5 314:19 391:11 395:9,16 396:2 397:4 398:8 400:7 407:13,14 410:9 434:20 435:11 436:12 477:5 478:22 483:7,8,11 483:13,16 484:7
cases 43:9 138:1 160:20 162:14 178:10,12 183:3,7 183:7 217:21 218:1,17 228:13 260:4,19 397:9,19 399:19 423:1 431:6 434:20 438:18 439:20 440:18 478:9,17 479:6,7,9,12
cast 384:16
Casualty 234:17
CAT 93:2
catalog 101:4,20
catch 277:6
catching 92:14 94:3
catchup 488:15
category 138:5 271:4 422:9
cattle 469:20
caught 6:21 92:18
cause 29:3 137:13 137:13 207:2 325:4
caused 124:19
causes 202:2
causing 27:1 134:17
caution 408:4
caveats 229:14

264:20
CDP 78:9 186:8 231:11,18 232:4 257:11
CDR 2:14,18 175:6 182:10,17 195:13 195:18,22 196:16 197:3 201:15,18 202:1,5 205:5 211:21 214:12 220:14 221:3 227:12,17,22 228:3
cease 269:9 450:6
celebrate 486:2
cell 19:13 91:5 437:21 438:7 457:3
center 47:5 49:16 49:17 51:9 56:6,8 56:9 77:1 78:2 79:17,19 81:2 90:1,10,16 97:5 102:8,14 104:4 108:4 113:10 120:10 150:20 174:9 175:18 176:6 185:16 198:9,11 230:17 231:3 236:3 288:1 296:16 297:18 342:8 376:17,18 378:21 379:4 381:11 388:19 441:18 442:9
centered 141:15 168:20 198:17
centers 2:10 46:22 56:6,13,14 58:19 79:12 81:1,4 89:4 89:18,19,19,21 90:5 92:3 94:8 108:3 118:7 126:19 232:10 284:9,12,14 316:2 326:2 332:11 341:15 342:3 347:22 394:3 441:15
central 294:12 462:13
centrally 450:7
ceremony 372:1
Cerners 295:22
certain 30:16 44:4 66:15 132:22 153:15,20 159:21 183:21 193:8 206:15 223:5 250:16 251:14 252:16 258:1 361:18 435:4 445:12,13
certainly 66:1 183:4,8 196:5 207:20 216:15 309:10 325:20 330:5 358:6 394:11 473:1
certainty 184:1
certification 207:12
certifies 18:1
certify 208:4
certifying 36:7
CEUs 187:9
CFI 442:1
chain 83:11 246:9
Chair 273:16
challenge 103:12 364:10 399:19 407:20 419:14 463:3 474:16
challenged 272:12
challenges 103:2 190:14 192:9 259:7 282:18 378:10 391:16
challenging 27:13 193:22 223:13 441:8
champagne 387:19
champion 344:11
chance 380:22 381:1
change 7:19 15:18 15:18,19 77:7 149:7 194:20,21 274:17 305:7 325:22 339:12 344:22 345:3 351:12 418:17 451:14 472:10,14 486:18
changed 204:8 280:14 473:4
changes 42:22 124:4 193:15 200:2 208:15 472:20
changing 126:11
channel 132:22
channeled 150:19
chaplain 246:1
chaplains 236:21 237:5 423:17
characteristics 253:8
characterized 203:15
charge 427:1
charged 44:2
charity 464:21
Charles 1:11,14 2:11 3:9,25 128:13 220:6
Charlie 371:21
chart 199:12 257:17 291:1,11 291:12 307:7,21
charter 280:9
charters 331:11
charts 193:7,10
chatted 5:21
check 6:16 39:5 459:16
checking 290:7,8
cheese 387:15,20 486:1
chest 467:4
Chiarelli 372:5
Chicago 288:1 296:16,19 297:12 297:14 298:5,12 299:15,18,21 300:3,4,14 301:5 302:3,15 303:1,13 303:16,18,20 314:7,10 315:17 332:12 344:17 345:16 346:9
Chief 2:4,21 129:1 273:7 292:13
children 126:14
chime 262:15
choice 30:3 190:19
choose 15:21 414:18
chose 429:8
CHRISTIAN 1:17
chronic 179:9 202:19 269:17
CHTS 275:6
chunk 16:19
churning 201:1
CIO 292:15 293:1 325:7
Cisco 457:17
City 331:18
civil 186:6
civilian 8:9 19:6 23:11 24:11 29:4 30:20 31:2,11 34:21 52:16,22 53:8 78:6 83:18 117:7 124:12 133:18 159:14 161:5,7,10 192:19 208:3 215:13 438:21 440:21 442:15 451:22 456:18 492:13
civilians 451:16
claim 400:20
clarification 195:12
clarify 390:5
clarity 27:12 121:16
class 189:15
classes 420:5
classic 372:20 373:5 386:11
classroom 265:11
clear 122:3 256:16 403:22 425:16 483:12
clearing 75:4
clearly 5:10 18:17 19:18 34:16 178:16 354:21
clerk 370:21
clerks 398:7
click 456:21 457:4
clicks 456:3
climate 55:8 67:14 421:9,11 422:1
clinic 147:19 151:16 153:10 158:20 173:22 189:8 244:3 258:14,21 262:17 262:21
clinical 2:14 50:5 51:9,13 56:8 57:7 57:11 62:20 68:14 69:19 72:19 73:1 73:15 76:4 79:10 93:13 96:11 99:22 100:6,6,8,9,13 101:9 102:8 104:19 108:3 128:17 129:13 136:3 142:11,20 143:2 153:12 154:19 172:19 195:10 197:11 199:21 200:18 206:4 210:4,9,15 214:9 217:4 220:3 229:11,17 230:8 231:9 268:7 483:8
clinically 181:2 202:7
clinician 197:5

215:5 216:13 217:5,12 232:8 271:12 294:20
clinicians 164:1 169:8 171:10 173:22 192:22 197:16 209:13,15 216:3 232:12 271:14 272:3 278:19 289:6 290:14 293:8,16 294:17
clinics 108:2 158:13 233:15,19 256:13
clip 381:2
clock 475:21 477:11
Clonopin 270:22
close 22:7 30:12 42:8 45:10 254:10
closed 66:19 68:1,5 68:8 75:5 141:1 167:20
closely 110:20 322:17 454:13 460:6
closer 239:11 453:13
closes 387:12
closing 389:7
cloud 316:12
Clubb 376:14,14
CNN 472:1
Coach 113:19
Coalition 462:18
code 175:12,12,13 190:18 295:7 305:21 351:21
coded 131:2
codes 226:16
CoE 104:3
CoEs 104:6
coexisting 131:11 174:11
cognition 95:20
cognitive 73:7,8 78:12 94:11,21,21 95:1,4,6,15,15 96:3,8,18 111:6 114:15 122:12 135:16 136:11 137:14 139:1,5,18 140:9 141:17 142:4 144:11 149:15 160:12 163:20 165:12,14 165:16,22 168:2 169:3 181:10 187:4 190:8 191:4 196:1,2 268:15 441:17
cohesive 429:21
COL 1:17 2:4 44:10 162:11 163:6,9 207:11 212:19 220:13,15 220:18 221:10 223:2 227:16,18 228:1,9 239:4,16 239:20 242:16,18 243:8 244:22 245:13 249:12 250:5 251:22 259:16 260:5,10 262:5,14 263:2,12 263:17,21 270:10 272:19 366:1,16 367:21 376:8,13 377:20 379:8 386:13 390:2,14 391:8 392:20 402:11 419:5,11 419:12 422:19,22 423:9,13 424:14 425:11 427:21 430:11 433:13,17 433:22 434:6 435:9 436:10,17 436:21 437:16 438:9 441:1 442:19 443:6,10 444:15,21 447:18 448:1,14,19 449:3 451:7 453:1 454:7 457:8,21 458:20 460:22 461:15,20 461:22 462:3,11 463:16 467:12 468:10 472:12 473:6 474:6,9,13 474:21 475:2 481:5 483:5,15 485:20 488:20 489:12 490:5,21
collaborate 103:16
collaboration 103:5 257:11
collaborative 62:18
collaboratively 388:20
collapse 311:22
collateral 214:21 215:18
collect 57:4 199:7
collected 159:2,4
collecting 183:11
collection 51:10 95:17,17 96:3
collections 102:4
collective 352:13
collectively 340:3 340:21
college 459:14,14 487:11
Colombians 380:15
colonel 128:22 179:5 223:1 262:22 366:15 384:15 394:13 395:13 396:21 422:5 429:8 433:12 440:4 444:13,13 445:3 454:3 460:21 461:19 467:5 469:15 483:4 489:7
colonels 421:17
Colts 466:7
columns 410:13
comb 240:5
combat 75:5 119:8 124:11 130:9,12 130:12,13,17 131:20 132:5,21 133:8 137:10 151:1,3 155:8,11 155:18 156:21 157:9,12,18 168:5 172:14 175:18 176:7 183:7 198:11 202:10 210:12 211:10 218:13 220:7,12 221:2,8,12,15 222:11,15 229:21 234:17 236:16,17 241:2 248:11,13 251:4 253:11 258:7,9,10 265:5 267:3 272:4 369:21
combat-focused 240:20
combat-related 183:4 201:13 202:4,16 267:15 479:8
combination 156:14 160:20 322:14
combinations 180:21 181:1 182:2
combine 298:2
combined 158:2
come 4:6 20:16 29:7,14 31:7 34:13 38:22 41:10 51:3 53:18 63:8 64:17 86:1 91:4 117:13 126:9 130:11 132:9,19 134:2 135:6 142:17,18 143:5,6 148:5 151:15 168:1 169:11 171:21 172:10 173:13 174:12,13 174:14 177:20 193:21 194:18 208:14 210:11 212:5 227:1 240:12 245:5 258:13 279:8 281:6 286:22 295:8,20 301:2 306:13,14 312:16 326:2 338:11 354:1 363:21 373:4,9 375:4 380:20 381:20 387:21 389:2,7 395:14 404:2 431:5 432:2 439:15 452:9 457:15 461:1,4,8 461:10 463:7 469:21 483:20 489:2
comes 24:19,21 27:3 71:4 86:15 92:15 181:5 206:5 214:15,19 231:19 264:14 313:7 321:7 350:1 361:22 379:18 384:21 399:19 451:18 471:5 486:17
comfortable 15:20 16:1 168:13 246:14
coming 6:12 9:7 11:22 14:5 23:6 38:18 42:8 48:10 61:19 67:17 71:6 85:19 91:21 93:3 94:8 127:22 151:2 177:18 184:10 196:13 201:9 205:20 223:12 235:19 242:20 260:17 267:3

294:10 311:14 363:2 401:5 436:19 456:9 457:14 479:4
command 36:20 52:9 57:18 104:22 178:9 182:20 398:1 421:9,10 422:1 427:6,15 431:2 437:9 450:15,22
commandant 367:5 425:17 441:4 478:6
commander 17:22 36:6 82:16 128:16 128:19 175:7 176:13,21 182:9 190:4 233:20 383:15,16 419:16 420:14,17 431:20 437:1,2 449:17 451:1,3 486:19
commanders 394:15,17,18 427:10 430:19 431:3,11,12 433:20 441:10 443:14
commander's 431:17
commanding 366:3 453:2 463:11
commands 156:9
comment 8:22 147:6 210:15 211:18 309:7 347:7 353:18 427:7
commentary 122:4
comments 11:16 115:13 129:22 193:11 259:22 394:14
commercial 91:5
commercially 304:18,20
commingle 297:2 305:17
commissioned 61:14
commit 336:5,16 336:16
commitment 340:21
commitments 275:18
committed 184:8 338:5 478:7
Committee 21:5,6 48:4,9 129:9 293:10,11 472:18
committees 43:12 52:7 71:18
committing 336:17
common 42:18 143:3 246:19 277:19 283:4 284:7,15 285:2 286:4,15 287:9,9 288:4 289:16 290:4,12,21 294:11,20,21 297:19 298:19 307:18 308:14,20 308:20 315:9,13 316:2 317:2,11,15 320:8 321:15 323:11 331:16 332:10 341:16 342:1,2,5 346:17 351:21 355:1 357:15 358:3 359:21 379:7 385:2,2 484:21
commonly 137:8 362:6
communicate 135:5 174:7 285:15 342:9
communication 402:6 483:10
communications 310:19
communities 58:6 58:17 126:6,10,11 126:16,22 243:22 292:16
community 9:12 11:10 56:12 57:21 65:6 78:6 82:19 97:19 243:7 244:10 250:7,8,9 394:22 395:4,6 397:17,18 450:3
community-based 6:3,4,5 32:10
companies 29:14 351:4 444:7 470:15
company 116:21 283:12 286:19 287:5 289:2 296:2 306:12 321:9,10 345:2 371:22 376:20 465:7,19 473:16
company's 288:18
comparable 137:20
compare 159:10 247:19 268:19
compared 26:11 254:3 268:14,15
comparing 160:8
comparison 9:16 27:1 70:15 252:18 268:12
compendium 61:17
compensation 458:7 479:9
competency 215:15
competing 187:14 358:16
competitive 380:7
complain 124:14
complaining 421:21
complaints 219:7
complete 19:17 20:18 109:2 153:1 153:4 196:19 234:11,11 239:14 400:17 406:12,21
completed 18:12 18:14 36:6,15 101:22 102:2 145:16 187:18 331:21 406:18
completely 7:14 34:8 283:15 302:12 313:9 347:15 348:11
completers 153:15 153:19
completes 448:2
completing 153:15 153:19
complex 88:15 90:7 95:4 97:4 123:7 209:1,4 223:11 291:15 362:10 384:11 439:17
complexes 75:20 119:1
complexities 87:20
complexity 480:13
compliant 379:6
complicate 131:12
complicated 419:22
complications 112:10
component 40:9 41:4,12,16 56:6 58:19 81:1 108:3 139:17 216:14 438:4
components 136:11 139:2,8 140:14 141:14 194:3 195:7 212:16
comports 405:21
COMPO-2 17:19
COMPO-3 17:19
comprehensive 49:8 50:3 63:1 74:5 82:17 90:20 213:5 217:20 254:16
Comptroller 292:18
computable 363:15
computer 298:17 316:7 407:11 419:13 459:18
computer-based 384:5,20,22 420:4 443:1 481:11
computing 284:12 316:12 324:14
coms 326:8
concentrate 133:3 181:7
concentration 174:19 185:8
concept 34:14 45:17 377:9
conceptualize 208:12
conceptualizes 56:1,4
conceptually 255:17
concern 111:19 173:11,12 395:8 415:16 475:14
concerned 43:12 60:5 206:10
concerning 338:20 439:7
concerns 44:3 148:21 149:2 195:6 203:19 204:16 208:13,13 208:16,17,18,21 209:2,8 261:13 330:20,21
concert 394:16 405:17
concluded 493:8
concludes 493:5
conclusion 4:7 219:21
concussion 76:10 77:1 79:12,16,19

89:20
concussions 94:3 131:21
condition 74:16 131:11 132:13,14 135:7 153:14 438:22 440:7,14 440:17 449:20
conditions 51:16 131:17,18 132:8 157:15 174:12 203:15 208:22 400:18,20 440:16 480:13
conduct 392:18
conducting 60:15 62:7
conference 63:10 334:15,16,17 483:18
conferences 52:11
confidence 160:6 172:22 334:2 373:11 441:22
confident 333:1,17
conflate 302:7
conflict 71:2 83:4 92:16 203:10 254:9 255:7
conformance 322:22
confound 252:22
confounded 479:21
Congress 24:21 60:22 99:17 227:15,19 318:17 459:10
Congressional 71:18 81:9 281:12 439:13
Congressionals 24:21
conjoining 394:21
connect 64:19 312:5 455:7
connected 58:3 65:6 109:14,16
connection 187:7 483:7
connections 56:11 56:17 325:5
connectivity 309:21,21 324:11 324:18 325:5 326:11 353:11 360:14
Connie 390:3,14
consensus 5:15 223:8 430:22
consider 165:9 217:15 402:20 473:2
considerable 129:12
considerations 431:1
considered 156:21 156:22 162:4 239:8 356:4 395:3
considering 107:15 182:12 305:1
consistency 439:4
consistent 11:3 50:1 80:8,13,16 160:14 221:6 226:10 229:2 378:12 471:1
consistently 130:15 238:19
consists 435:10 438:11
consolidate 316:5
consolidating 63:2 316:1
consolidation 316:17
consortium 118:6
CONSTANCE 1:16
constant 122:14 486:16
CONSTANTINE 1:15 25:3 151:7,9 152:3,10,18 160:22 161:2,8,14 161:18 244:21 245:1 267:22 269:6 270:5 272:9 301:1,18 427:5
constantly 110:15 369:19,20 431:6 432:18 439:19 441:7,22 449:4
constellation 203:18 205:1
constellations 206:2
constitute 135:20
constitutes 135:12 135:22
constrained 211:14
Consultant 2:12 128:14
consultants 189:4,5
consultation 230:15 232:3 234:6
contact 5:21 190:5 401:14 417:8,15 417:16
contained 379:2 471:17
content 237:7
contested 439:12
context 59:11 132:11,14 133:20 133:21 134:14 166:15 174:8 215:18 314:8 332:15
contingency 31:1 31:10
continual 260:3
continually 166:16
continue 66:15 97:18 106:19 133:10 192:12 194:12 244:13 300:19 310:22 350:14 352:19 399:21 477:19 482:7
continued 8:13 312:22 458:14 479:19 480:4
continuing 66:17 188:11 356:6
continuity 438:16 439:4
continuous 290:2
continuum 50:8 52:1 55:15 275:22
contract 10:17,17 10:19 11:4,7 186:6 331:12 342:12 345:2 376:19
contractors 464:13
contribute 425:10
contributing 210:1
control 139:22 153:7 155:9,19 157:13,18 175:19 176:7 181:15 198:12 222:1,2 252:12 253:14,22 255:1 264:21 265:2 357:11,14 453:3 463:11
controlled 153:14
controllers 226:18
controlling 253:7 253:10
controls 188:18
CONUS 57:1 95:2 240:16
convenience 476:22
conversation 140:2 323:22 334:19 352:19
conversations 346:3 482:5
convince 358:10
convinced 270:9 443:21 487:18,19
convincing 417:6
convoy 236:17
cool 321:10 370:16 375:17 378:6 458:20 468:20 487:3,7
Cooper 459:17
cooperation 230:16
cooperative 115:8
coordinate 103:22 104:11
coordinating 226:20
coordination 102:13 377:3 396:11
coordinator 360:2 396:22 397:2 416:17 449:11 450:14,18,20 480:9,16
coordinators 382:3 388:18 396:15,16 482:1
cope 270:4
copies 399:13
copy 17:17 18:3 71:21 228:5 392:5 404:15
core 49:21 123:4 139:2 140:13 141:13 149:13 194:3 195:7 196:8
corner 369:1
corporal 368:1,5,6 368:10,15 369:10 370:2
corporal's 368:9,10
Corps 3:15 41:13 74:10 79:6 102:1 102:5 107:13 119:8 186:7 224:9 238:21 366:4 367:5 368:6,12 369:22 376:16 379:16 383:12 384:4 386:8,17,19 388:8 391:9 392:13,22 394:6

394:18 395:11 396:9,12 398:2 405:17 419:8 426:11,12,18 429:12 439:5 441:4 449:14 453:12 459:2 462:9 469:7,10 470:10 471:8 473:1 475:8 478:8 480:22 482:9 489:4,14
Corpsman 372:18 438:18
corpsmen 182:14
correct 35:13,14 37:21,22 162:15 195:20 223:13 326:19 365:22 445:17 450:8
corrected 37:4
correctly 30:9 162:13 263:15
correlates 221:20
correlation 222:18 406:14
cost 61:7 63:1 211:22 470:2
costs 25:10 71:8 288:8 325:20
Council 60:20 103:19 290:16 293:10
Councils 103:20
counsel 400:15
counseling 108:11 407:10 417:19 427:16 443:15 446:2
counselor 444:18
counselors 151:10 192:4 445:19
counterparts 239:11
countries 235:21 288:20 379:22 380:2,17
country 79:2,13 116:4 316:13 490:7
counts 477:10
couple 14:4 29:16 50:13 62:4 67:14 84:3 102:9 103:13 154:2 164:17,19 180:15 201:12 224:2 235:5,21 236:7 240:9 281:2 299:2 311:7 334:7 391:12 470:21 493:2
coupled 282:15,20 282:21 289:21 343:19
course 51:21 63:9 144:10 167:4,6 183:2 184:2 185:20 197:19 202:19 232:9 234:16,17 252:22 274:18,22 275:16 308:4 312:10 344:20 368:9,10 372:8 373:6 375:8 391:18 419:19 426:13,17 431:17 432:6
courses 431:19
court 87:19
courtesy 71:21
courtroom 177:14
cover 388:2
coverage 13:12 16:13 17:2 20:18 21:19 33:19 38:13
covered 223:5 440:3 448:21 475:6 481:9 489:7
covers 20:13 95:8 215:1
cowboy 459:8
cows 373:14
Co-Chair 1:11,12 1:14,14 3:2,25
co-chaired 52:4 292:11
co-locate 284:10
co-located 19:5 284:14,17 287:21 346:10
co-occurring 51:16 123:19
co-opting 248:18
co-pay 21:18
co-pays 16:15,19 22:4
CPG 271:22,22
CPT 140:9,12,15 151:5
crack 264:3
craft 40:21
crashing 419:2
crazy 56:3 167:22 172:13
create 325:12 354:16 455:20 456:17
created 377:11 388:12 399:15
creates 112:10
creating 345:18,19 376:10
creation 28:5
credential 150:3 360:6
credentialed 150:2 151:22 152:16 158:15
credentialing 158:12 188:10
credentials 359:14 360:10
credible 197:2
credit 344:12 384:2
criminal 215:15
criteria 80:3 101:6 101:6 124:18 179:12 200:2,7,11 205:10,17 206:20 219:19 220:2 410:13 430:12,18 432:8
Criterion 179:12 180:2
critical 108:4 164:1 167:11 173:15 233:7 388:16 426:16
criticisms 49:12
Crockett-Jones 1:12,14 3:2 4:3 9:15 16:12 23:21 120:19 121:12,22 122:7,17 123:1 127:8,13,17 239:2 239:5,19 273:3 304:15 305:9 364:20 365:2,5,12 365:17 367:20 402:18 404:7 408:3 445:9 492:12,17 493:6
cross-reference 18:5
crowd 372:9
Crown 1:10
CRP 402:16,20,21 402:22 403:17 404:8,11,15 405:12,15,16 407:5 410:14 411:19 412:17,18 413:5,11 414:21 416:8
CRPs 405:21 406:17 413:11
crucially 285:8,9 342:11
crunch 26:7
CSM 1:15 10:10 15:8 22:6,14 23:3 24:7 29:11 105:21 401:1 407:4 414:10,13,21 415:1,4
CT 93:2,6
CTO 320:22
CTP 487:14
cultural 335:5
culture 147:22
cumbersome 299:7 405:2
cure 270:2 432:15
cures 270:1
curious 377:13
current 38:2 55:7 69:14 70:17,20 76:22 100:20 136:4 249:8 295:21 311:11 312:18 455:14 472:8
currently 66:20 104:20 147:7 358:9 395:17 396:19 397:9 454:16 473:14,19
current/existing 324:7
curriculum 52:10 232:11
custodial 294:6
customize 287:13 350:21
cut 29:21 252:10 392:15 478:4
cute 373:2
cutting 55:7 372:20 373:5 386:10 390:8
cycle 331:7
cycles 242:13
Cyprus 236:5
C-coded 259:15,19
C-O-N-T-E-N-T-S 3:1

D

D 1:15 271:4 272:1
dabbling 26:15
Dailey 3:5 4:8,16 5:6,20 8:21 11:2 12:11,14 31:22 32:3,9,14 33:2 35:20 37:15,21

40:8 43:11,18,21 44:8,15,20 45:5,7 46:19 82:11,22 109:1,5 110:9 111:13,22 126:3 126:21 127:20 222:22 228:6 263:19 264:1 437:20 450:10 457:20,22 458:5 458:16 488:11,22 490:22
daily 367:6 383:10 404:4 405:8 412:15 458:8
Dakota 91:2 469:19
dance 373:1,5
dang 466:7 483:21 486:10
Daniel 176:2
dashboard 99:9
data 42:15 43:7 51:10 57:4,5,5,6,8 57:8 72:10 89:5 98:15,20,22 102:4 141:16 142:10 145:17 159:2,4 160:16 163:2 178:8 183:10 197:4 199:8 202:6 210:15 218:8 220:20 225:5 227:10,20 242:21 252:8 255:10 259:17 277:9 278:6,6 282:15 283:4,10,19 284:5 284:9,13,16,18 285:1,2 289:7 294:11,12,15,20 307:18,19 309:13 310:8 312:6,7,17 312:20 315:1,11 315:12,12 316:2,2 316:5 317:6 320:2 320:9 321:15 326:2,12,13 331:16,19 332:10 341:15 342:5 347:20 348:1,2,13 348:13,14,15 349:1,9,9 350:9 351:5 353:18,19 354:11 355:1,21 355:21,22 357:1 357:15 358:3 359:10 363:4 395:15 396:8
database 278:7 283:5 284:7 312:18,22 356:10 383:19 385:3
databases 285:15 355:2 356:16
date 7:6 34:10 187:17 188:16 189:13 210:5 392:12,14
dates 5:8 31:20 44:12,22 45:2 244:14
daughter 180:14 467:18
Dave 275:15 330:9 341:12 345:4 357:5 363:5
David 1:19 2:4,21 3:12,14 128:22 273:6,15
DAXORD 17:15,17 17:17 18:3,6,7,11 19:3 21:8
day 12:21 20:16 29:12,17 64:20 119:20 151:5 156:19 157:10 187:15 194:15 245:10 266:20 272:22 273:16 274:3 307:22 309:15 368:17 372:10 388:16 397:10 409:16 412:13 420:9,16 420:19,21,21 439:11 468:6 470:9 471:4 472:3 483:3 486:14 489:18
days 7:18 20:13,17 21:19 22:7,12,16 23:1,10 27:17,17 27:18,19 28:3,6,7 28:15 29:19 34:10 35:17,20,20,22 36:3,5,16 37:7,8,8 38:14 42:2 64:10 65:16 71:21 119:5 119:5 157:10 236:7 238:11 264:8 266:7 341:2 343:12 383:17 384:21 397:6,11 397:13 447:5 469:11 475:18 476:4,7,9,16 477:1,3,5,13,18 477:18 479:2,3,22 491:12
daytimer 487:19
day-to-day 294:3
DCoE 3:6 48:21 49:7,12 54:10 56:5,9 59:21 69:19 81:1 91:3 94:11 99:19 103:14 104:17 112:13 113:2 120:9 147:14 201:11 211:5,5 230:19 255:2
DCoE's 72:10 85:14
DD 388:9 390:19 391:15 392:10,14
dead 222:21
deal 14:1 20:19 39:19 53:1,19 57:22 125:15 284:21 306:22 434:14 491:21
dealing 125:21 127:1 205:14 242:14 408:5
deals 472:6
Dean 482:12
death 241:2
debate 266:1 356:9
debt 432:22
decide 146:6 363:14 432:15
decided 68:9 169:1 302:10
deciding 314:22 447:12
decision 35:1 36:10 220:4 292:12 340:1 361:2 429:22 434:15 435:8 436:13 479:22
decisions 42:22 63:5 66:14 348:17
deck 386:21
decompensate 156:17
decompression 236:3 266:2,5,16
decouple 321:7
decrease 267:6
decreases 475:10
dedicated 233:22
deductible 20:14 33:18
deductibles 20:19
deeper 61:22 379:4
deeply 278:19 289:10 294:4 339:8 359:6,9
default 67:15,19
defense 1:1 2:10,22 15:11 40:20 46:22 47:5 56:8 61:7 69:22 71:17 81:2 273:18 283:9 284:11,12 292:21 293:2,3 326:5 388:10 451:12 464:13 485:9
defer 360:1 436:22 452:18
define 21:4,5 153:3 426:4
defined 49:15 101:7 153:15 182:20 203:22 204:2
defines 182:21
definitely 5:16
definition 86:3,5 153:17 182:22 204:2 240:22
degree 97:7 265:14 266:19 269:19 400:4
DeJONG 1:15 10:10 15:8 22:6 22:14 23:3 24:7 29:11 105:21 401:1 407:4 414:10,13,21 415:1,4
delay 45:14 177:7
deliberately 243:2
delineate 145:9
deliver 49:2 135:21 139:10 140:13 141:13 142:13 144:21 168:19 169:11 174:5 274:7 337:7
deliverables 330:15 331:9 346:20
delivered 97:8 139:4 291:9 307:8 332:20
delivering 280:4 339:18
delivery 8:9 19:10 71:21 84:6 90:5 90:14 112:6 158:18 240:1 337:10 338:13
delve 145:13

demand 322:22
demanding 322:15
demands 310:16
demob 8:15 9:2,3 35:9,13,18,21 36:1,4,12 37:7 45:16
demobilization 8:6 8:18 17:10,16,19 17:20,22 18:15,22 19:14,15 34:15 35:2 36:9 40:11 40:17 41:4,17
demobilizes 10:13
demobilizing 36:11
demobing 11:4
demonstrate 213:17 287:1 306:13
demonstrated 213:7
demonstration 303:5,12
Denise 3:5 33:8 43:10
denominator 150:10
dental 9:18 10:11 10:13,15
Department 1:1 2:22 40:20 273:18 280:8 283:9 292:16 310:20 478:19 479:13 485:8
Departments 275:7 275:17 278:15 279:19 280:7 285:17 290:14 293:13 297:9 324:15,17 328:13 329:1,6 332:1 361:2
departure 288:12
depend 262:17,20 348:18 357:2
depending 112:17 130:16 317:3 348:18 410:10,10
depends 251:9,15
deploy 155:22 237:20
deployed 76:11 118:10 137:9 157:15 174:16 198:15 218:12,13 229:22 239:9,11 247:14 342:8
deploying 126:8
deployment 2:15 2:19 13:4 14:6 51:9 56:7 78:3 97:6 102:8,14 108:3,14 126:7 128:20 175:11 185:16,16,20 198:16 210:6,8 230:17 231:4,14 235:20 238:11,11 248:22 249:3 253:10 259:1 264:5
deployments 224:17
deployment-relat... 185:21
deploys 155:11
depression 123:21 131:15 196:6 221:7 265:7
deprivation 132:2 156:15
depth 128:2
deputy 2:21 104:9 273:7 292:13 403:3 478:5
DES 400:14
describe 69:18
described 123:10 290:21 296:12
Description 70:14
Desert 214:6
design 173:18 459:18
designated 240:20
designed 70:9 74:6 94:9 243:20 255:18,19 256:11 300:11 343:10 382:11 385:21 459:22
desire 445:21 470:5
desired 377:2
desk 396:3,4
destigmatizing 260:16
destination 391:1
detachment 401:20 431:13
detachments 155:19 385:8
detail 62:3 277:7
detailed 281:17
details 160:2 164:7 316:4
determinant 335:9 336:5
determinations 427:11
determine 61:3 100:20 136:19 479:16,19
determined 230:22 347:14 348:11
detriment 16:16
develop 49:7 50:2 61:9,16 97:13 99:7 100:5 198:6 222:8 248:11,14 248:15,16,17 267:18 296:4 342:4 378:20 400:10 403:22 412:2 454:14 471:14
developed 51:14,20 100:8 232:10 287:10 303:17 341:17 375:1 376:17,22 383:20 385:13 410:4 415:21 447:2 454:6,8 457:14 481:11,14
developer 377:17
developers 163:19 165:14 351:4
developing 49:1 97:6 109:19 198:6 308:18 410:15 411:14 449:15 457:3
development 147:8 221:21 232:8,11 282:13 286:22 306:10 342:8,15 403:14 435:15
develops 376:20
devices 112:20 325:2 465:20 487:1
devil 367:22 419:18
devil's 86:12
devise 197:5
diagnose 184:1
diagnosed 119:10 121:19 122:1 130:21 131:6 228:13 250:19
diagnoses 131:2 205:6 208:8 209:10 251:5 258:5
diagnosing 121:16
diagnosis 49:9,19 49:20 50:10,20 55:19 70:12 122:4 122:10,14,22 130:18 131:12 181:22 200:21 205:3,11 206:14 210:17 214:9 216:16 217:13 220:22 222:4 224:20 225:15 228:22 229:4 249:9,16 250:10 255:11,19 257:20 258:14,16
diagnostic 9:5,14 124:8 179:11 183:21 200:2 205:9 219:19 220:2
diagram 120:10 330:6
dialogue 437:17
Dickey 2:4 3:12 129:1 207:11 212:19 220:13,15 220:18 221:10 223:1,2 227:16,18 228:1,9 239:4,16 239:20 242:16,18 243:8 244:22 245:13 249:12 250:5 251:22 259:16 260:5,10 262:5,14 263:17 263:21 270:10 272:19
Dictionary 283:10 283:19
Diego 116:5,9 176:22 186:1 199:6 483:19
diesel 459:3
difference 142:7 201:20 202:3 203:9 212:7 255:11,15 265:4,9 265:14,15 267:8 298:4 378:15 430:7
differences 133:18 254:20,22 266:17 324:5
different 26:10 56:10,11 61:15,22 81:12 90:5 95:13 95:18 99:14 107:13 112:19 120:5 123:3 124:10 141:14 142:12 154:12

177:4,15 178:22 180:16,21 182:1,2 203:13,14,19,20 221:13 228:12 235:7,8 240:9 241:15 253:1,1,2 262:19,20 274:12 275:21 279:10 291:20 292:20 294:8 297:22 298:1 308:13 317:17 320:14,16 334:2 337:22 348:4 354:1 358:21 380:1 383:12 415:2 426:20 431:1 432:8 439:6,20 456:15 459:7
differentiation 240:13
differently 8:2 80:18 201:14 276:14 290:6,8 333:4 347:15
difficult 23:14 24:12 32:19 34:3 38:9 86:13 88:16 88:19 171:5 181:17 192:7 202:17 203:1 221:16 252:17 411:9 418:6
difficulties 29:8 33:6 48:17 134:18 419:1
difficulty 24:9 29:3 58:21 81:20 84:18 87:22 96:12 97:3 99:14 103:11 125:22 253:18 382:13
dig 295:13 304:12
digest 57:6
digestible 378:1 379:6 385:21
digging 215:18
dignitary 437:13
digs 291:2
dilemma 167:9 170:18
dim 367:11,12
diminish 270:3
diminishes 378:14
dimmed 367:12,13
dinner 389:8 489:15
Dir 3:5
direct 353:10 458:15
directed 318:3 319:3 398:1
direction 40:12 48:21 274:5 294:3 339:1
directives 83:10
Directive-type 76:9
directly 402:8 414:5 455:10,21 457:5 470:11
director 2:7,14,18 47:3 128:17,20 175:10 176:6 273:22 279:17 281:9 294:1 341:1 353:10 459:17 466:12
directorate 176:14 176:15,20 189:1
directorates 175:16
directors 104:10 383:13
director's 48:20 49:6
dirty 320:11
DISA 284:11
disabilities 111:18
disability 42:16,18 42:20 43:22 214:11 215:13 217:21 218:1 219:1,2,5,12 329:3,12 370:18 382:16 385:14 440:8 479:7,17,17
disabling 156:12
disadvantaged 309:22
disagree 343:17
disappointed 255:13
disaster 124:12 202:20
disasters 203:3
DISA-VA 332:8
discern 14:16
Discharge 43:13
disciplines 206:22
disclaimer 177:10
discomfort 121:15
disconnect 406:22 416:20 456:11 485:4
disconnected 415:5
discontinued 67:7
discrimination 423:2
discuss 128:12 134:13 149:3 197:17 223:4
discussed 98:1 212:4 318:11,16
discussing 243:3
discussion 5:18 7:2 36:22 42:14 64:10 130:2 208:10 212:20 221:14 238:2 243:7 247:5 257:15 264:15 330:10 404:19 462:6
discussions 41:8 229:14 245:22
disease 8:13 18:20 19:18 22:15 28:4 28:12 34:11 49:21 71:5 91:22 209:16 347:8 354:1,4
disgruntled 421:20
disincentives 258:20
Dismantling 141:17
disorder 27:21 123:20 124:3 128:11 135:9 156:13 157:1 178:17 196:7 199:21 200:12,14 200:14,19 207:7 214:17 217:1 221:7
disorders 55:19 102:15 125:10,12 178:18 198:17 201:5
disparate 355:2 356:13
dispersed 6:12
displace 433:10
disposal 226:14 236:16
disqualification 249:10,18 250:4,6
dissatisfied 423:4
dissemination 104:18 173:1 272:2
distance 462:9,11 462:13 463:9
distances 427:15
distinction 221:17
distorted 168:4
distortion 168:18
distracted 185:8
distress 197:15
distributed 356:18
distribution 83:12
district 388:17
disturbance 174:18
dive 61:22 289:9 379:5
diverse 176:19 199:20 251:20
diversion 353:6
diversity 221:14
divide 390:9
divided 328:6
Division 318:10
doc 141:2 169:16 188:7 287:17 298:17 482:14
docs 11:4 15:13 189:9 288:3 297:21 300:11
doctor 152:19 270:7 285:20 399:13 438:14
doctors 11:5 15:18 31:11 288:2 290:21 453:20 483:21 485:17
doctrine 119:8 157:5
document 106:8 363:12 402:21 403:2,5,6,7 405:2 405:14 407:15 410:21
documentation 11:21 12:4 160:17 163:4 237:9 403:6
documented 130:14 258:22
documenting 289:22
documents 69:16 331:11 410:22
DoD 1:11 3:14 38:22 49:16 51:7 51:12 53:5 55:12 60:22 61:8 70:2 70:21 77:11 78:3 78:14 92:8 100:20 105:9 106:5 108:5 111:15 127:6 147:13 208:2 272:7 273:8 274:22 275:5 276:18 282:20 283:19 284:9 288:13 290:6 292:13 293:14 294:8,9,19 296:18 298:11,19 306:10

309:6 311:16 316:22 318:19 321:20 323:11 325:7 326:4 328:8 331:2,17 336:3,20 340:22 345:14 359:5 360:8 361:9 362:3 374:3 382:15 383:2 409:11 445:17 451:17 457:11 458:10,15 473:7 486:17
DoDI 458:1,18
DoD's 54:15 340:3
DoD/VA 72:19 73:1,15 99:1 136:3
Dog 367:22
doing 6:14 25:8 32:2,4 49:18 59:1 66:11 67:16 68:13 75:7 77:22 83:17 85:21 87:14 94:6 94:13,19 95:2 97:4 99:11 105:11 108:6 112:11 114:6,10 115:14 115:18 117:5 118:8 120:14 124:22 125:22 134:7 155:3,6 157:21 170:14 172:2 173:22 174:9 188:4 196:7 199:11,12 200:16 208:4 211:19 215:11 216:11 223:10 227:5 233:8 235:11,13 237:19 241:4,8 252:20 255:3 268:9 276:22 279:3,10,13 288:19 300:18,22 303:19 310:14 321:1 329:19 330:6 349:5 351:19 352:4 359:6 373:16 375:18 376:4 383:14 384:15 388:4 393:19,21 398:20 401:7 403:12,19 409:7 409:13 415:20 416:13 423:18 425:17 426:7 429:17 430:1 442:2,2 444:9 451:21 458:21 468:6,12,20 479:6 479:6 482:22 485:21 486:14 488:22 491:11
dollar 352:15,16
dollars 16:10 353:14,15
donated 90:15
donors 465:1
door 193:21 478:21
double 257:17 398:17 431:7
doubled 430:15
dovetails 108:5
downgraded 271:22
download 114:3 374:12,16
downloaded 51:18 376:3
downloading 53:8 419:2
downtown 31:6
Dr 4:9,9,10,13 14:19 23:14 25:13 25:15 30:2 38:11 38:20 39:8 42:1 45:1 48:8 53:10 64:8,12,17 65:1 73:17 74:1 115:22 116:8,11,15,17,19 117:2,6,10,16 120:21 121:4 128:13 129:7,8 141:18 145:4,10 146:18,20,21 147:10 151:8,11 152:7,11,20 153:2 153:5 154:5,7 155:5 161:1,6,9 161:16,19 162:16 163:8,10 166:19 166:21 167:8 170:19,22 171:2,9 177:21 179:6 186:10 193:18 198:7 201:12 202:12,14 203:12 207:3 208:9 210:18 211:17 217:19 225:17 249:6 257:4 259:13 261:8 264:17 267:22 268:5 269:12 272:10 309:4,6 318:1,6 319:5,9 319:14 322:1,5,8 324:3 325:16 326:19,22 327:5 336:7,10 343:3,14 347:7 349:13 353:17 355:9 377:15 418:18 419:5,10 433:12 433:14,18 434:1,9 437:7
Drach 4:14,15 152:19,21 153:3 154:1,6 155:3 444:13,16 454:3 454:21 467:5 468:5
dramatic 27:20 76:16 254:21 261:18 274:17 399:17
dramatically 309:15
draw 118:18 153:6 214:3
drawing 317:5
dressed 371:21
drill 125:20 191:2 420:1,2
drilled 88:22
drive 472:10 477:19
driven 261:19
drives 56:3 173:21 348:3
driving 146:4,12 169:22 293:17 344:3
Droid 286:3 375:15 375:15
drone 239:9
drop 142:22 143:4 144:13 145:6
dropped 145:18 228:15
dropping 143:20
drove 474:14
drowsiness 137:13
drug 290:8 299:12
drug/drug 290:7
drum 339:17
DSM 205:9
DSM-IIIR 201:1
DSM-IV 200:11
DSM-V 124:7
DSM-5 199:21 200:22
DTC 102:14 237:22 243:16,17 252:3,7 252:15 253:17 254:22 255:3,17
DTM 89:21 94:1 98:2
dual 402:22
due 71:16 404:3 405:4 427:7 453:16 482:4
Dunford 441:5
duplication 403:18
duration 270:13
duties 13:11 23:4 25:4 38:17 249:11 259:14
duty 11:1 13:14 14:18 20:12,15,17 22:22 25:9,12 28:12,17 35:9,11 39:21 99:12 102:12 109:17 129:17 150:1 157:7,10 186:6 190:6 251:11,13 257:22 258:3,16 259:2 262:4,9,13 263:11 266:8 276:3 277:15 299:11 331:7 379:20 429:18 437:6,6 439:8 440:5,5,12,13,18 440:20 449:6,11 449:18 450:2,14 450:16,17,20 451:14 469:5 481:18
dwell 220:8 238:9
dynamic 366:19 408:12,14 484:18 489:17
dysfunction 210:1
D.C 84:14 474:20

E

earlier 59:8 61:15 116:1 204:18 307:12 346:12 394:13 417:3 445:11 452:2 467:8 469:15 489:7
early 60:20 94:3 201:9 264:22 299:15 344:13 346:16 365:11 382:13 392:15 397:6 416:22 417:13 426:5 453:9 482:6

ease 197:17
easier 34:17 203:4 278:13 316:19
easily 125:19 476:17
East 80:9 190:3
Easter 32:18 33:4
easy 302:7 323:2 338:1 344:22 356:12 385:21 411:18 428:17 467:21
eat 387:20 428:21
EBT 256:9,17
economy 16:14
EDIPI 277:20
education 52:9 76:6,11,15 135:5 147:11,12 188:11 188:12 234:8,15 368:9 411:22 413:10 425:14 426:8 431:19 446:13,14
educational-type 484:19
effect 39:10 133:5,6 133:7 138:21 170:12 254:5,17 254:19 265:11 268:3 371:8 397:7
effective 60:10 63:19 67:21 91:15 114:5,9,10 115:20 140:11,14 147:16 154:18 157:5,6 169:6 170:13 189:17 194:22 196:9,13,20 212:15 268:8 450:21 472:15
effectiveness 60:16 63:18 64:5 67:13 69:20 97:17 98:10 113:14 136:7 144:6,8,14 212:1
effects 132:7 137:14
Effexor 189:16
efficacy 299:22
efficiency 478:12
efficient 219:14 393:16 456:10
efficiently 478:16
effort 31:12 90:19 99:20 100:2 108:4 127:4 236:13 248:20 265:16 302:15 338:8 351:7,11 352:8 353:2 403:19 405:11 418:12 492:20
efforts 154:9,11 213:1 321:21 336:3 413:16 475:6
eight 35:16 122:12 123:12 125:7 245:20 380:1,3 471:3
either 19:4 22:14 22:15 23:11 24:22 33:4 60:11 102:11 109:16 119:11,21 120:11 153:13,19 179:15 183:7 190:2,7,21 191:8 193:14 226:1 249:9 265:10 367:13 436:1 456:16
elaborate 393:10
elected 22:8,19
electronic 190:14 275:8 277:4 280:19 297:3,8 327:2 328:1 358:2 359:17 363:6 414:14 420:10,20
electronically 408:10
elegant 362:17
element 45:22
elements 193:8 398:3 401:21 454:22
Elevate 459:12,13
elevated 226:11
eliminate 94:4
eliminated 63:6
email 4:10
emailing 409:13
emails 410:20
embarked 89:16
embed 112:20 242:10
embedded 107:9 107:20 149:10 155:16 157:19 231:15 241:20 242:3 243:19 244:10
embedding 107:7 108:7,18 176:17 189:3
EMDR 73:13 139:6 140:9,11,15 149:15 151:5 160:12 163:21 164:22 165:4,7,8 166:2,4 169:5,5
emergence 8:13
emergency 28:19 28:20,22
emergent 74:20,20
emotional 267:16
emotions 133:8,11 146:3
empathy 142:2
emphasize 76:13 181:21 222:14 303:1 373:22 492:1,8
emphasizing 224:20 260:16
empirical 211:20
empirically 72:7,18 76:2 135:12 229:7
empirically-based 213:14
employee 129:19
employment 29:4 411:22 424:5 452:16 454:5,14 454:18 455:16 457:5
enable 388:21 482:1
enables 381:17,17
enacted 147:7
enamored 319:19
encourage 183:15 264:2 377:20 378:7 381:19 387:11 401:17 421:11 428:15 447:15 459:16 470:12 471:7,11
encouraged 420:18
encouragement 305:14
encourages 85:17
encouraging 161:12
encumbered 469:6 472:7
encumbrances 477:12
endeavor 306:18
ended 37:8 40:4 71:3 253:13
endorsed 254:7,9
endorsement 261:13
ends 303:5 319:17 490:4
enduring 272:13
energetic 464:2
energy 349:21 350:14,16,20 352:5 464:1
enforce 77:5
engage 7:10 140:19 148:10 171:7 173:12,19 181:8 185:14 194:2 233:3 450:22
engaged 7:20 394:11
engagement 147:19 174:1 429:11 446:2
engaging 103:18 195:1
engine 346:21 375:4
engineering 331:21 398:22 399:9 478:15
enhance 148:5
enhanced 79:16
enhances 147:19
enjoy 489:19 490:2
enjoyed 127:16
enjoyment 424:18
enlisted 150:6 431:18,18
enrolled 153:12 190:7
ensure 207:18 382:5 400:15 404:4 437:4 441:10
ensuring 231:12 402:20 435:20 478:7
enter 278:6
entered 445:18
enterprise 284:12 285:13 307:16,20 312:3,5,19 331:12 342:7,13,21 350:8 353:1
enterprises 309:7 324:4
enterprising 354:16
enthusiastic 367:2
entire 61:9 105:6 159:11 276:5 321:5 334:10 369:22
entities 471:19
entitled 169:2

entrance 430:12,17
entrepreneur 444:5 468:2
entrepreneurship 467:7,11
entrusting 418:14
environment 75:5 133:10 211:14 241:10 287:1 290:22 299:9 306:10 325:14 326:3 342:15
environments 224:13 310:2
EOD 182:14 226:13 237:18 238:21 245:19 252:18
Epics 295:22
episode 202:19
equal 11:13
equate 84:19 135:15
equipment 111:2 233:16 246:6
equipped 106:1
equity 44:4
equivalent 142:4
equivalently 140:11
Eric 198:7
Erica 383:22 454:11 482:13
Ernst 467:9
ERP 337:19
error 35:3,4 164:18
ESB 311:9 348:3
esoteric 121:10
especially 16:19 28:10 29:1 83:8 200:6 214:16 217:10 373:12 420:21 451:20 464:12
essentially 74:13 139:19 140:5 142:3 154:14 203:17 220:1 314:18 315:2 363:5
established 90:4
establishment 89:17,22
estimate 173:3
estimating 173:2,3
etcetera 35:11 472:2
ether 10:3
ethnic 71:10
evaluate 57:6 59:22 60:3 94:11
evaluated 63:14 81:11,14 92:17 101:1 102:18 219:8
evaluating 66:4 92:9
evaluation 49:9,20 50:20 55:18 60:8 61:8,10,18 63:8 63:21 66:13 69:16 80:20 217:20 264:20 329:3,13 370:18 382:16 383:7 385:14 440:9 451:6 478:1 478:20
evaluations 60:1,15 62:1,7,15 66:14 215:11,13,16 264:18
EVANS 1:16 79:21 81:8 92:18 93:1 110:11 182:9,11 227:8 228:2,4,8 390:1,3,16 452:3 483:4,6
evening 491:7
event 154:10,16 164:7,8 179:14 222:9 380:11,18 390:11 421:13
events 133:16,17 139:11 156:6 230:1 274:21 423:17
eventual 51:11
eventually 262:10 312:20 313:4,14 313:18
everybody 4:4 71:4 77:21 87:6,7 92:9 92:15 96:5 114:7 123:14 144:15 165:11 177:19 178:2 210:18 223:11 227:3 236:15 266:22 285:3 305:21 306:4,7 318:19 342:22 362:13 382:2 384:20 398:16 443:15 460:17 488:3 491:10 493:4
everybody's 362:14 402:12 475:3
evidence 73:13 75:11,16,21 86:15 115:19 136:5,7,15 137:15,19 141:7 144:1 146:11 154:18 155:1,2 157:3 173:5 198:21 199:8 212:7,22 213:2 217:10 218:4 231:2 255:21 268:12 271:4 272:1
evidence-base 101:17
evidence-based 3:8 72:2,12,20 73:3,4 73:14 75:12 77:16 78:7 86:14 87:15 88:6 94:15 126:1 128:10 130:3 135:10,13,15,20 135:22 136:1,4,14 138:6 142:15 154:21 160:18 162:4 163:5 166:10 168:19 191:12,15 195:8 198:6 199:8 233:2 256:5 257:8,10
Evidently 273:10
evolving 201:3
exacerbated 22:16
exact 142:19
exactly 17:5 29:7 37:10 63:17 84:12 89:10 117:6 125:21 134:21 163:12 208:4 320:20 371:19 383:6 397:3 407:22 408:1 428:6 430:9 467:13,15 484:7
exaggerating 215:22 217:2
exam 188:15
examination 469:22
examine 124:5
examined 114:18
example 109:15 111:6 181:5 207:14 213:4 215:12 216:1,17 222:6,7 224:12 240:18 241:21 243:16 252:19 254:15 289:15 323:1 399:1 489:17,22 490:6
examples 305:15 337:8 442:12
exasperated 45:18 46:5
exceeding 397:9
excellence 2:10 47:1,5 49:17,18 54:13 90:10,17 104:5
excellent 54:20,21
exception 471:15
exceptions 130:8
exchange 327:3 357:18 358:19
exchanges 283:8 307:17
excited 149:9 238:16 321:1 326:1 409:21 415:14 460:16 466:1
exclude 22:4
excluded 101:9
excuse 168:8 349:15 444:14,22 488:19
Exec 3:5
execute 29:22 34:2 38:9 476:12
executed 30:6 38:6 40:22 76:17,18 81:18 85:9,16 407:19
executes 407:6
executing 21:21 85:1 406:3
execution 39:2 48:19 49:2 81:17
executive 104:17 104:22 290:15 293:9,10,11 470:19
exempted 243:17 243:18
exemption 244:12
exercises 140:5
exhausted 72:22 364:21
exhaustive 76:3
exhibit 386:16
exist 15:4 30:13 55:5 313:3 397:5 450:6
existed 341:10
existing 61:17 101:4 147:3 293:12 298:21

302:16 331:2
exists 96:18
exorbitant 23:7
EXORD 30:11 36:14
expand 68:15 110:4
expanded 107:11 108:10
expanding 345:9
expect 105:1 160:14 220:3 466:20
expectancy 251:10
expectation 76:7 76:12 156:8 248:3 248:10
expectations 400:10
expected 134:16
expecting 105:3
Expedia 286:12
Expeditionary 234:16
expending 350:14 352:5
expenditures 70:20 71:9
expense 350:1 472:17
experience 43:5 124:19 130:17 156:6 167:19 169:12 180:3 197:1 200:9 204:9 204:10 210:15 214:5,7 220:7,12 221:2,22 222:15 248:22 267:4 319:18 400:6 456:6,13
experienced 182:5 202:8 237:2 248:21 265:5
experiences 134:14 135:1 139:16 141:20 164:12 167:18 168:5,15 189:11 197:18 218:11 221:8 298:1
experiencing 39:16 151:19 181:5 196:10 197:14 221:5,14 239:9
experiential 247:8
experiment 109:7
experimental 93:10
Expert 129:11
expertise 50:5 230:21 435:13
experts 128:3 135:14
expires 25:9
explain 277:7 343:8 390:7 457:13
explained 25:1
explore 70:10
explosion 241:7
exported 399:16
exposed 46:4 236:16 241:1
exposure 73:7 78:12 87:5,6,16 88:7 90:3 128:1 135:16 136:11 139:5 140:8 144:12 149:14 163:21 164:5 166:3 167:15 169:4 181:9 183:7 190:7 191:3 220:7 233:5,7 253:11 258:7,9,10 268:15
exposures 221:9
expounding 25:22
expressed 422:10 429:14
exquisite 387:6
extend 322:19
extended 23:8,8
extending 108:14
extension 46:10 283:20
extensions 283:18
extensive 66:21
extent 152:2 223:5
external 103:3 189:5
extra 31:12 364:10 422:14 477:22
extract 395:15
extraordinarily 123:7
extraordinary 90:1
extreme 156:15
extremely 428:2
Extremity 47:1
eye 353:13
eyes 141:1 167:19 273:11 467:17
e-fax 363:11
e-faxes 363:21

F

fabulous 375:2 383:19 386:20 387:8,9 392:21 443:2
face 192:10 378:11
Facebook 386:3,5,6 486:11 487:3
faced 101:16 103:12
face-to-face 410:19
facilitate 148:4 151:21 174:1 219:11 264:9
facilitated 245:22 247:2
facilitates 169:21
facilitating 231:21 279:18
facilitation 280:13
facilitator 246:1 247:3
facilitators 197:16 238:3
facilities 79:1 192:20 294:13 302:21 312:17 313:9,10 316:22 334:4 383:13 458:22
facility 8:18 77:15 80:2 192:18 276:8 287:20 296:21 297:14,20 299:5 301:11,13 381:15 395:22 401:10
fact 6:6 25:18 29:9 34:9 36:8 37:5 70:2 85:8 134:20 137:19 142:9 146:14 149:10 170:6 193:19 216:13 217:15 326:1,5 377:22 379:3 400:2 401:16 410:1 424:11 444:2 445:21 446:22 447:11 468:18 472:1,16
factor 162:1 183:6 219:10,10 378:14 470:10
factorial 180:18
factors 103:3 148:9 174:5 206:8,17 217:13 220:21 222:10
facts 26:18 373:20 447:15
failed 488:7
failing 18:13 19:7 85:20
fair 165:6,7 166:8 340:6 439:15
Fairfax 1:10
fairly 80:13 98:3 101:5 123:11 130:1,14 137:20 205:13 206:15 208:20 223:11 230:13 269:13 425:5 448:8
fairness 255:10
faithful 72:12 98:17 257:7
faithfully 72:9 85:9 85:15 97:1,14,21 98:3,5 100:3 189:19 256:2
fall 71:16 106:6 150:2 159:4 301:10 422:9
fallen 37:6
familiar 244:7 457:9
families 54:12 126:14 369:4,5 375:19 378:2 381:16 407:7,15 408:1 417:2,22 418:2 421:15 433:10 453:18 482:2 486:15
family 6:11 90:15 129:15 171:6,11 171:18 175:3 176:19 236:22 246:21 254:10 266:12 276:4 340:22,22 369:2,6 388:14 399:22 405:18 414:19 415:16 416:14,17 416:21 417:8,12 417:15,17 418:5,9 421:12 423:17 435:16
fan 285:11 451:11
fans 386:6
far 75:21 79:4 80:22 88:22 112:15 144:21 148:7 187:21 196:1 197:3 218:14 232:13 295:14 299:4 309:19 347:11 364:20 367:3 368:22 381:15

392:11 422:7 456:11 463:9
fascinating 65:12
fast 190:9 191:7 197:4 304:4 336:6 340:2 352:14 398:16
faster 299:21 335:20 339:18
father-to-son-type 427:3
fathom 22:13
fault 18:9
faults 12:9
favorite 402:12 460:19 475:4
favorites 372:13
FDA-approved 137:5 138:7
fear 124:14 179:17 200:10
February 1:7 70:8
federal 279:19 287:22 296:15 320:22 360:8 456:17 482:9
feed 21:2 373:6 386:14 486:3
feedback 68:16 115:13 141:22 187:21 193:7,11 196:11,14
feel 7:1 14:20 134:15 135:7 139:21 145:21 148:22 157:21 197:17 219:19 222:2 294:22 308:15,22 317:3 317:12,16,17 331:14 336:7 346:18 367:3 408:1 415:4,7,11 419:16 423:11
feeling 174:14 408:2 423:7 427:19
feels 8:2 320:9
fee-base 361:14
fell 8:10
fellow 234:21
fellows 121:2
felt 8:17 11:20 222:1 295:3 425:7 425:9 427:13 434:21
fidelis 367:6
fidelity 97:7 100:12 158:3,18 166:1 170:6,10,15 173:7 173:10 256:9
field 135:15 203:7 235:15 238:3 241:7 246:1,9,11 247:2 248:9 309:21 347:12 479:2
fields 226:9 236:14 237:2 238:10 243:4 249:1 251:14 252:16
fight 369:19,21 432:13
fighter 292:7 326:9 459:8,21
fighters 133:22 459:4
fighting 110:15
figure 50:18 81:13 85:15 93:16 144:18 264:7 352:18 407:22 480:3
figures 471:3
fill 50:4 57:14 455:8 461:6
filled 193:11 455:11 488:6
film 368:5 488:21
final 26:8 69:1 177:6 186:18 363:1 391:1 433:15 439:6 489:14
finally 204:15 234:20 301:11
financial 60:6
find 53:22 62:9 82:15 84:2 168:12 199:3 210:21 252:17 259:21 262:7 341:6 344:6 350:3 364:9 371:4 374:21 378:18 400:3 402:10 418:1 427:1 428:9 430:5 441:9 476:15
finding 52:19 242:9 280:6 304:19 365:11 425:3 441:11
findings 41:20 383:9 391:21,22 398:11 453:4 476:7,16,21 477:6 479:1
fine 141:2 169:13 300:6 331:7
fingers 120:10
finish 448:10,12 491:13
finished 159:1
fire 133:21 462:3
fired 222:19
firemen 472:2
first 17:16 32:17 42:3 47:19 48:11 51:20 53:11 59:13 59:20 60:2,4,14 60:17 71:15 97:2 133:21 135:11 154:4,7,8,8 155:7 167:9 182:18 201:1 212:17 232:22 235:6 246:3 252:6 254:6 266:8 269:10,19 269:20 284:10 287:20 290:3,10 296:19 299:18 300:3,4 303:17,21 316:21 331:19 334:15 353:22 354:9 370:4 371:17 391:13 398:14 409:2 410:16 417:10 418:11 430:13 455:5 456:3 458:14 467:22 470:3 479:16
Fisher 90:15
fit 51:22 56:19 206:2 222:10 278:22 350:22 370:19 423:12 435:7 480:4
fitness 51:5 74:6 213:5 254:17 412:15 479:19
five 35:20,20,22 36:3,5,16 132:4 151:5 163:21 180:4,5,6,6,7,7,10 180:11,12 226:16 230:22 337:6 374:2 381:2 388:3 398:7 429:4 478:20 485:22 489:15,22
fix 29:13 365:11 411:18
fixed 9:8 29:18 485:8
flag 372:11 429:10
flagged 259:1
flashes 462:16
Fleet 437:3
flesh 321:3
fleshed 283:15
flight 250:10 286:12
flipside 10:21
Flores 454:10,11 455:1,4
Florida 40:16
flow 185:10 229:18 309:13 310:11 312:5
flows 342:11
flying 249:11,15 250:7,8
focus 24:8 26:5,10 33:3 49:2,11,19 87:2 98:12 133:3 147:17 155:22 167:17 175:21 176:19 209:9 227:4 275:22 306:2 371:2 386:15,16 414:16 414:19
focused 50:1,17 54:10 75:8 130:1 148:3 149:20 160:19 162:6 208:20 247:6 267:10 277:9 278:17 329:1,10 368:18 449:4
focusing 49:15 147:18
folder 406:9,15 412:19
folks 10:5 12:3 16:16 31:2 46:21 50:14 53:14 68:13 102:11 112:8,14 114:20 121:18 124:13 145:6 201:11 214:8 222:18 224:6 225:9,18 226:14 226:15 227:5 231:13 232:1,18 235:1,12,19 236:8 236:15,16,17,17 236:22 237:1 239:14 240:21 241:5,22,22 242:10 243:12 244:5 245:20 246:12 247:13 248:9 252:5,7

258:17 260:22 272:13 277:20 292:19 293:21 320:22 345:5 354:1 375:2 377:18 393:21 414:4 420:22 422:16 423:18 424:3,16,21 428:8 428:13 434:16 439:11 448:12 482:11,13,17 483:22 485:14 486:9 490:19
follow 12:5 163:6 170:4 377:17 385:21
followed 72:9 98:3
following 145:1 170:5 177:21 281:11 332:5 414:12
follow-on 251:15
follow-up 10:8 13:9 82:12 117:21,21 407:21
food 386:22 428:22
force 1:3,9 2:5 3:11 3:16 47:6 48:9,12 51:5 58:16 59:8 60:19 74:9 79:7 80:11 83:12 89:2 99:21 104:15 128:8 129:2 157:16 213:19 223:18 224:5,7,16 225:7 226:16 228:21 229:19 230:7 231:8,16 234:21 235:10,15 240:1,6,11 250:20 252:21 256:9 257:2 258:4 276:22 367:17 396:10 398:14 431:12 437:3 439:4 468:19
forced 169:9
forces 1:4 53:10 71:12 226:14 407:4,18 437:4
Force's 393:1
Ford 399:5
forefront 217:7 442:6
foreign 379:22
forensic 177:12 214:13 215:9
foreseeable 91:20
forest 318:7
forgetting 113:20
forgive 293:8 334:18
form 73:12 141:7 253:21 417:9 465:6 482:14
formal 160:11
formally 175:19
format 265:11 329:19
formation 437:4
formed 289:20
formerly 56:14
forming 441:15
formula 169:1
formulated 255:17
formulation 142:10
Fort 9:2,3,5,5 11:6 11:9 19:6 35:1 46:10,12 90:18 107:11 109:6 115:2 118:3 120:14,14
forth 117:20 137:14 146:9 150:13 202:18 304:2 385:7
Fortune 470:14
forum 42:12
forward 57:16 285:10 291:10 295:2 312:11 313:12 326:14 329:13 382:6 397:4,20 400:8,17 400:21 414:11 418:16 458:2 492:21
found 82:13 96:16 101:5 107:18 160:5 218:3 274:1 331:3 370:19 375:22 376:6 391:16 411:2 429:10 434:20 436:15
four 31:13 64:1 113:16 151:4 165:5,21 175:16 180:6,10 226:16 245:15 307:3 330:22 335:3,10 337:15 338:2 402:16 465:18
fourth 361:8
fragile 305:11
frame 6:15 27:22 33:11 475:16
framework 61:18
frankly 8:10 266:17 279:6 280:7 301:6 334:21
fraudulent 218:4,6
FRC 483:11
FRCs 482:3,6
free 7:19 22:17 114:3
freeze 106:5
French 380:13
frequently 138:6 452:11
friends 254:10 386:5
friend's 428:22
FRO 416:17
front 66:22 184:10 195:10 220:2 371:13 393:9
frontier 132:2
fruition 51:4 479:5
frustrated 352:2
fuddy-duddy 375:22
fudge 467:20
fulfilling 103:4
full 13:2 105:3 106:3,9,16 135:20 142:4 167:4,6 371:8
fully 29:21 105:22 105:22 106:8,19 134:5 423:13
fun 247:12
function 106:19 132:17 133:10 156:18 270:4
functional 278:20 290:11 291:7 293:8 354:22
functionality 122:12
functioning 123:13 131:10 134:19 209:17,18,21
functions 196:8
fund 187:3
fundamentally 139:10 203:16
funded 60:17 106:1 187:4 336:20
funding 60:21 112:3 117:21 120:22 211:16 332:21
funk 389:15
funny 372:3
further 13:9 35:7 55:16 61:5 92:7 120:1 212:9 216:18 269:15 322:19
furthers 10:16
future 32:22 70:20 155:15 190:11 199:3 284:7 311:20 335:1 346:18 389:19 416:3 454:12 475:15 487:20
futures 334:22
FY10 257:21
FY11 232:2
FY12 62:6

G

gain 21:6 215:20 481:6
gained 382:2 481:8
gainful 425:10
gainfully 424:17 425:21
gaining 19:16
gains 482:11
gal 467:14
gals 366:18 373:3 376:1 457:12 487:13
game 287:4 301:21 316:16 380:3
Gameboys 428:13
games 379:18 437:14
gaming 88:12
gamut 135:20
GAO 48:17
gap 81:14 388:10
gaps 18:8 50:3,4 101:15
gather 98:20 100:12 151:16 178:8 199:14
gathering 72:10 98:15,22
gazillion 345:3
GE 319:22
geared 327:12
gearing 265:17
Gekka 198:8
GEN 1:14 5:3,10 6:21 10:4 12:15 21:16 22:10,20 31:16 32:1,6,21 33:5 35:6,15,22 37:13,17 38:1,12

39:3,11 42:6 43:16,20 44:1,17 45:3,6 46:21 65:21 66:2,7,10 67:22 68:3,12,20 69:10 93:20 128:7 195:11,14,21 196:15,18 213:18 219:17 242:8 244:11 250:3 251:7,18 272:11 313:22 314:3,6,13 315:21 316:11,15 341:12,21 347:13 351:1,9 355:10,13 355:16,19 356:3,7 356:11 363:1,17 365:21 366:2 393:13 423:15 424:15 430:8 434:10 436:5,11 436:18 442:17 443:4,9 447:21 448:6,15 449:2 450:5,9 460:20 461:1,13,17,21 490:12 491:9 492:15 493:2
gender 253:9
gender-specific 71:10
general 2:13 4:9,22 5:11 6:20 7:9 14:20 20:1 21:10 25:16 46:18 68:11 73:13 80:19 82:1 92:5 105:16 128:15 129:20 130:8 147:21 158:7,10 160:9 175:9 186:5 188:2 190:13 206:19 209:19,19,20 224:8 234:8 235:9 275:10,13 323:17 332:14 339:10 360:20 366:16 367:4 372:5 394:5 398:1 437:15 441:5
generalized 131:17 208:16
generally 32:9 77:15 93:6 96:16 106:3 150:20 203:4 222:16
generate 396:15
generating 28:11
generation 203:13 204:1,12
generations 126:17 127:2
generic 333:9
genetic 118:21
genius 384:1
gentleman 374:2
gentlemen 40:14 46:20 47:20 127:21 128:8 222:22 471:5
Georgetown 426:9
Germans 380:13
Germany 236:13 237:17
GEs 295:22
getting 3:4 4:20 11:10,11 12:6 13:19 15:14 18:22 22:6 23:10 35:5 54:9 58:3 67:18 68:16 69:12 77:7 87:18 88:1,8 89:1 92:7 99:13,15 102:9,12 108:16 109:15 119:3 122:3 135:8 143:16 166:10,11 166:17 167:10 188:14 193:20 210:7 237:7 272:5 293:5 294:21 304:16 305:1 315:10,16 317:16 325:17 344:13 346:16 350:16 352:16 378:11,16 391:18 397:4 409:5 410:21 411:17 413:1,22 415:8 419:19 420:7,19 424:6 425:21 427:14 434:22 435:5 441:12 443:14 444:8 445:15 446:15 460:7,12 461:18 472:22 473:22 483:2 487:9 488:4
giant 361:4
gifts 466:4
Gilman 105:16
girl 467:16
girls 454:8
give 13:7 38:2 43:3 43:7 47:22 54:6 87:6 115:13 138:18 156:20 172:5,5 184:19 185:6 186:13,18 191:6,7 248:9 259:9 264:7 277:18 327:1 337:8 344:11 350:18 354:19 358:15 361:2 367:10,18 368:15 383:15 386:15 392:4 432:16 437:10 464:16 470:19 474:17 482:8
given 10:14 20:2 122:10 140:7 193:11 195:19 275:14 310:12
givers 170:21
gives 374:17 417:2 417:14 424:10
giving 14:15 196:14 240:2 465:14 466:14
glad 4:15 385:10 393:9 457:15 492:13
glass 305:11
global 193:16 309:7,20
globally 310:18
glory 372:10
glue 276:15 281:20 298:13 301:9 349:22 350:14
gluing 297:12 330:1
go 5:12,16 7:12,15 8:7 9:12 11:17,18 15:22 16:3,7 19:7 21:6,13 25:14,17 26:3 30:17 32:10 32:16 33:8,11 34:8,19 39:13 40:2,6 44:12 46:1 46:1,10,11,13 47:15,15,22 59:14 67:20 75:1 81:22 83:12,19 84:13 87:19 101:4 105:8 113:2 114:3 117:13 118:14 119:11 121:18 125:2,6 144:16 145:6 150:17 155:21 156:21 159:20 162:18 176:22 180:10 184:7,20 190:18 200:4 206:18 211:10 220:14 231:8,9,9 232:22 235:6 237:16 238:1 242:14 244:4,5 248:13 251:11,12,13 252:7,11 253:17 253:22 258:21 259:10 260:1 261:5 267:2 271:20 274:2 278:4 280:16,16 281:17 282:14 283:18 287:14,16 287:18 289:3 290:19,22 291:8 292:1,9,22 293:20 300:2,3 303:7 308:7,7,8 312:11 313:11 315:17 316:6 319:21 323:3 328:11 334:15,17 335:12 335:14,20 338:4 340:1 343:9 345:2 349:6 352:10 361:3,17 367:16 368:11,22 373:14 374:8 375:3,9 381:7 384:22 386:6,21 388:2 391:17 392:6,22 393:7 397:2 400:20 402:13,15 404:18 405:6 410:7,7,12 413:20 420:1 422:7,14,18 428:12,22 430:6 431:21 437:5 443:9 444:9,12,14 446:4 447:22 448:9 451:15 452:7,8 453:5 454:17 455:12 456:16 457:5 459:5 460:22 461:3,15 462:19 466:22 468:1,14 469:8,9,18 470:2 480:9 481:10 483:17 486:1 488:5,18,19 490:20
goal 58:10 89:11 191:14 250:17 256:22 397:10 426:5 435:3,14

475:16
goals 6:9 405:3 411:14,21 412:21 466:15,22
God 117:13 248:11 466:7
goes 20:21 24:20 38:16 39:4 56:17 58:12 71:3,7 112:11 138:15 179:21 189:7 245:4,5 309:18 312:22 330:8 336:6 353:4 385:7 388:8 395:16 426:15 476:2
going 4:6 5:22 7:4 7:21 8:12 9:9 15:7 16:17,20,21 18:2 21:1,14 27:11 29:19 30:1 31:5 32:10,12,14 32:18 33:3 34:13 35:6 39:6 40:15 41:9 42:13 44:19 46:17 48:2,15 50:16 54:5 56:2 57:16,17,20 58:4 58:9 59:14 61:21 63:18 66:12 68:13 69:6 71:1,6,20 73:18 83:1,7 84:16,17 89:9 94:11 97:11 98:14 101:11,21 102:21 105:8,10 106:12 106:15 107:7 108:20 109:18 116:3 120:11,13 123:17 126:8,9,17 126:22 129:22 130:2 144:1,2,17 144:19 147:12 149:7,12 152:21 153:9 154:11 155:13,14 156:16 165:16 167:17 169:2 170:12,13 176:5 177:15 178:21,22 179:1,5 180:8 181:8 184:20 188:12 194:10,14,16,22 197:9,21 198:13 199:1,12 204:11 207:6,8 209:3 210:20 211:9,18 212:17 214:10 215:20 216:7,11 217:12 220:15 222:11 223:3,4 225:1,15 226:2,3 227:6 228:17 229:3 231:2 232:8 233:18,20 237:16 237:19,21 238:10 238:12,22 244:4,5 248:11 249:13 258:22 259:1,9 261:2 262:16 265:20 267:8,9,19 273:8 274:13 277:11 279:2,5 281:2,6,15 282:4 288:18 289:10,17 291:3 292:1 301:8 301:15,16,19 302:10 305:3,3 306:22 307:1 308:19 312:9 315:18,19 316:1 316:13 317:20,21 321:3,16 322:22 323:11 324:21,21 325:12 329:4 332:4 333:20 335:7 341:14,15 347:21 348:1 349:7,19 352:6 354:6,15 355:20 355:22 356:22 357:2 359:3,16,17 360:12 363:13,14 363:21,22 364:1,3 366:17 367:9 369:15 377:10 384:8 386:11,14 387:4,15,20 390:18 397:20 398:10,18 400:16 401:1,11 402:2,11 405:15 407:16 409:1 411:16,22 416:5,11 417:1 418:13 425:20 426:11,13,14,17 427:2 429:6 441:19 443:5 444:6 446:12 447:12 450:6,7 457:11 458:1 463:8 468:1,3 469:17 474:19 477:7 478:2 480:4 486:2 491:2,5,20 491:22
gold 455:21
golf 464:17,19
golly 487:15 488:5
good 4:3 6:19,19 25:4,16 30:11,13 40:11 45:7,7 60:11 61:4 67:15 81:15 111:4 136:7 137:15 140:12 141:7 144:5 146:3 156:20 157:3 162:10 163:11 171:17,18 175:1,6 217:11 225:20 229:14 231:21 240:10 245:9 249:13 250:1,15 259:18,20 262:7 268:11,16 269:4 273:14 289:22 290:1 294:10 338:15 343:15 346:2 352:13 366:22 379:12 386:8 408:18 413:20,21 442:20 442:20 447:20,21 448:4 449:13 452:19 453:4 454:2,10 461:18 472:6,7 474:9,16 487:17 491:8
goodness 380:17 381:17 390:15
gosh 237:15 455:1
gotten 17:4 25:11 192:11 204:18 236:10 238:20 369:3 442:11
governance 281:7 281:7 290:15 291:11,22 293:12 296:13
Government 56:16 291:21 360:8
grade 353:2
gradual 266:11
graduate 477:8
graduating 368:6,8
granted 424:3
graph 228:17 243:5 243:11 260:2 261:15,17
graphic 56:1
graphical 285:19 300:9
grateful 339:8
great 30:1 38:22 57:22 58:8 59:17 63:17 82:13 85:22 87:5,6 88:8 92:2 114:8 115:19 116:18 123:13,15 210:4,20 238:12 239:16 243:8 245:14 255:14 260:11 275:9 297:17 300:14 353:21 358:14 373:10 378:5,5 381:22 384:3 389:3 395:8 408:17 419:17 421:10 422:1,20 424:12 425:8 426:2,17 428:3,6 429:14,17 430:2,4 437:17,17 443:19 444:6 463:2 465:15,16 466:10 472:18 473:21 489:16 490:5,5,12 490:13 493:2
greater 397:18 402:1 452:1
greatest 367:3
greatly 122:11
green 1:11,14 3:25 5:3,10 6:21 10:4 12:15 14:20 21:16 22:10,20 31:16 32:1,6,21 33:5 35:6,15,22 37:13 37:17 38:1,12 39:3,11 42:6 43:16,20 44:1,17 45:3,6 46:21 65:21 66:2,7,10 67:22 68:3,12,20 69:10 93:20 119:9 128:7 195:11,14 195:21 196:15,18 213:18 219:17 242:8 244:11 247:15 250:3 251:7,18 272:11 275:13 313:22 314:3,6,13 315:21 316:11,15 341:12 341:21 347:13 351:1,9 355:10,13 355:16,19 356:3,7 356:11 363:1,17 365:21 366:2 393:13 423:15 424:15 430:8 434:10 436:5,11 436:18 437:15 442:17 443:4,9

447:21 448:6,15 449:2 450:5,9 460:20 461:1,13 461:17,21 490:12 491:9 492:15 493:2
Green's 323:17 332:14
grew 352:1
grief 131:15
ground 46:13 204:8 237:1 238:15,17 414:15
group 14:20 33:4 63:22 73:2 76:4 88:10 104:8 145:11 195:17 196:7,10 197:9,15 244:18 245:21 252:10,12,18 253:19,20,22 264:21 265:10 492:4
groups 10:19 24:8 26:5,10 64:1 71:10,12 82:5 104:9 195:20 196:3 197:21 254:3 255:12 265:2 291:9 313:12 357:12 414:17,19 415:10 423:21
grow 384:14 432:5 466:19
growing 468:21
grown 175:14 430:15 432:4 486:21
grunts 485:11
GS 129:19
GS-15 438:15
GS-3 399:14
Guard 7:9,10 10:12 13:10,18 14:14,22 15:2,5,11 17:10 18:6 20:5 21:9 22:21 23:15 26:20 27:8 28:10 31:1 38:14 39:13,14 52:19 53:15 64:21 83:9 239:7,18 240:11 457:18
Guards 17:13
Guardsman 20:12 91:1
Guardsmen 34:4
guess 12:12 24:4 39:12 88:22 169:15 201:17 219:17 225:4 259:18 307:2 315:16 329:17 338:14 341:22 366:17 393:3,22 427:18 477:10 490:9
GUI 305:2 331:13 341:16 342:1,2,5 343:4 347:17 350:19 351:5 363:4
guidance 22:2 38:2 38:5 51:13 57:7 57:11 76:10 232:6 234:22 385:9 450:11 473:9
guide 63:11 328:8 400:1 401:15 404:1
guideline 73:1 100:9 136:4,5 154:20 172:19 210:4,6,8,9 230:6
guidelines 68:15 72:20,22 73:16 76:4 100:6 104:19 142:11 183:16 184:4 196:4 200:18 229:11,17 230:3 256:5 382:4
guides 229:20
guilt 139:20
Gulf 353:22
gun 382:20
gunned 399:10
guy 41:6,9 87:4,10 87:17 92:11 119:16 123:16 125:7 204:8 464:15 465:12 467:13
guys 12:5 29:20 31:6 87:8 92:14 115:9,11 119:19 204:13 238:8 289:11 365:18 366:18 367:1 373:19 375:18 376:4,10 377:12 378:6 411:8 414:2 414:12 416:13,15 418:10,16 423:20 428:9 439:2 452:5 465:4,15 466:11 468:17 470:14,18 473:18 487:9 490:10
GW 4:12

H

H 2:4
hair 487:11
half 4:4,17 17:9 116:4 142:15 166:4 218:7 249:7 252:10,11,11 341:5 384:17 447:14
hall 432:1
Hammer 2:7 3:6 47:3,7,11 52:14 53:2,6 64:11,16 64:22 65:3 66:1,5 66:8,16 68:2,10 68:19 69:3,13 73:21 74:2 79:21 80:5 81:15 82:21 83:5,15,22 84:8 86:6,11 89:6,10 89:14 92:5,22 93:6,12,15,19 94:18 106:2 108:22 109:4,6 111:3 112:21 113:3,6,9 115:22 116:7,10,13,16,18 117:1,4,8,11,22 121:3,6,21 122:6 122:16,21 123:2 126:20 127:3,12 127:15,19 178:7 179:13
hampering 479:11
hand 16:9 258:4 325:2 369:13,14 387:3 405:8
handbook 168:22 385:14,15 396:22 397:3 416:16 443:1
handful 380:9
handle 10:15 31:4 204:18 324:15
handling 250:1
handoff 19:15
handout 177:5
hands 346:14 387:8
happen 18:18 82:10 106:21 147:4 194:6 226:3 339:2,19 359:15 364:7
happened 18:5 34:22 138:3 274:16 289:19 303:12
happening 77:2 89:13 276:17 288:15 303:13 305:10 319:18 408:20 410:18,19 425:18 489:18 490:6
happens 56:22 57:1 57:11 82:9 131:5 187:7 245:10,12 245:16 317:19 330:4 358:9 438:12 453:14 469:20
happier 213:11
happy 183:12 186:13 271:21 275:15 421:19
Harbor 41:5
hard 22:13 23:17 23:19 24:2 88:4,5 171:11 190:9 191:7 195:2 197:3 216:10 237:16 268:10 271:11 282:16 304:7 348:9 370:10 439:10 453:6,17 482:13,22 483:9 491:17
harder 88:16,16
harm 136:8,19,21 217:16 271:4
harmful 216:19
hat 44:11 215:17
hate 281:7 362:8 407:11,12 421:4
hats 373:3
Hawaii 344:16 369:13
head 113:17 236:9 268:11,16 304:22 311:4 444:4 462:16
headquartered 175:10
headquarters 18:16 83:13 392:13 397:22 439:5 449:14
heads 176:14
heads-up 20:3
headway 108:15
health 2:5,9,15,19 13:19 15:13 19:3 19:6,8,21 21:10 27:16 38:16 47:4 49:14 51:9 52:3

52:10 54:13 56:8 60:19 71:11 78:16 99:1,7,8,22 102:8 104:4,8 107:2,3,8 107:9,20 108:1,3 108:11,19 109:20 110:3 126:19 128:20 129:1 131:17,18 132:8 134:9,11 135:7 143:15,15,16,21 146:17 148:2 149:10,22 150:6 150:15 151:10,12 151:12 152:4 154:4,8 155:12,15 155:17 157:15,19 158:22 159:12 160:9 172:20 174:12,17 175:11 176:16,17 178:9 183:19 185:16 186:17 189:1,4,5 191:14 198:14 203:14 204:16 205:6 208:8,12,13 208:16,17,17,21 209:2,7,8 210:6,8 219:7 221:4 223:17 224:16 225:15 226:5 232:9 233:14,15 233:19 239:10 241:20 242:4 244:3 248:9 258:14 261:11,13 271:15 274:9 275:8 276:11,19 277:4 280:19 283:10,19 288:1 288:14,17 290:15 292:17 293:2,4,10 295:21 296:15 297:3,8 309:10,19 321:16 327:2,3,11 327:14,20 328:12 328:16,17,18 334:16 340:3 349:11 364:12 429:15,19
hear 11:16 23:15 24:8 26:5,9 34:6 121:17 122:5 166:16 172:11 276:21 279:7 372:2 452:4,5,11 452:21 453:18 483:6,8
heard 9:1 14:4 21:11 28:5 30:7 38:21 46:22 61:13 64:9 69:4 149:1 178:18 179:5 183:19 190:15 201:11,11 230:18 245:1 295:10 326:20 398:15 418:20 419:7 425:22 437:11 455:16 456:8 472:15
hearing 21:8,9 25:21 167:1 241:18 344:14
heart 138:15 281:20 282:5 285:1 288:9 289:12 320:6 467:17
heavily 289:6
heavy 226:13 294:19,20
HEC 290:16 332:1
heck 337:17 419:18 466:6,17 467:21 487:15
Heidelberg 247:9 267:2
heightens 233:5
held 37:7 325:2 440:12
help 16:9 22:17,18 42:1 44:14 50:18 57:19,21 59:11 63:12 64:3 91:3 91:19 102:11 114:21 134:15 140:19 148:9 177:1 181:13 185:11 188:1 197:2 199:15 215:8 247:22 261:21 270:2,3 278:8 279:12 292:22 293:4,21 297:1 299:3,11,19 304:12 306:15 307:15 310:4,14 314:4 321:21 326:14 329:20 330:5 337:2,9 338:3 341:9 343:22 347:12 353:3 355:5 357:13 360:12,15 369:15 377:15 386:1 388:11 398:8 401:4,5 413:22 424:18 426:5 428:9 432:16,20 456:4 463:18 465:4
helped 12:4 101:16 176:11 187:22 442:11,13
helpful 24:8 93:7,8 111:8 132:11,21 133:12 197:22 210:22 288:5 297:15
helping 16:11 52:8 273:16
helplessness 200:10
helps 133:3 138:11 138:22 148:8 299:20 472:10
Henry 399:5
hey 29:16 67:17 92:12 113:2 115:8 120:16 238:10 244:2 249:1 371:13,15,16 372:2 389:2 390:1 431:8 464:16 486:8
Hi 376:14 403:3
hierarchy 127:6 147:3
high 17:11 121:9 131:9,10,10 166:1 166:2 172:21 180:14 182:15 202:21 238:9 369:11 390:11 477:8
higher 161:9,10 171:19 218:2 222:13 227:6 261:12
highest 265:5
highlight 42:21 50:12 224:3
highlighting 213:19
highlights 29:8 51:2 381:2
highly 88:9 131:14
high-level 281:18
high-risk 248:22 267:11
Hill 301:19
HIMS 334:15,15
hip 95:10
HIPAA 485:6
hire 101:11 399:14
hired 466:8
hiring 106:5
historical 214:5 446:3
historically 241:11 244:1 253:19
history 71:5 189:11 338:15 485:15
hitting 17:6 340:19
Hoge 2:11 3:9 128:13 129:7,8 145:4,10 146:20 147:10 151:8,11 152:7,11,20 153:2 153:5 154:5,7 155:5 161:1,6,9 161:16,19 162:16 163:8,10 166:19 166:21 167:8 170:22 171:9 177:21 179:5,6 186:10 193:18 201:12 202:12,14 203:12 207:3 208:9 210:18 211:17 217:19 225:17 257:5 261:8 264:17 267:22 268:5 269:12 272:10
hold 6:6 279:13 341:2 372:21 390:19 412:20 439:8 440:7
holding 337:14 392:8 402:14
holistic 9:1 174:20
holistically 209:8 210:2
Hollywood-looki... 369:2
home 8:7 11:18 15:13,13 19:1 23:6 34:19,21 38:17 46:1,1 71:4 108:6 130:11 132:19 134:20 149:5,6 174:9 204:14 209:6 230:1 236:9 240:17 391:17 392:3,5 453:13
homework 194:15 492:4
honest 85:10,11 249:14 256:14
honestly 412:4 445:1 488:8
honesty 147:15
honor 129:9 178:1

hoo 448:14
hook 47:18 367:18
hope 303:8,20 322:9 333:7 350:18 381:10 400:8 426:19 442:8 468:22 472:5
hopefully 179:1 204:11,17 223:7 371:8 400:3 451:19
hopeless 281:22
hopelessness 179:18
hoping 6:2 354:20
Hopkins 398:21
horizon 91:20
Horoho 147:22
horrible 181:6
horror 124:15 179:18 200:10
horse 372:14,16,20 373:5 386:10 459:9
horses 372:17
hospital 82:14,16 233:20 276:8 287:18,19 297:17 391:14
hospitals 186:4 224:14 284:6 302:20 333:8 345:11
host 171:20 222:10
hosted 394:15
hosting 52:10
hot 382:1 386:9
Hotel 1:10
hour 4:5,17 265:9 463:22
hours 7:12 128:2 132:4,5
house 394:7 429:1 475:12
housing 459:20
hub 462:13
huge 21:22 79:18 284:21 306:18 337:6 372:14 380:21 381:6 384:6 385:4,4 441:7 443:17 445:7 451:11 459:12 463:20
hugely 339:11 343:18
hugest 74:4
Humphreys 322:17
Humvee 382:20
hundreds 8:9
hung 416:5
hurry 29:18
hurt 259:5
husband's 389:13
hyperarousal 138:13
hypervigilance 246:22
hyper-alert 132:18
hyper-vigilant 132:18

I

idea 60:9 63:17 67:15 114:8 120:15 195:1 211:1 212:14 213:3 222:11 235:17 239:14 241:19 242:1 250:15 259:4 263:11 277:8 278:18 286:7 291:16 295:11 302:8 306:3,8 321:6 453:5
ideally 5:17 252:9
ideas 41:15 121:18 344:18 470:21
identification 224:21
identified 19:3 40:5 40:16 41:21 48:18 101:13 103:2,15 237:21 399:9 449:10
identifier 277:19 323:12
identifies 17:18 397:1
identify 40:14 57:5 91:4,19 183:22 237:14 260:17 261:21 449:16 450:20 455:13 456:5
identifying 45:15 45:19 92:20 323:5
identity 277:17 298:8 323:1,5,13 323:20 324:1 359:18,20
IDES 3:22 366:8 382:11 385:17 393:13 394:1 397:6 398:15 402:12 445:22 461:6,8 469:16,20 475:4,15,21,22 477:11 479:4 482:11,16,20
IED 182:4
IEDs 117:7
iEHR 280:19 297:3 298:6 299:16 314:20 317:10 328:19 330:4 336:19 356:4
II 203:10
III 386:11
ill 1:4 2:15,19 128:21 175:11 367:7 396:12 401:22 422:9 424:21 444:17
illness 123:9 127:1 480:21
images 309:13 325:1
imagine 105:7 276:13 334:3,6 484:10
immediate 40:1 93:5 154:9 156:1 156:1,2
immediately 119:2 154:15 267:2 374:19 406:2 464:14 486:12,22 487:2
immunization 307:11 332:5
impact 58:8,11 63:1 131:9 445:15 480:17
impacted 218:15 477:14
impacting 55:15
impairment 131:14
impatient 92:2
impediment 418:20
implement 112:9 283:16 319:22 332:22
implementation 72:12 98:17 99:4 192:16 257:8 332:10 336:6 340:4 346:16
implementations 337:18 344:7
implemented 37:1 79:11 97:2,22 100:10 189:21 256:3 299:4 312:16 313:13 331:15 334:9 350:17 353:6 382:4 419:19 420:7 460:12
implementing 100:3 109:11 297:5 334:7 378:3 458:15 473:8
implicit 357:20
imply 344:3
importance 417:6 484:2
important 51:17 54:22 55:2 57:13 98:18 107:21 134:1 139:17 140:1,17,18 141:6 141:11,11 155:5 164:6 165:15 168:11 171:10 172:1,19 173:11 173:12 174:4,21 191:18 194:5 212:21 219:11 224:10 231:5 233:17 245:18 247:7 248:5,7 251:1 257:16 264:19 285:9,9,22 298:3 302:6 309:17 325:6 327:14 339:11 342:11 343:1,18 343:20 346:2 348:3 352:21 404:22 412:5 415:7 448:17 467:1
importantly 397:13
impossible 271:16
impressed 393:14 406:11 423:19,21 442:18
impression 8:11 121:13 171:6 327:1 458:17
impressive 233:10
improve 50:5 54:11 54:18 56:20 58:22 62:12 67:8 120:18 144:1 173:18 219:16 295:9 482:7,15
improved 354:22
improvement 122:18 144:2 290:2 331:5 344:19 375:9

443:17
improvements 55:14 331:3 394:10 397:15 399:18 412:5 482:20 486:8 487:12
improving 84:11 144:19,20 173:17 233:3 308:22 431:16
inability 11:21 12:2
inappropriate 18:8
incapacitation 440:19
incident 178:15 228:17
incidents 183:5
include 68:1 100:14 139:12 275:20 276:3
includes 136:10 158:11,12 176:16 186:16 215:12
including 131:17 131:21 150:5 160:18 186:1 370:15 459:20
incorporate 201:3
incorporated 157:4
incorrect 7:22
increase 107:5 213:20,22 214:4 214:10 260:3,15
increased 78:14 122:12 180:11 481:17
increases 27:20 131:21 309:15 475:9
increasing 310:16
incredible 382:19 387:11 421:14
incumbent 324:16
incur 440:5
incurred 440:15,17
incurring 25:9
incurs 440:11
indefinitely 270:14
independent 70:1 150:3 152:12 351:19
Indianapolis 466:7
individual 15:7 18:16 96:7,7,10 96:15 126:2 158:19 160:16 190:22,22 196:5 216:5 218:10 219:15 233:1,9 269:13 270:15 359:20 385:17 396:16 406:2 449:17 450:10 451:4 456:16,20 475:17
individualized 96:21 195:15
individually 193:14 195:19 196:3,14
individuals 6:12 18:1 25:2 29:16 71:22 95:20 112:10 124:1 126:12 132:19 138:2 141:19 143:4,20 144:9 145:1,21 146:16 157:8,14 162:21 185:1 187:20 189:9 191:18,19 191:20 192:1,14 196:10 197:6,20 198:15 200:6 202:8 205:14 208:14 215:12 218:18,18,20 221:5 247:22 253:7,15 257:20 265:4 266:6 267:11 269:14,17 455:17 462:20
indulge 282:2 286:1
industrial 398:22 399:8 478:15
industry 399:6
infantry 74:20 75:1 115:6 132:4
influence 400:8 427:10 434:22
inform 230:8 399:21
information 15:9 50:1 57:9 65:19 69:17 83:9 84:2,7 117:17 128:9 129:6 137:2 151:16,20 160:1 180:19 184:12 186:9,21 199:14 199:15 207:10 218:5 272:3 275:2 275:3,21 276:19 278:3,11,13 280:13 282:20 283:8 284:11 288:5 307:17 310:10 312:4,6,21 317:17 321:17 326:5,16 327:3,14 328:16 329:4,17 342:10 355:7 356:13 357:19 358:8,19,20 359:13 360:14 362:6,14,19,22 366:14 378:2 379:2 381:8 396:6 400:16 406:5 417:15 455:9,9 456:1 468:9 481:6 481:16 482:6 485:3,7,13 488:3 488:16 491:12 492:19,21
informational 224:1 246:10
informed 171:4
infrastructure 310:19 324:5,6,8 324:14 325:13,18 325:20 331:2 359:5
ingenuity 84:5
ingenuous 236:20
inherent 140:6 340:12
inhibitors 75:14,16
initial 40:1 52:5 56:21 69:6 105:2 105:13 151:14 185:6 332:18
initially 167:3 176:8 181:10 188:5 216:4 217:6 329:22
initiated 69:19
initiative 53:10 240:11 339:19
initiatives 99:2 107:6 230:16 278:15 415:20 454:12,18
injured 1:4 2:17,20 128:21 131:20 175:12 367:7 388:17 396:12 422:9 424:22 429:13 438:5 444:18
injuries 49:10 81:13 92:1 93:9 95:22 182:13
injury 2:9 47:2,5 49:15 50:22 54:14 56:9 76:6 77:8 81:2 89:18 90:7 90:11,22 91:8,10 91:19 95:21 131:19,21 175:20 179:16 428:14,15 440:6,12,15,20 441:16,17 480:2 480:21
inklings 42:12
innovation 238:6
innovations 235:5 395:14
innovative 100:18 109:19,22 295:5 465:16
inoculation 73:10 73:22 136:12 140:4 160:13 184:15
INOVA 320:16
input 97:18 219:21 377:1
Inquisition 85:19
inside 372:15 428:21
insight 43:3
inspection 385:6
inspire 490:8
inspired 428:19
inspiring 460:13
installation 30:19 121:14 239:6 408:19
installations 398:9
instance 13:3 68:22 87:21 134:18 146:13 157:17 161:22 162:2 268:14
instances 276:10 300:21
instantiation 287:6
instill 389:4
Institute 70:4,7 145:12 178:6 183:11
instituted 411:3
institution 58:7 484:4
institutions 56:15
instruction 51:12 229:19 230:7 451:18,19 473:8 487:5
instructor 420:1,3
insurance 13:20 17:6 23:12 28:2
insured 14:11

intake 197:7
integrate 58:18 90:12,13 245:17 488:1
integrated 52:3 57:20 90:20 99:1 103:20 108:1 191:13,13 230:2 277:3 280:19 296:20 297:3,7 329:12 382:16 385:13 388:20 421:2 482:4 487:21,22 488:2
integrating 420:22 484:5
integration 57:22 58:3,20 176:16 189:2
integrator 55:10 98:19
integrity 54:21
intel 241:5,22
intelligence 355:7
intend 275:19
intended 97:9 232:20 345:6 402:22 475:16 476:7 477:17
intense 124:14 200:9
intensities 90:6
intensity 130:17 220:7,12 221:1
intensive 155:21
intent 48:20 49:5,6 281:13 379:1 405:22
intention 7:12 408:17
interact 152:2
interaction 279:18 317:13 397:17 404:4,12 407:12
interactions 134:8 299:13
Interagency 3:13 273:5,21 279:21 281:13 283:2 290:18
interchange 360:15
interdictors 432:17
interest 255:9
interested 4:22 18:9 43:19 44:18 46:17 69:11 128:9 225:1 274:20 343:22 443:22 464:10 468:7
interesting 65:5 109:7 112:1 119:22 235:5 238:4,15 240:4 242:20 252:4 253:4 254:2,15 255:2 259:13 300:13 334:13 416:4
interests 187:14
interface 285:19 300:9 311:10 341:18 342:4 363:9 376:12
interfaced 328:4
interfaces 281:22 286:17 306:6,9
interfere 185:4
interim 360:14
intermittent 310:1
InterMountain 288:17
internal 58:21 103:2 189:4 423:7 450:17 478:12
international 356:8 379:22 380:11
Internet 53:21
internship 392:18 425:15 462:8 469:6 470:6,7
internships 208:6 426:8 459:7 464:11 467:10 471:18
interoperability 279:18
interpretation 86:8
interrupt 460:21
intervening 313:7
intervention 223:13 229:21 237:8 241:13 255:18
interventions 173:18 193:17 196:1
interview 197:7 417:10
interviewing 151:15 411:5
intimately 275:11
intractable 232:21
inTransition 102:10,11 109:12
Intrepid 90:9,16
introduce 4:14 47:8,10 366:10,17
introduced 366:10
introduction 279:4
inundated 455:18
invest 68:18 349:17
invested 68:17 208:1
investigation 20:7
investigations 20:8 226:17
investment 325:18
invisible 307:22
invite 365:7 417:3 417:17 418:9,10
involve 139:11 179:17 196:20
involved 10:11 19:10 58:4 66:20 81:5 98:22 99:19 100:2 105:6 171:7 217:14 239:21 250:11 264:10 275:11 278:12,19 293:1 294:5 336:22 337:4 339:10 389:16 415:8 417:13 425:18 486:15
involvement 294:19,21 344:8
involves 289:21 348:6
involving 170:21 289:6
in-house 375:1 383:4
Iowa 3:4 4:7,19,20 7:1 9:7 18:5 23:5 24:8 25:19 29:7 31:18 39:4,19 44:18 45:10 46:4 46:18 491:3
iPad 291:19 409:15 411:17
iPads 110:16 409:5
iPhone 286:3 291:18 308:7 320:13 374:6,11 374:15 375:15
iPhones 110:1,16 286:1 305:15 374:7 376:2
IPO 274:5,14 279:17 280:9,20 280:21 281:9 292:4,11 328:6,8 328:20 341:1 353:9
Iraq 117:4 118:1 118:10 232:16 237:20 326:9
Iraqi 117:9
Iraq/Afghanistan 233:4
irritability 181:6
Irwin 118:3
isolated 58:6 87:21 423:1
isolation 219:4
issue 24:4 25:6 95:4 142:14 193:22 210:10 243:6 301:22 302:11 309:20 310:16 322:21 323:13 329:2 359:4 362:3 394:6 395:4 416:7 441:6 445:10 458:7 470:1 485:13,18,18
issued 332:2 392:11,15
issues 10:15 15:10 26:1 40:21 41:4 42:13 53:19 57:15 87:12 99:18 103:5 105:5,10 106:4,7 123:18 185:21 197:14 237:8 239:10 255:6 274:19 300:1 302:8 308:5 309:8 323:6 326:15 339:12 362:11 379:7 427:8,18 439:18 476:1
itch 40:1
itching 463:17
item 404:19 406:16
items 3:4 5:18 253:11 254:5 406:14
iteration 124:7
iTunes 308:7
IT-IM 449:13
ivory 58:7

J

James 287:22 296:15
January 48:8 51:19 100:17,22 103:1 105:14 342:13
Jean 2:14 128:17
JEC 224:18
jeeps 464:20
JFTR 469:6
Jim 390:1,3
job 55:9,17 56:20

74:15 114:7 259:2 273:16 274:3 277:5 294:10,15 299:21 313:2 344:1 391:5 395:7 400:11 413:6 424:8 452:19 456:22 484:5 488:7
jobs 17:3 113:12 150:12 241:8 334:22 343:2 444:1 457:5 464:12
jobs.net 456:22
John 3:17,19,21,23 398:21
Johnston 176:5,9 198:13
joined 277:13 401:19 480:15
joining 53:9 384:21
joint 51:5 52:6 56:18 83:12 115:3 224:13,14 287:20 292:6 293:9 301:13 303:4 346:8,9
Josh 466:8
journey 284:15
JPEGs 363:22
judge 302:1
judgment 168:7,8 206:5 217:4
juggle 146:1
July 236:18
jump 12:16 178:22 221:11
jumped 258:18 479:3
June 381:19 392:14 397:8 477:8,9
jury 266:15
justify 55:8
JUSTIN 1:15
jut 455:18

K

K 1:19
Kaiser 320:15
Karen 1:18 351:2
Karen's 347:16
KEANE 1:17 44:10 162:11 163:6,9 419:5,11
Kearny 116:14
Keefer 175:15
keep 26:15 35:17 67:16 110:21 129:22 171:3 198:2 263:5 308:22 309:1,18 353:13 365:8 388:3 390:20 391:2,10 412:14 412:20 434:17 435:3 443:5 465:6 469:1 478:2
keeping 35:9,18 167:2,10 416:15 442:22
keeps 27:10
key 35:3 103:15 142:14 148:9 151:18 155:6 166:5 168:9 169:19,20 248:3 292:16 335:9 336:5 369:2 399:9 400:13 463:3 483:16 486:10 487:8
kick 267:20
kicked 215:2
kickers 214:22
kicking 53:11
kid 428:19
kids 466:17 487:11
Kilpatrick 48:8
kind 7:3 39:15,16 39:22 42:7,20 61:17 62:18 76:14 81:6 98:1 101:12 120:7,8 124:14 145:8 156:9 163:16 169:8 170:17 172:14 180:18 200:5 207:12,18,22 213:5,8,19 214:3 221:15 222:5,9,16 223:12 224:19 225:3 226:5,10 227:1 229:15 230:8,20 231:12 233:2,4 234:4 235:15 237:6 238:7 239:22 240:5 241:8,9,10 241:14,17 243:12 243:22 244:2 245:3,6,21 246:13 246:16,18,22 247:4,4,6,17,21 247:22 248:18 252:15 253:5,13 253:22 254:4 255:4 257:17 258:18 260:21,21 272:5 280:13 281:3 282:1 288:6 292:20 298:20 302:21 304:7 310:4,7 312:2 317:20 319:5 323:19 330:2 341:13 344:21 349:6 351:17 359:14,18 361:11 362:17 373:18 381:2 389:1 390:5 390:9 391:22 393:8 395:4 412:9 424:9 435:14 452:17,18 455:21 471:16 472:4 488:18
kinds 42:21 81:21 106:14 115:16 147:9 279:5 286:18 288:20 292:5,8 297:22 298:1 323:20 348:17
kit 51:16 52:17 63:21 64:3 454:5
kits 51:13,18 53:6 69:16 89:8
Kleenex 47:13
knee 95:10
knew 180:17 455:22
know 5:3 7:5 8:17 12:2,21 13:12 14:6 15:3,5 16:17 18:7 21:21 22:5 23:20 24:5 25:6 26:6,6,7,16,22 27:2,4 28:18 29:11 30:22 34:20 42:4 44:19 45:22 46:17 51:5 52:1 52:22 54:2 55:4 59:11 61:4 64:15 65:14 66:12,20 67:11 71:2,4 74:15,19 75:2,4 76:21 77:19 80:9 80:11 81:19,20 82:3,8,22 83:9,11 83:16 84:2,13,15 84:17,20 85:10,12 85:18,20 86:3 87:8,12,13 88:3,8 88:17,19 89:1 90:1 91:5,17 92:11,15 93:14 95:8,11 96:18 97:3 98:13 99:11 99:13 101:11 102:21 106:13 110:1,7,17 111:3 111:7 112:3,15,19 114:14,14,22 115:10,13 117:6 117:14,20 118:13 119:10 120:1 121:9,9 122:11,17 123:6,13,17,19 124:21 125:8,17 125:18,20 127:5,6 127:9,10 132:3,6 133:1 134:5,13,16 134:19 136:18 137:12 138:1,16 139:10,15 142:21 144:11 145:16 146:3,4,8,9,10,10 147:8,15,21 148:1 148:1,5,8,9,10,20 148:21,22 149:8 149:14 150:3,9,12 151:4,18 152:2,16 153:5,13,19 154:13,14,21 156:1,8,17 157:7 158:11,14 161:6 162:1,2,9,21 163:13,22 164:7 165:2 166:4,5 168:3,5,14 169:22 170:3,4,5,6 171:4 171:10,12,13,22 172:4,7,11 173:20 175:1,1 176:1 177:15 181:21 182:17 183:3 184:19,20 185:18 186:5,19 188:4,10 190:6 191:21 193:13,14,15 194:3,16 195:4 196:6 197:4 198:20 199:16 200:17,22 201:4,4 202:7 203:4,5,20 203:21 204:1,2,3 204:10,12 205:16 205:18 206:7,9,20 207:16 209:5,14 209:18 210:3 211:2,11,11 212:11,14,15 214:21,22 215:1,6 216:9,10 218:4

219:1,15 221:10 222:15,16 224:7 224:12 225:21 226:7,22 231:5 233:10 235:8,18 239:5 242:6 245:14 247:13,19 248:12,12 249:2 249:15,16,21 250:8,9 251:6 252:10 253:8 254:14 257:15 258:17,19 259:4 259:16,17 260:11 260:12,13,22,22 261:1,6,12 262:5 262:22 263:4,13 264:14 265:6 266:3,7,8,9,11 267:1,2,6,10,14 267:17 269:9,18 269:20,22 270:2 270:13 271:1,1,9 271:10,12 273:12 274:14 275:1 276:3,16,18,21 277:16 278:19,21 280:5 281:8 282:13 284:1,16 284:22 285:6 286:3,8,20 287:11 289:1 290:19 291:21 294:16,18 295:15 296:4,20 297:21 298:1,16 298:20 299:2,4,10 299:22 300:5,15 300:17 301:6,22 302:1,9,19 304:6 304:6,12,14,22 305:6,10,18,22 306:19 307:1,9,14 308:3,6,12 309:14 309:22 310:17,20 311:9 315:11 317:3 318:14,15 319:22 320:11,16 321:6,7,10,14 322:8,16,18 323:3 323:8 324:9,12,14 324:16,20 325:6 325:12 326:10,15 326:16 327:3,12 328:8,9 329:3,9 331:10 333:7 334:14,18,21 335:13 336:22 337:3,18 338:6 339:6,8,8,14,22 340:9,20 341:2,4 341:14,15,18 343:7,9,10,21 344:7,20 345:5,13 346:7,14,20,22 349:12,17,18,20 350:13 351:3,4,5 352:7,13,20 353:1 353:7,9,10,15 355:3,19 357:9 358:13 359:7,8,22 360:5,7,13 361:17 362:11,21 365:6,9 369:18 370:18 371:3,9 372:3,13 372:13,14 373:7 374:7,13 377:7,10 381:12 382:1,17 382:19 384:1,11 385:15,19 386:20 387:17,18 388:4 389:18 390:15,17 391:4 393:11 396:1,4 398:16 402:4 403:1,12 410:17 411:7,8,16 411:17 413:1,13 413:15,17,18,19 415:22 416:2 419:10,17,21,22 420:3,9,12 421:10 421:17 424:18 425:9 426:4,9 427:17 428:18,22 430:22 432:19 435:1 439:16,21 441:3,13 443:20 445:1,2,4,4,12,22 447:8,11 448:3 452:7 453:10,12 454:16,19 457:2 458:22 459:15 460:4 462:9,13,14 462:17,19 463:11 464:3,17 465:5,8 466:6,7,9,16,17 466:18,19,21 467:2,15,22 468:10,13 469:1 469:22 471:3 472:6 473:19 474:1 481:5 483:15 484:7,22 485:6,16,21 486:6 487:5,13 491:10 492:12

knowing 244:2 400:7 431:12

knowledge 49:8 50:5 53:4 54:17 55:11 57:8,8 68:15 70:17 272:15 374:20 375:5 466:5 481:8

known 193:2 221:19 286:18 305:21 430:20

knows 245:7 306:7 397:3

Korea 203:10

L

lab 115:11

label 132:16 206:10

labeled 135:8

labeling 168:17

labels 203:14

laboratory 287:7 293:18 300:14 307:10 312:14 321:11 332:4 334:8 335:12,13 336:22

lack 341:9 344:7 408:9

lacking 395:17

ladies 40:13 46:20 47:19 127:20 128:7 222:22 386:11 486:4

lady 53:11 482:12

Lake 331:18

Lakes 297:17

lane 111:12

language 244:8 280:11 319:16 385:2 415:2

languished 295:4

large 16:5 53:15 60:21 142:18 143:4,6 144:13 166:8 186:20 205:1 234:2 254:4 265:10 269:16 303:13 339:19 354:4 421:22

largely 203:22

larger 231:16 398:9 432:6

largest 74:5 79:4 131:8 166:17

late 64:15 159:3,3 301:20

lately 443:13

latency 348:18

latest 178:4

latitude 452:2

launched 51:8 374:22 386:5

law 451:14

layer 300:10 303:16 307:16 308:21 315:9,10 317:1,7 334:5 342:21 350:19

lead 7:8 12:10 42:22 52:3 60:15 70:5 149:8 183:5 234:2 267:5

leader 384:8 404:2 406:1 407:14 412:12,19 435:11 435:20 460:13

leaders 292:17,18 374:18 378:3 403:16 405:6,12 420:13 425:8 428:3 460:4 481:19 484:17

leadership 99:17 236:12 339:7,11 394:21 408:13 428:8 429:12 435:11 453:3 475:8

leading 100:19

leads 138:16 470:8

Lean 290:1

leaning 460:17

learn 133:13 201:4 248:19 462:13 469:19

learned 246:4 492:6

learning 69:20 120:16 300:21

Leatherneck 79:14 89:22

leave 36:20 37:3 134:3,4,6 143:7 145:14 150:12 168:8,9 391:13,14 392:17 426:2 433:1 458:18 476:22 477:1

leaves 20:12 432:14

leaving 17:20 18:13 18:14 452:18

led 204:1 218:8 236:21 238:2 265:16 382:8

leeway 13:5

left 257:19 277:5 369:12 380:12 387:3 406:19

leg 117:14 370:3,15

Legacies 313:5 325:11
legacy 275:4 281:21 297:13 298:13,21 299:9 304:3 307:4 312:7 312:18 313:3,4,9 313:10 315:11,22 316:16 325:14 328:15 330:21,22 331:6 333:13 349:22 350:2,6,15 350:21 353:12,14 355:2 361:3 478:22 479:5,15
legal 87:12,18 88:14 458:21
legislation 71:19 458:2 471:17
legitimate 156:12
legs 368:19 371:15 466:20 480:1
leisure 291:6
Lejeune 82:14 90:18 120:13 186:3 381:19 393:14 394:3 398:19 399:8,17 422:4 424:20 438:2 441:21 451:20 454:1 462:6 471:21 474:6,11 478:14 482:14
Lejeunes 126:6
length 13:2 39:20 128:3 253:9 476:6
lengthy 332:13 439:17
lens 208:19 329:18
lessons 246:4 248:19 426:15
letter 48:19 49:6 476:1
letting 324:18 344:15
lettuce 88:18
let's 35:7 39:15 40:6 47:15 48:22 48:22 49:1,2 60:2 67:16 87:6,9 120:17 141:5 168:14 182:7 190:20 333:9 383:5 413:21 448:9 461:3,9 476:3 490:2
level 29:22 56:22 56:22 69:14 73:12 77:18 108:20,22 117:19 121:16 130:16 136:7,15 136:17 147:14 149:17 155:1,2 160:17 163:5 207:17 222:1,5 226:11 232:3 233:5 235:8,16 253:11 272:1 315:3 380:11 395:15 397:19 398:11 408:18 424:17 431:4 439:1,13,13 460:7 460:11,13 466:5 471:2 479:2
levels 65:10 137:20 265:5 322:11 478:3
leverage 50:4 60:12 61:5 62:16 293:15 314:17
Lewis 9:3,6 11:6 115:3
Lewis-McChord 115:3
LG 1:11
liaison 406:10
liaisons 449:6
liberty 428:12
library 322:2 374:19 481:15
licensed 158:14
licensing 377:3
lieutenant 128:22 384:14,15 459:8
lieutenants 473:15
life 213:9,13 276:2 276:7,12 278:8 286:10 291:18 322:6 328:7 428:10
lifeplan 405:22
Lifetime 327:22
lifting 389:17
light 340:8 437:5
lighting 370:10
lights 367:11
liked 294:17 333:4 333:16 343:13
likelihood 171:19
LIMDU 450:6
limit 463:9
limitation 470:3,10
limitations 159:8
limited 6:15 70:10 202:15 429:18 437:6 449:6,11,18 450:2,14,16,17,19
limits 462:8 463:10
line 13:11 14:18 22:22 23:4 25:3,8 25:12 35:8,11 38:17 39:21 107:8 132:3 225:5 226:13,15 232:22 394:18,21 395:4 397:17 399:7,15 420:22 427:10 429:14 431:11 437:9 439:8 440:5 440:11,13,17,19 440:20 448:18 481:12
lines 225:2 291:6 405:17,20
link 6:9
linkages 316:19
linked 163:17
links 364:4 382:10 437:22
list 63:1 66:3,9 67:22 72:6,17 76:1 101:20 111:14 113:1 219:6 229:6 383:16
listed 47:8 102:20 152:4 366:9
listen 164:13 167:21 432:2
listened 179:3 374:1
listening 142:2
listing 396:17
literally 48:10 247:14 389:12 396:3 404:19 486:13
literature 73:2 75:12 76:3 153:6 203:8 204:4,5
little 26:7 31:17 33:13 34:6 48:1 48:13 54:5 80:18 88:15 111:11 115:12 122:18 130:3 142:6 153:7 159:1 166:15 195:3 208:10 227:7 247:1 249:20 264:12 277:7 291:20 301:6 319:17 320:11 327:16 338:12 415:12 422:13 432:7 435:1 438:6 454:4 456:10 465:20 483:12 491:10,14
live 286:10 291:17 296:18 299:5 301:12 346:21
lively 372:4
lives 54:11 389:14
living 458:8
load 396:2 410:9
loads 159:15,17
LoA2 60:17 66:18
local 16:17 34:4 53:14 91:2 115:6 345:7 392:17 431:22 439:1 470:4
locally 31:8
located 81:3 234:21 273:10
location 81:19 83:19 84:5 236:3 237:3 262:19,21 378:13,14 410:10 441:20 452:14 469:8
locations 27:8 400:14 409:6 474:5
locking 146:3
LOD 28:14,14,21
LODs 18:12,14 23:5 28:19
logical 26:2 46:9 260:14
logically 284:18
LOINC 283:14 322:3 357:17
long 28:13 106:15 107:17 110:7 125:2 140:20 251:10 270:6,12 279:4 301:5 307:9 308:11 317:19 343:18 350:1 367:18 380:3 393:12 427:15 445:22 452:7 458:3 480:3 486:20 487:11
longer 13:8 14:17 94:4 313:5 316:7 392:8 476:12 480:7,20 481:2 491:11
long-term 57:3 71:1 411:21 474:1
look 7:16 9:1 12:7

15:6 21:3,12,14 23:22 27:6 30:4 32:7 37:4,11 38:3 44:9 45:13,19 46:7 50:7 52:9 55:2 61:2,8 62:9 64:2 65:19 67:20 70:19 71:14 75:2 75:22 76:17 83:2 91:3,12,12 95:19 98:12 101:18,21 112:4 113:13 114:4,7 115:9 119:1 120:6 129:4 146:21 147:1,5 157:6 158:1,16 165:1,12 167:22 168:7 178:10,11 179:11 180:21 182:19 187:20 201:18 202:5 203:16 212:17 214:17 221:5 225:3 237:15 239:22 241:16 257:19 268:18,20 273:17 287:6 288:4 289:3 294:21 295:8 296:4,6 298:21 303:19 308:13,15 308:22 315:18 317:3,11,15,17 323:10 331:14 344:15,22 346:17 347:15 351:13 352:6 355:2 362:14 366:12 371:6,10,18,19 377:21 378:7 382:6 387:18 404:3 407:21 408:11 409:15 410:14 413:5,19 414:1,9 415:1 418:16,17 422:17 441:16 462:18 467:13 472:4 474:4 475:15 478:15 485:2 488:18

looked 61:15 83:8 101:14 158:8 159:12,18,19 186:15 235:18 252:6 255:10 288:13 318:21 329:22 399:2

looking 7:1 8:17 30:3,18 42:15 44:3 55:20 57:2 62:6 67:1 70:16 71:9,13 92:9 94:20,22 97:14 100:13 102:20 109:22 113:22 114:16,19,20 118:20,21 119:22 120:1,8 124:5,9 127:7 145:17 210:18 239:1 242:1,2 255:4 264:11 282:4 292:6 295:17 337:21 347:5 372:7,8 373:2 375:6 377:4,9 409:18 410:14 418:8 424:4 425:10 438:20 441:14 467:18 470:13,15 471:11 473:7 477:15

looks 84:3 163:10 191:15 320:9 328:20 385:7 484:13

Lord 2:14 128:17 176:13,21 190:4

lose 133:9 170:2,11

losing 393:11

lost 370:3 461:13

lot 4:11 9:4 11:17 15:12 16:16 22:8 23:22 60:20 75:18 78:10,17 79:17 83:17 93:22 94:5 95:5,8,12 99:13 104:11 106:9 107:19 110:17,18 114:20 115:17 124:20 130:21,22 131:1,4 133:17 134:2 135:14 145:19 148:3 151:13,13,14 153:6 154:11,17 156:11 162:2 167:13,21 168:4 169:4 171:19 172:4,9 175:1 181:6,22 182:1 204:8,13 205:15 206:17 210:20 214:14,17 215:4 221:13 223:3,8 224:12,13,19 229:8,13 236:10 237:12 238:5,20 241:6,14 244:14 248:17 252:13,19 259:3 261:8,12,19 264:19 268:7 270:10,11 271:13 272:9 273:12 275:2,2 278:13 281:12,16 283:17 286:1 291:4,7 294:5 297:20 299:1,5 300:19,20 300:20,21,22 301:14 302:15 305:11 310:20,21 315:22 316:12,19 318:22 319:1 326:10 328:7 330:19 331:5 332:12 335:11,16 336:21 337:3,17 338:3 344:12 348:22 349:5 352:5 357:10 359:6 377:22 391:16 408:5 418:13 419:1 425:19 428:11 431:1 432:6,11 439:10,12 443:18 446:8 453:16 454:1 461:5 464:1 466:4 476:2 480:12 481:9 483:9 487:15 491:12 492:19,21

lots 21:2 266:1 426:6 439:6 445:1 445:3

loud 489:16

Louisville 84:15

love 319:14 367:21 369:10 373:18 448:19 453:15 468:17 473:17 483:20

loved 379:9

Lovell 287:22 296:15

low 161:15 225:10 226:8 263:13 310:1 340:11,15

lower 170:7 224:9 369:1

LT 1:14,17 2:4 5:3 5:10 6:21 10:4 12:15 21:16 22:10 22:20 31:16 32:1 32:6,21 33:5 35:6 35:15,22 37:13,17 38:1,12 39:3,11 42:6 43:16,20 44:1,10,17 45:3,6 46:21 65:21 66:2 66:7,10 67:22 68:3,12,20 69:10 93:20 128:7 162:11 163:6,9 195:11,14,21 196:15,18 207:11 212:19 213:18 219:17 220:13,15 220:18 221:10 223:2 227:16,18 228:1,9 239:4,16 239:20 242:8,16 242:18 243:8 244:11,22 245:13 249:12 250:3,5 251:7,18,22 259:16 260:5,10 262:5,14 263:2,12 263:17,21 270:10 272:11,19 313:22 314:3,6,13 315:21 316:11,15 341:12 341:21 347:13 351:1,9 355:10,13 355:16,19 356:3,7 356:11 363:1,17 365:21 366:2 393:13 419:5,11 423:15 424:15 430:8 434:10 436:5,11,18 442:17 443:4,9 447:21 448:6,15 449:2 450:5,9 460:20 461:1,13 461:17,21 490:12 491:9 492:15 493:2

luck 378:14

lucky 474:2

lunch 272:18 273:4 304:6 364:17 367:1

Lyons 465:17

M

M 2:21

Mac 84:14,16,17 88:17

machine 298:9 382:20

Mack 46:9 89:15 313:22 314:3

377:15
MacKENZIE 1:17 8:16 11:14 12:12 25:14 26:12 30:15 45:11 52:13,15 53:3 83:6,16 84:1 86:1,7 88:20 89:7 89:12 111:20 112:1,22 113:4,7 242:17,22 244:17 251:16,19 311:2,6 311:13,19,22 313:16,20 314:1,5 315:15 317:14 336:14 376:7,9 377:6 406:4 412:22 413:4,9,13 446:5,11,20 447:1 447:3,8 462:2,4 462:12 470:8 472:9 474:3,7,10 474:14,22
Macs 84:20
mad 87:13
magic 316:16
magical 387:2
magnitude 266:16 266:19
mailroom 479:1
main 73:5 164:21 225:2 230:15 355:21
maintained 436:9
maintenance 382:21
major 4:22 6:20 57:15 58:2 79:5,9 107:6 124:4,17 126:7,21 127:4 186:2 302:20,20 325:18 374:14 375:21 384:15 415:16 438:17
majority 67:10 190:1 195:14 225:9,18 231:6,6 248:13 250:18 258:5,15 429:13 440:3
Major's 78:6
makers 135:14
making 27:13 31:6 88:2 92:14 108:15 192:10 194:12 205:11 208:1 212:7 217:17 227:3 240:1 246:13 283:21 288:6 361:2 369:8 408:18 465:10 468:15 471:2
MALEBRANCHE 1:18 262:1,11 263:10,16 327:9 328:3 345:4,10,21 351:22 352:10 354:6,13 357:5 361:6,13,16,21 362:5
malinger 218:19
Malone 2:18 3:10 128:19 175:6,7 182:10,17 195:13 195:18,22 196:16 197:3 201:15,18 202:1,5 205:5 211:21 214:12 220:14 221:3 227:12,17,22 228:3
man 334:19 337:16 425:12 469:16 471:21 474:19 480:1 482:12
manage 110:2 114:17 393:18
managed 20:22 326:12
management 1:3 2:22 76:10 140:4 190:17 191:1 273:7 280:5 292:4 292:8,14 314:9 323:6 328:8,10 330:17 331:10 332:15 338:22 396:6
manager 19:9 129:10 274:8 376:15 403:4 407:13,14 435:12 483:8,8,11,13,16 484:7
managers 63:12,22 434:20
manager's 436:12
manages 328:20
managing 328:14 479:5
mandate 70:8 318:17
mandated 70:1,3 252:15 254:12
mandatory 98:3 425:13
manned 106:1,8
manner 37:1 174:7 205:4 209:19,20 388:20 429:21 478:9 479:12
manning 106:8
manpower 439:14 478:6 481:20
manual 124:8 141:3,9 170:11 205:10
manualized 165:2 165:10 173:7
manuals 141:10 145:1 170:4,5
map 50:16 127:11 355:3
maple 318:8
mapped 290:4
mapping 283:20 331:18,19
march 5:7,9,17 31:21,22 44:12 59:15 70:8 100:18 366:5
marches 201:5
marine 3:15 41:13 65:7 74:10,22 79:6 80:12 102:1 102:5 107:13 118:4 119:7 186:7 224:9 238:21 366:4 367:5 368:10,12,18,21 369:22 371:1 373:8 374:18 376:16 379:16 381:16 382:15,18 383:12 384:4 386:1,8,16,19 387:7 388:7,8,11 388:14,21 390:17 391:8,10,13,20 392:2,11,13,15,22 394:6,17 395:11 396:9,11,17,19 398:2,12,15 399:22 400:9 401:10 403:9,12 403:13 404:1,5,8 404:12,17,20 405:4,8,17,19 406:3 409:14,14 411:6,9,17 412:1 412:15,20 415:17 415:18 417:6,16 418:6 419:8 423:8 424:12 426:1,10 426:12,18 429:12 431:2,14 432:10 432:15,22 435:15 435:16,17 436:3 436:13 437:2,3,22 439:5,7 441:4,9 445:2,20,21 449:14,18,19 450:15 451:5 453:4,12 455:6 459:2 462:9 469:4 469:7,10 470:10 471:8 472:22 475:8,22 476:5,12 476:15,20 477:5 478:8 480:8,14,22 481:1 482:8 483:14 484:15,20 488:7 489:4,14
marines 3:18 65:9 80:12 81:10 116:22 117:13 118:9 178:13 190:2 367:7 369:5 369:20 370:7 371:4,11,16,18,20 372:7,16 373:4 378:4 380:9 382:8 382:22 383:17 387:5,21 389:5,7 390:7,13 394:9 398:9 401:3,14,18 401:19 406:7,8,10 406:18 408:2 409:5,7 417:10 420:15 421:20 422:8 425:20 426:6,9 428:2,11 429:13,17 432:11 433:19 436:8 437:5 438:17,19 441:11 442:3,7,10 443:20 444:7 446:13 450:12 451:20 452:5,21 453:17 454:17 458:14 459:6 460:6,14 464:15 464:17 465:9,12 466:3,16 471:20 472:16 474:17 478:1,11 480:21 482:2,8 486:13 487:6 490:7
Marine's 392:13 403:13 413:6
marital 175:2
mark 65:17 119:21 420:8
markers 118:21,22
market 306:16 465:2,9 468:22

473:20
marketing 415:19 418:12
marketplace 308:8
marriage 134:19 389:14
marriages 146:8
married 464:2
mart 348:15
Mary 388:2
massive 147:10
master 232:8,11
match 28:3 34:11 253:6
matching 253:14
mate 318:8
material 97:19 104:21
materials 66:6 85:4 250:2
materiel 57:18
math 180:14
matter 129:11 183:20 187:7 192:20 217:4 230:21 282:6 284:19 287:16 288:9 296:11 320:13 407:8 414:17 444:2 468:17
mature 315:5
Mayer 3:17,19,21 3:23 365:22 366:1 366:1,2,15,16 367:21 376:8,13 377:20 379:8 386:13 390:2,14 391:8 392:20 402:11 419:12 422:19,22 423:9 423:13 424:14 425:11 427:21 430:11 433:13,17 433:22 434:6 435:9 436:10,17 436:21 437:16 438:9 441:1 442:19 443:6,10 444:15,21 447:18 448:1,14,19 449:3 451:7 453:1 454:7 457:8,21 458:20 460:22 461:15,20 461:22 462:3,11 463:16 467:12 468:10 472:12 473:6 474:6,9,13 474:21 475:2 481:5 483:4,5,15 485:20 488:20 489:7,12 490:5,21
ma'am 111:21 121:11 227:12,14 228:3 367:18 438:9 445:17 448:5 457:21 483:5
McCoy 11:9 19:6 35:1 46:10,12 458:22
McDonalds 84:13 86:5
McGrath 292:13 294:3
MCWIITS 488:2
MD 1:18,20,22 2:11,18
mean 5:6 11:5 13:5 13:6 16:14 21:21 22:12 24:3 29:6 31:3 32:9 34:9 38:7,8,12 40:22 64:14 65:18 67:11 68:6,8 76:22 84:19 85:7,11 86:18 112:4 157:4 170:22 193:20 205:10 218:18,19 219:6 230:4 239:13 251:10 258:8 262:2 266:18 269:4,6 280:2 281:4 304:17 305:9 306:4,19,21 308:3 308:12 309:11,13 309:19 310:15 318:7 320:12,13 320:15 322:2 323:1,4 324:20,22 329:8 333:7 337:22 339:10 345:14 347:3 352:14 355:5,14 357:22 360:5 361:19 362:10 363:6,17 364:2 382:15 408:7 420:5 423:19 425:11 434:1 435:22 447:4 463:1 464:9 466:13 467:14 474:10,14 483:17 486:9 487:3
meaning 295:7 428:10
meaningful 3:20 451:7,21 466:14
means 35:15 106:10 140:22 194:7 281:19 290:7 305:20 314:16 317:16 416:8
meant 354:10
measurable 267:6
measure 63:18 97:7
measures 64:4 67:13 75:2 97:17 98:9,11 99:9,14 100:12,14 340:16 341:3
measuring 114:9
MEB 258:2 383:16 383:17 394:7 395:3 397:8,16,19 399:18 400:15 401:12 475:11 476:3
MEB'ed 250:21 257:21
mechanics 459:3
mechanism 402:8 435:4,22
MEDCOM 20:1
media 69:4 486:8,9 487:10
medic 246:1
medical 2:5 7:8 10:8 13:12 14:13 14:16 16:5,10 30:20,21 31:2 40:10 42:3 52:9 53:14 57:18 58:5 58:13,16 82:13 84:19 86:13,21 103:19 104:21 108:6 112:18 129:2 132:12 149:5,6 156:4 157:1 172:9 174:9 187:6 198:9 209:6 226:15 234:15,16 234:21 237:7,8,12 237:17 255:18 258:6,21 259:6,10 276:8 294:13 334:3 383:7 384:9 394:15,17,22 395:4,6,20,21 397:18 399:13 401:10 421:1,6 427:11 433:5 434:15 435:5,12 435:12 437:12 438:11,22 439:8 440:6,14 441:8 450:2 453:7 480:13 483:17 484:1,5,14,14,17 485:6,13 487:21
medically 262:10 425:13
medication 137:21 161:21 162:1 190:17 191:1 268:4,13,18 269:22
medications 75:17 75:19 137:3,6,7 137:10,11,17,18 160:20 162:7 181:13 185:11 188:3,6,20 189:16 189:18 193:6 216:21 268:7 269:2 270:11,20 270:21 271:1,2,15
medicine 70:4,7 138:8,19 175:8,13 178:6 183:12 187:3,19 212:2,13 322:2 353:21 394:5,12,16 475:7
medicines 77:17
medics 234:18 236:21 237:5 435:7
mediocre 321:11
meet 26:20 96:10 164:2 195:9 200:11 215:6 216:5 339:16 417:17 444:3,18 476:4,18
meeting 37:14 272:20 339:15 432:1 490:22 493:7
meetings 86:2 105:13 275:9 301:20 383:11 479:14 482:5 485:1
Megalink 382:10 382:10 401:7
member 6:11 13:14 17:19 80:2 133:9 167:16 168:11 181:4 182:3 218:6 378:16 400:15 403:1 414:16,19

417:13
members 1:4,13 15:12 17:13 29:5 37:5 47:16 52:21 54:12 90:2 92:4 96:20,22 108:12 109:13 129:15,16 130:11,19 133:13 134:2 139:21 140:19 142:16 146:2 156:5 160:15 166:9 167:13,22 168:7 171:11 172:4,6 173:4 178:2 206:9 224:14 235:10 239:7 271:9 276:4 400:6 403:16 405:13 407:8,9 412:7 417:16,18 448:17 451:15 455:17 492:13,15
membership 292:15,22
memorandum 76:9 447:4
memory 96:13 174:19
mental 2:4 52:3 71:11 78:16 99:1 107:7,20 108:11 108:19 126:19 129:1 134:9,11 135:9 143:14,15 143:16,21 146:16 150:6 151:9,12,12 154:4,8 155:11,15 157:15 176:17 183:19 186:17 191:13,14 200:14 205:6 208:8 224:16 225:15 233:14,19 241:20 242:3 244:3 248:9 258:14 261:13 271:14
mentioned 26:4 52:18 90:1 92:6 152:22 179:13 184:16 198:5 244:19 248:6 318:12 433:14 440:4 467:8 469:15
mentored 473:22
mentoring 473:14
mentors 465:3 467:2
mentorship 427:3 465:21 470:16,20 471:1 473:13
merged 396:9
merit 68:6,9
Mesa 116:14
message 272:5 378:12 490:10,13 490:13
messages 258:12 449:17
messaging 248:7 486:16
met 1:9 18:6 290:20
method 468:13
methods 70:11,15 412:14
metrics 63:13 64:4
Mexicans 380:14
MFLC 259:8
MG 1:20 7:7 17:8 23:17 27:15 32:8 32:13,16 33:1 34:7 35:14 36:2 46:9 89:15 93:10 93:13,18 203:8 204:22 220:5,17 263:14 264:4 330:9,14 332:21 333:16,19 335:19 338:6,11,19 429:8 472:13 473:2
MHAT 264:10
middle 37:15 383:22 482:13 491:1
migrating 284:13
migration 333:15
mike 32:22
mikes 472:5
mild 77:8 90:6,21 93:7,9 95:20 96:5
military 11:5 30:19 56:13 58:13 62:17 74:13 77:15 78:5 78:11,22 81:3 102:13 103:19 104:3 107:3 124:13,20 130:9 133:19 159:14 179:19,21 183:6 192:19 198:8 200:7 213:1 252:13 258:21 276:1 277:13,18 287:17 368:8 431:19 437:8 479:19 480:4 492:15
military-specific 53:18
Milk 415:22
mill 74:14
million 306:20 323:10
millionth 51:10
Milstead 398:1
mind 264:22 265:9 265:18,19 289:13 309:18 317:15 369:6 375:12 405:18 421:11 424:10 432:10 435:17 489:18
minds 465:16
mindset 244:8
minimal 207:18,21 475:12
minimize 177:17
minimum 404:13
mining 353:18
minor 108:18
minuscule 265:12
minute 89:16 221:11 235:2 260:7 365:18 371:13 374:13 381:2 461:9 489:15
minutes 190:19,20 245:15,15 279:8 374:2 388:4 448:13
misdiagnosing 217:17
misread 461:2
missed 239:18 436:15
misses 87:17 435:18
missing 4:8 12:8 200:15,16 353:20 368:19 369:12 371:15 395:1 436:13 480:1
mission 54:8,10 103:4 175:22 227:21 244:7 246:6,7 252:20,20 255:22 264:6 273:17
missions 242:5 250:16
mistakenly 164:20
misunderstand 424:13
misunderstood 95:5 268:1
mitigate 326:15
mixture 453:21
mobile 51:8 113:16 231:19 385:6
mobilize 117:15
mock-up 343:6
modalities 69:21 72:3,7,8,19 76:2 77:11 78:21 98:18 128:10 149:18 150:16 169:6,10 174:2 188:17 189:20 192:17 193:2 229:8 230:11 232:15 256:3 257:9
modality 163:18 173:6 187:16
model 97:7 209:16 253:6,19 283:4 284:5,16,18 285:2 286:3 294:11,20 305:16 307:18,19 312:7,20 315:12 331:17 355:1 357:15 358:3 423:18
models 97:22 311:8 311:8,14 312:7 371:3
modern 353:21
modernize 275:7 280:17
modest 475:9
modular 288:11,21 291:16 333:7
module 234:10,13
modules 384:20 385:1 489:9
Mojave 118:2
moment 4:10 276:1 277:13 336:13
moments 92:21 273:22 274:15 302:7 371:12
Monday 339:16 346:4 396:14 491:7
monetary 318:14 318:14
money 63:15 67:18 318:22 336:8,10 336:19 352:5 465:10 468:16
monitor 158:6 187:19 192:15 257:7 438:18
monitoring 158:3

158:18 192:20
monolithic 282:14
monster 456:21
monsters 281:21
month 13:4 31:13 32:11 51:19 105:14 331:18 342:16 366:21 387:13 420:1 432:4
monthly 383:11 394:14
months 13:12,13 25:4,7 35:16 69:5 273:19 303:2 312:11 317:4 333:22 334:5,8,10 465:19 484:19 491:15 493:3
monumental 380:6 483:2,2
morale 422:14,18
morning 4:3 6:19 6:19 23:20 175:6 201:7 396:14
morphed 305:3
MOS 227:22 228:2 455:3 456:5
MOSes 456:12
motivated 88:9,12 428:2
motivation 84:4 415:10 470:13
motto 369:18
mountain 482:17
move 40:9 91:16 262:20 278:1 279:16 285:10 291:10 302:10,19 312:20 325:21 329:13 337:11 338:16 339:18 352:14 357:21 362:16 367:19 402:11 430:8 433:9 442:16 448:8 453:12,22 458:1 480:22 489:20 492:21
moved 277:2 297:19 303:18 338:17 340:2
movement 325:11
moves 395:9
movie 116:12 281:11 461:16
movies 387:18
moving 105:6 148:13 279:14 281:4 284:9 295:1 326:3 329:16 332:10 339:1 357:8 368:21 382:20 387:4 397:4 400:8 449:9
MRIs 93:11 325:1
MRMC 106:13 120:11
MSGT 1:17 8:16 11:14 12:12 25:14 26:12 30:15 45:11 52:13,15 53:3 83:6,16 84:1 86:1 86:7 88:20 89:7 89:12 111:20 112:1,22 113:4,7 242:17,22 244:17 251:16,19 311:2,6 311:13,19,22 313:16,20 314:1,5 315:15 317:14 336:14 376:7,9 377:6 406:4 412:22 413:4,9,13 446:5,11,20 447:1 447:3,8 462:2,4 462:12 470:8 472:9 474:3,7,10 474:14,22
MSH 97:12
MTF 8:19 9:9,11 9:11,14,22 11:8,8 19:5 28:21 30:20 31:3 34:16,18 45:17,18 46:3,6 46:11 80:1 81:3 256:9 263:9 391:14
MTFs 11:3 15:14 57:1 79:5,9 95:2 98:4 186:2 192:4 231:16 234:2,3 257:2 333:21 417:22
multiple 24:13,14 90:22 215:2 308:9 430:20 436:14,16 466:9
multi-disciplinary 198:20 485:1
multi-layered 17:5
mumps 348:6
museum 386:17,20 486:3
muster 6:7,7,10,16 6:18
mystery 421:6
M&RA 478:11
M2 225:14 252:8 255:10

N

n 1:10 202:10
Naclerio 20:6 23:18
nail 64:18
name 43:15 44:11 288:18 314:14
named 71:18 320:5
names 203:20
narration 139:11 141:1,6,8,21
narrative 142:13 169:16,18 185:6 268:10
narrow 491:18
narrowly 209:9
nation 321:5
national 7:9,10 10:12 56:6 69:22 83:9 90:9,16 113:10 118:7 198:8 207:12 283:13,17 284:2 321:4,21 322:2,21 323:3,22 354:2 357:16 358:5 360:1,3 368:2 451:12 457:18 462:21 471:22
nation's 54:11
natural 71:5 124:12 202:20 203:3
naturally 243:10
nature 204:7 279:10 421:22 433:8
Naval 82:13 175:17 176:6 297:17
navigate 435:16
NAVMED 80:9,10 190:2,3
Navy 3:10 28:6 41:2,5,9 47:12 58:16 74:10 79:6 80:9 107:15,17 128:18 182:12,13 185:18 186:7 187:17 198:9,11 212:12 214:1 288:2,3 297:16 298:17 372:18 393:22 421:1 433:4 438:14,17 441:9,14 458:21 475:7 478:19 479:13
Navy's 231:19
NCCOSC 176:6
NCO 450:6
NCOs 237:2 248:21
NDAA 36:17,18 37:11 458:9
NDAA-11 330:10
NDAA-12 473:9
near 486:11
near-term 352:21
neat 370:17 381:3 382:12 386:19 459:11
necessarily 17:2 144:20 147:18 153:9 166:11 169:22 170:8 171:3 173:10 179:8,20 205:16 209:16 213:3 216:22 225:20 232:21 250:14 343:15 356:3 358:18 464:11
necessary 18:2 132:21 227:4 302:18 433:3 435:6
need 5:11,16 7:2 10:8 12:20,22 13:9 16:9 17:16 18:3,4 19:20,21 20:5 22:1 24:4 26:3,18 27:12 31:4 34:6 37:11 38:4 39:8 45:9 53:19 57:4 61:11 62:10,12 63:6 82:3 84:22 90:6 96:7,20 110:13 115:9 126:4,13,13 137:22 138:2 142:16 156:6,9 167:16 172:10,17 175:21 180:3,9 181:11 191:8 193:15 194:21 201:9 216:22 217:7 232:6 234:5 240:2 242:13 244:6 269:15 293:17 306:7 310:8 318:17 323:14 324:21 336:22 338:6,16 338:17 340:21

352:18,21 357:20 358:1 359:1 363:20 374:10,21 377:18 378:17 383:5 388:6,11 395:11 405:10 411:18 412:10 427:2 428:9 432:17 441:12 445:10 448:8 457:10 464:18,19 464:20,21,22 481:16 484:8 485:3 487:20 492:9
needed 59:10 80:21 104:15 332:19 364:19 385:9 456:1
needing 479:21
needs 5:12 7:15 26:20 40:18 96:8 96:11 110:19 221:4 267:12,14 278:22 290:20 294:9 296:8 311:1 375:8 391:18 411:15 412:18 422:14 455:13 456:3 473:3 478:8
negative 133:5 134:8 143:14,22 145:7 146:12,15 147:9 429:4 489:21
negatively 218:15
neither 280:7
nervous 238:7
Netherlands 380:14
network 359:1,2,9 359:12 360:14 361:22 363:3
networks 107:4
neurons 180:19
neuropeptide 121:8
Neuropsychiatry 2:12 128:14
neurosurgeon 438:13
never 130:9 184:18 204:13 219:4,4 268:5,11 289:19 353:1 412:16 421:17
new 40:5 43:17 51:7,12 82:16 109:17,17 126:12 130:8 154:4 178:12 183:10 231:13 260:3 278:1 279:9 281:10 290:21 296:2 297:4,7,8 297:10,16 298:6 299:17 300:2 301:10 303:10,19 307:9 312:6,13,14 312:20,21 313:15 313:18 314:18 315:4,8,8,11,12 316:22 325:17,21 328:15,19 331:19 333:10,22 334:4 348:1 350:10,16 350:22 351:11,12 351:15 353:15 361:4 381:4,9 382:4 404:15 414:7 442:14 451:11 458:2
newly 191:20
news 241:6 386:8 486:17
NFL 466:10
nice 189:22
nicely 206:3
niche 57:13
NICUs 441:13,19 442:1
night 7:8,11 472:1 486:13
nightmare 138:15
nightmares 138:12 138:12,21 181:6 214:20
nights 380:12
NIH 318:10
nine 90:16 303:2 471:3 477:22
non 156:3 239:8 384:8 484:16
non-combat 201:21
non-combat-rela... 201:14
non-DoD 1:12
non-health 328:1
non-medical 75:8 156:4 407:13 421:6 484:2,6 485:14
non-standard 244:14,15
non-technical 399:10
norepinephrine 75:15
Norfolk 491:3
normal 13:18 38:18 87:20 133:12 134:16 266:5
normalization 156:7
normalize 134:13 135:3
normalizing 246:22
North 91:1 288:1 296:16,18 297:12 297:14 298:5,12 299:15,18,20 300:3,4,14 301:4 302:3,15 303:1,12 303:15,18,20 314:7,9 315:17 332:12 344:17 345:16 346:9 452:7
Northern 46:13
notable 333:8
note 51:17 75:18 79:14 80:22 99:18 101:8
notebook 420:17
notebooks 420:14
notes 373:3 410:20
notice 47:12 369:11
noticed 126:5 390:19
notification 451:4
Notoriously 407:18
November 101:3 301:13
nuances 357:10
nuclear 250:1,9
number 9:16 23:7 34:7 48:17,22 51:7,12,22 52:5 52:11 53:14 56:10 56:11 61:15 67:2 71:12 74:18 75:3 75:6 78:16 79:5 99:11,12,20 100:2 101:13 103:2,4,6 105:5 123:5 136:13 138:4 139:9,15 140:13 153:16,21 158:6 163:7 182:12,15 186:10,19 205:1 223:17 226:8 228:20 229:1,3 254:6 258:1 260:3 263:13 269:14 275:9 277:21 329:15 333:8 348:19 397:12 401:16 422:15 427:8,12 430:13 441:6 445:13 446:2,3 468:21 472:16 475:19
numbering 278:1
numbers 9:19 10:7 15:4 46:2 178:11 186:22 190:9 228:14 260:15 262:2,3 318:21 346:6,7 390:10 397:13 437:11 443:11 447:10 461:7 477:13,20
numbing 133:8
numerator 150:10
numerous 72:4 421:15 442:12 482:4
nurse 14:5 77:13 152:13 188:8 223:20 435:11 483:7,11,13,16 484:7
nurses 152:13 223:20 483:21
NYCO 102:17 110:21

O

oak 318:8
Oaksville 372:21
object 319:20
objective 46:7
observed 266:10 413:2
obvious 253:9
obviously 68:7 69:12 77:19 176:9 184:9 186:20 188:11 208:2 270:7 470:3,9
occasions 418:21
occupation 225:7 227:11 424:11 440:22
occupational 132:11,14 133:20 134:14 172:8 174:8 242:12 424:17
occupationally 425:4
occur 64:15 193:17 333:17 404:13

occurred 330:16
occurrence 64:19
occurring 102:15 123:9 125:10
occurs 23:2 219:4
OCONUS 240:16
October 105:2,4,12 105:22 477:7
OEF 204:4
offer 94:14 295:18 319:15 340:21 455:6 467:10
offered 476:21
offering 174:2 344:18 401:5
office 2:12 3:13 4:5 20:1 21:9 51:7 111:16,17 128:14 129:19 216:9 226:17 273:6,21 274:7 279:21 281:14 283:3 290:18 292:5 327:11,21 328:10 357:3 360:1 460:9
officer 2:22 7:8 155:12,15 273:7 292:14 366:3
officers 155:17
offices 356:18
officially 106:21
off-guard 92:19
off-site 247:10
oh 54:1 87:11,16,18 87:19 117:13 119:19 123:13 126:20 151:11 220:13 237:15 242:18 248:11 263:21 356:20 366:1 390:15 402:14 444:15
OIF 204:4
oil 473:16
okay 5:17 17:8 20:14 32:6,13 33:1,20 35:16 38:10 39:11,18,22 40:4 43:22 44:8 44:15,20 45:3,5,6 45:7,10 46:21 49:5 63:17 66:7 67:16 68:20 69:17 74:1 81:8 86:15 94:9 100:8,9 114:1,7 127:19 128:7,13,19 141:3 152:3,10 156:8 163:11 165:6,11 166:7 168:2 169:16 183:15 213:15 214:7 220:4 224:2 228:2 228:8,10,11,14 229:6,6 230:10 232:14,14 234:7 235:2 239:20 250:6 252:1 254:19 256:1,4 257:14 273:3 284:8 311:12 318:5 325:16 330:18 347:14,15 348:2,7 367:20 384:5 385:16 389:1 390:2 392:21 406:6 413:4,5,14,20 419:10 421:8 430:12 437:16 441:1 442:16 443:6 448:1,18 450:9 458:16 461:13,20 469:17 475:3 477:6 481:5 489:12 490:16,17 491:22
old 76:5 295:3 312:17,18 315:11 351:13 375:21 378:6 420:14 487:9
older 174:15 397:11
Olympics 379:17
once 6:14 28:14 39:3 71:2 101:19 193:18 269:10 339:22 350:8 363:3,18 368:18 383:4,7 391:20 404:13 451:18 455:11
ones 44:2 68:1,4 79:9 99:3 174:3 231:16 312:18 332:11 410:6 457:18 458:21 464:12 486:12
OneSource 259:8
one-off 15:3 33:22 353:7
one-page 405:3
one-pager 405:5
one-to-one 238:9
ongoing 112:6 157:14 158:5 198:7 475:7
on-line 53:7 187:4 312:16 489:8,9
on-site 192:1 410:19
oops 368:20
Oorah 490:21
open 42:12 282:10 283:21 284:4 285:2 296:12 306:3 322:14 349:3,6 351:3,7 351:21 354:8,9 362:12 363:6 381:18 467:19 473:12
opened 236:18 296:20 297:14 301:9,11 331:17 381:10
opening 372:1 381:20 449:1
openly 283:21
OpenSource 294:5 294:6 295:7,11,14 296:3,9 305:18,20 306:2
operate 211:14 224:13 324:7
operating 54:19 105:2 290:22 325:2 437:3
operation 43:6 405:18,21 459:4,7 459:21
operational 97:18 105:3,22 106:3,10 106:16 155:9,20 175:18 176:7 198:12 229:21 246:4 431:12 437:1
operations 234:22 242:15 243:3,12 243:17
operative 70:10
operators 239:9
ophthalmology 24:16
opine 339:21
opinion 261:7 319:12
opportunities 135:4 175:1 282:8 451:8 460:15 462:1,8,17,20 463:4,7 470:16 474:11,17,18
opportunity 37:18 47:20 48:12 143:8 176:22 177:16,20 209:7 353:21 360:9,17 364:12 400:19 417:2,14 455:6 464:4 466:2 471:6,7,12 476:21
opposed 275:20 305:22 350:15
ops 243:21
optimism 333:20
optimistic 213:10 362:8
optimization 99:8
optimize 127:7 349:18
option 259:9
options 447:5
orally 139:13,13,14
orange 119:9,10,15 119:17,18,21
oranges 318:9
Orbitz 286:13
order 17:16 19:8 19:11 28:16 29:15 50:17 59:9 60:22 61:10 62:9 86:22 111:11 163:16 164:2 285:14 332:16 341:16 437:13 445:14 469:8 471:4,9
orders 28:5,11,15 29:12,17,20 39:22 237:21 240:12 381:5,9 392:3,5 438:1,20 439:8 463:10 470:2,18
Oregon 17:9,13
organization 70:4 99:19 105:6 134:12 147:13 280:3,14 281:9 290:19 296:17 328:9 338:12
organizational 340:13
organizations 110:18 290:9 300:16 303:14 325:7,9 335:17 336:2 340:11
organize 50:18
organized 48:22 105:17 291:14
oriented 282:9 286:9
original 66:18
Originally 176:1,4

orthopedic 24:1,1 29:2,13 95:7,9
OSCAR 102:5 107:14
OSD 460:8
OSI 226:16,17 235:18
ought 111:18 242:3 490:7
outcome 97:16 98:8,11 100:12,15
outcomes 55:15 98:12,12 198:22 199:9 201:20 202:3
outcome-based 340:16 341:3
outing 247:8
outlined 25:16 35:11
outreach 152:1
outside 20:21 52:21 53:5 112:11 240:21 241:1 262:13 372:15 399:16 428:20 434:11 435:2
outstanding 395:7
outweighing 136:8
outweighs 136:21
ovals 56:19
overall 144:4 223:17 234:11 240:1 310:15 389:2
overcome 341:9
overhaul 104:3
overlapping 125:14
overnight 307:1
overseas 361:17
overseeing 22:22 293:13
oversell 362:9
oversight 207:13 207:17,22 274:8
overtaken 274:21
overview 59:3,4 185:21 186:13 367:8,15
overwhelmed 386:7
overwhelming 445:5
over-simplify 308:4
over-used 324:10
oxygen 91:13
O*NET 456:7

P

P 129:6
Paccheco 370:2
package 142:5 382:18 383:8
packaged 189:22
packages 135:18 139:4,7,9 140:10 149:14,20 439:1 439:12
page 3:1 291:2 377:2 455:8 456:19
pages 419:2 455:20
paid 458:13
pain 133:4
painted 464:19
Palms 65:9 118:2 118:16 120:12 427:9,20 429:9 430:15 433:5 434:13,18 451:21 462:15 474:12 491:6,7
panel 3:8 127:22 178:2 210:14 263:18 272:12,17 334:18 375:6
paneled 263:20,21
panels 52:6
panic 123:20
PAO 177:6,9
paper 118:17 357:21 382:17 383:1 392:5 393:18 402:21 403:2 407:2 408:6 419:9
paperwork 12:8 391:6 452:10
paper-based 357:9
paradigm 174:10
paradox 170:17
parent 469:12
parents 428:18
Park 471:22
parking 4:11
Parkway 4:12
part 8:5,22 18:3 46:8 53:9 56:14 60:2 69:6 73:15 81:19 83:11 94:17 97:14 103:11 104:2 107:21 108:4 112:2,4 115:1 117:12 118:13 123:22 124:1 125:22 133:13 164:9,14 165:9 171:12,13 188:9 189:6,7 213:13,14 215:19 216:1 231:10,18 233:8 239:18 241:13 242:19 245:18 246:10,11 246:15 247:7 248:20 251:2 258:8 261:1 266:9 284:1 325:6 328:1 330:20 341:8 351:7 356:2,5 370:5 389:16 403:13 406:9,15 409:17 412:18 415:8 417:7 446:13 452:12
PARTICIPANT 386:12 434:4 447:20
participants 163:12
participate 425:14 459:1 469:5 470:6
participated 380:3
participating 197:20 211:22 394:18 405:19 428:1
participation 6:11 339:9
particular 50:8,17 62:4 79:13 85:8 96:15 138:7 163:17 164:3 175:22 176:14 178:20 182:3 191:5 192:5,17 194:10 198:10 199:4,16 212:14 217:1,1 234:19 370:9 373:7 395:21 404:1 431:9 434:19
particularly 4:21 48:18 94:22 106:6 111:14 196:21 330:20 478:3
partner 56:14 276:9 461:14
partners 99:21 274:9 275:10 357:16 358:7 360:4
partnership 293:14 343:19 457:17
parts 329:16 368:21 424:7 452:20
pass 248:19 360:17 402:13 416:19 437:14 472:7
passed 484:22
passes 446:4
passion 389:4 419:16 464:1
passionate 367:2
patents 465:18
path 15:22 275:7 279:14
pathophysiology 91:9
pathways 97:13 100:13 198:14
patience 176:3
patient 90:8 91:20 97:4 141:14 159:22 168:19 174:9 179:9 184:9 190:16 193:4 194:6,8,11 195:9 195:16 198:3 206:21 207:1,3 214:15 215:6,7 217:8,16 277:8 278:5 298:18 299:12 300:1 323:7 332:17 361:18 364:4,15 425:2
patients 86:17,18 86:19 126:2 136:22 148:19 153:11 159:21 160:3,7 162:19 163:3 165:8,19 179:8 193:19 194:13 196:12 217:6 220:11 256:14,18,21 258:11 259:19,20 262:9 278:6 288:2 288:3 297:22 298:15 306:21 374:19 395:7 430:14
patient-centered 108:6 141:12 149:5,6 169:20 174:6 209:6
patient-focused 289:7
pattern 392:1
patterns 168:17
Patty 141:18
Paul 2:7 3:6,18,22

47:3 65:21 89:22 90:8 384:6 439:22 449:7 463:17 467:4 469:2 482:10 483:1
Paul's 90:13 91:17 460:19
Paxil 137:4 157:17 189:14 270:1,17 270:19
pay 258:2 361:19 440:20 459:19
pays 20:20
PCSing 102:11
PDA 114:14
PDBR 43:16,18,20
PDEs 261:12
PDFing 409:13
PDHA 120:3 225:22 252:7 261:14
PDHRA 27:19 120:4 176:18 222:18 225:6,21 226:2 252:8 253:11 254:4 261:10,14
PE 140:8,12,14 141:3 151:5 160:12
peaks 64:18
PEB 383:18 394:8 395:3 397:20 398:2,7 399:20 400:17 475:12 476:3 478:7,19 479:4
PEBLO 479:2
PEBLOs 395:22 447:18
peer 192:20 196:20 256:4 257:12 415:10
peer-to-peer 175:2
penalized 476:11
pencil 118:17
Pendleton 65:9 67:1 74:19 118:16 120:12 186:3 370:7 372:19 375:20 379:15 381:11 421:13 431:22 453:22
Pendletons 126:7
Pentagon 2:6 111:16 129:3
people 9:4 10:7 19:22 21:20 24:5 26:15 28:11,16 32:19 34:2 36:11 45:19 47:8 49:13 52:12 53:17 65:13 71:6 74:12,16 75:7 76:21 77:7 85:17 87:20 88:1 88:8,11 94:2 95:6 99:12,12 100:2 106:11 121:19,22 124:20 125:5 137:22 142:22 145:14,17 148:8 148:10 158:14 164:9,13 166:17 170:3,11 173:13 195:3 196:19 197:2 198:1 208:6 210:21 213:8,10 213:11,16 218:15 237:7,13 241:7,9 244:3,6 246:19 248:13,16,17 250:19 253:2 258:15,20 259:9 260:7,8,18 261:2 261:21 268:21 270:10,12,17,18 289:22 290:1 292:5,8,22 293:19 296:1 297:2 299:6 300:20 301:7,21 303:2 305:18 307:9 308:6 309:22 310:21 313:2 323:10 336:21 337:4 338:3 342:9,17 343:21 346:17 350:19 351:6 358:11,19 359:7 359:12 360:9 363:2,7 364:11 374:9 383:4 393:11,16 399:3 399:11 402:2 416:9 424:19 427:22 430:4,21 431:7 434:22 446:8 471:1 482:21 484:22
people's 294:18 346:13
perceived 453:15
percent 21:18,19 33:19 38:13 67:12 130:10,15 131:6 137:8 143:3 144:7 144:8,16,18,18 150:15,17 157:8,8 157:16 159:7 160:6,10,16 161:3 161:14,17,22 162:7,8,9,14 163:4,11 164:15 164:21 165:4,19 165:20 170:6,7,10 170:15,15 173:4 184:1 218:2,8 228:22 238:19 251:11,12 257:21 258:3 259:14,19 263:15 267:6 268:21,22 269:2,4 318:16 337:16 341:6 398:5 410:9 426:22 427:1,22 444:19
percentage 130:19 142:18,19 143:5,6 144:13 166:8 218:20 254:20 262:8 398:3
percentages 262:3
perception 137:16 143:22 203:6 251:3
perceptions 134:8 139:20 143:14 144:3 145:7 146:12,15 147:9 173:20
perfect 487:14
performance 75:3 139:1 482:15
period 12:21 13:8 28:13 38:15 42:4 182:19 263:4,7 266:22 311:15 388:9,17 440:10 449:18 450:16 470:20 472:3
periodically 99:16
permanent 249:10 249:17 250:3,5 273:21 341:1 469:5,18
Permanente 320:15
permanently 250:16
permissive 392:16 469:10,18 470:17 470:17 477:2
Perot 473:13,14
person 4:21 7:4 96:12 112:18 123:10 138:17 164:11 185:2 199:17 214:19 215:21 217:18 270:3 276:6 278:2 372:14,15 423:20 429:3 431:9 484:12
personality 362:8
personally 268:6
personnel 26:21 105:8,9 106:4,7 106:12 150:5 274:10 396:10 398:1,4,5 442:16 489:4
perspective 54:6 172:9 183:13 187:1 209:14 260:13 268:8 425:12 453:3 485:12
peruse 291:5
PETERSON 403:3 404:9 408:21 413:3,8,12 414:9 414:11,20,22 415:3,11 419:4 455:3
PH 3:6 49:10 50:2 54:16 55:11 59:21 104:7,10,17
pharmacies 289:15 307:11
pharmacist 278:22
pharmacists 289:21 299:11 337:1
pharmacotherap... 73:5 184:17
pharmacotherapy 75:11,13
pharmacy 278:21 286:19 287:8 289:16 290:5,20 299:16 303:21 312:13 313:15 317:9 321:11 331:20
phase 71:15 394:8 394:8 397:8,16 399:18 400:15 475:11 476:4
phases 453:9 477:16
Phillips 1:18 4:9,10 25:13,15 42:1 45:1 64:8,12,17 65:1 73:17 74:1 115:22 116:8,11

116:15,17,19 117:2,6,10,16 120:21 121:4 170:19 171:2 318:1,6 319:5,9 319:14 322:1,5,8 326:19,22 327:5 377:15 418:18 419:5,10 437:7
phone 91:5 111:5 115:12
phones 110:1 487:6
photo 370:9 371:18
phrase 333:9 360:7
phrases 277:6
phrasing 295:10
phrasings 297:2
physical 16:22 24:15 43:21 131:18 156:15 219:7 222:5 267:16 478:1,19 479:7
physically 284:14 284:17 346:10 391:15
physician 10:19 174:17 278:10 298:7 317:13 343:9 437:8
physicians 10:17 77:14 188:22 287:10 343:11 344:16,17
physiologic 75:2
physiological 132:7 138:10,13,20 208:15 209:3
pick 286:5 289:4 336:1 346:15
picked 225:12
picture 59:2 209:11 277:11 281:2,17 300:8,10 310:7 367:21 368:5 369:17 371:6,10 372:12 373:18 390:6 416:4 442:8
pictures 387:1 389:3
pie 257:17,20
piece 9:6 19:2 20:10 21:13 46:4 141:16 394:22 408:6 417:5 419:8 480:18 492:4
pieces 21:2,7 142:9
piled 125:12
pilot 60:16 61:3 62:16 68:9 94:22 198:13,14,19 199:4 305:2 345:15 351:18,19 393:19
piloted 241:5
pilots 68:7
pins 95:12
pipe 326:17,18
pipeline 457:9,19
Pittsburgh's 459:13
PIV 360:7
place 11:9 21:8 90:2 96:8 109:17 242:2 247:10 261:10,21 269:10 271:11 285:14 291:22 296:8,19 299:18 301:5,9 302:20 303:10 305:5 306:16 307:3 312:9 325:8 330:2 332:16,17 342:15 348:8 350:4 359:15,22 380:10 386:20 393:15 411:4 422:18 429:7 433:2 435:21 436:4 447:10 449:12 453:18 456:9 467:22 483:18
placebo 268:19
placed 29:4 93:11 233:18 400:13 447:16
places 9:17 74:18 80:21 90:22 296:17 303:21 313:13 331:15 334:7 346:8 347:4 349:21 350:7 351:19,20 352:4 364:8
placing 91:14
plan 5:16 30:5,6,7 30:8,8,11,13 31:1 31:10 38:21 39:2 39:8,10 148:2 197:6 254:1 403:13,14,22 406:3 408:14 409:13 410:18 411:13 412:3,3,6 412:11 413:20 415:5,18,19 416:1 416:2 418:12 458:17
plane 247:15
planned 105:15 342:14
planning 52:6 105:13 171:13 400:11 403:8,9,10 405:14 410:22
plans 39:1 491:4
planting 177:17
plastic 357:22
platform 126:22 286:4,5,16 488:2
platforms 126:8 234:19
platoon 265:1,17 267:19 371:11 420:14,16 437:9
play 86:12 98:18 219:2,2 294:17 471:5
played 490:3
player 309:19
playing 379:10 428:20 465:9 468:22 473:19
Plaza 1:10
please 326:21 343:4 366:12 387:21 480:6
pleasure 129:20 272:10
plug 286:21 296:11 306:7 308:2
plugs 308:11
plus 350:8
pocket 400:1 401:15 472:17
podium 56:2
point 41:7 63:4 64:5 74:12 84:20 85:22 89:19 91:14 91:18 96:1 108:18 181:16 183:9 185:13 190:10,12 192:18 212:21 225:19 245:2 266:21 277:12 303:5 309:17 310:11,11 315:15 320:7,10 322:20 332:14 337:5 341:4 346:2,11,12 348:4 353:20 363:19 392:3 401:12 403:17 406:17 407:16 422:20 449:21
pointed 225:17 273:16 394:13
points 190:5 374:1 449:8
police 133:21
policies 20:9 82:2 85:2 148:3 378:4 381:5 486:18
policy 19:21 21:10 55:15 62:19 76:9 81:17,18 82:7 100:1 135:14 147:7 211:18 403:21 404:11 453:12 460:7 469:7,11 471:14 472:8,10,14,20 473:3,10
polytrauma 81:4
pomp 349:11
pool 150:8
poorly 47:14 407:6 407:20
popular 135:18 139:6 140:10 149:13,20
population 29:9 79:18 117:7 125:8 125:9,11,13 126:12 130:8 153:8 159:11 160:9 201:21 203:9 220:11 224:5 226:22 235:9 240:16 258:5 276:5 347:8 354:4 378:12 408:5 443:21 471:15
populations 53:16 240:14,19 241:3
population-based 254:18
port 387:3
portability 332:16
portal 346:21
portfolio 63:22 113:12 115:1 328:12
Portsmouth 32:2,4 186:1
posed 462:8
position 377:8
positioned 55:14
positive 76:6,12 174:11 236:11 238:5 429:5 489:22
positiveness 413:15

possibilities 466:1
possible 66:2 181:1 219:13,14 260:18 392:9 433:11
possibly 14:22 31:19 258:22
post 90:2 117:19 128:10 150:21 357:3 410:19
posters 371:4 415:21
post-deployment 27:16 65:11 261:11
post-surveys 238:6 238:14
post-traumatic 27:21 178:16 214:16 221:6 225:6 226:12 242:11
post-war 208:13 209:7
potential 472:14,19 472:20
potentially 180:1 180:16 200:16
pound 373:13
powerful 465:13
practice 28:8 60:12 62:20 72:20 73:1 73:16 76:4,22 77:19 100:6,9,19 104:19 136:3 142:11 143:2 154:19 164:3 172:19 183:16 193:9 196:4 200:18 210:4,6,9 229:11,17 230:9 231:10 233:2
practices 61:19 62:10
practicing 164:15 192:22 193:1
practitioner 150:3 167:15 188:8
practitioners 77:14 152:12,14 223:21
Prazosin 138:8,19
pre 238:6,14
precludes 112:4
precondition 73:19
preconditioning 74:11 116:2
predates 253:20
predating 253:17
predeployment 73:20 118:14 234:15
predicted 143:20 146:15
predictors 171:16 221:1
prep 426:12
preparation 284:8 379:17
preparatory 301:16
prepared 171:21 211:9
prepping 366:20
preprep 459:14
prescribe 77:16 152:13,14,15
prescribed 96:4 216:20 271:3,7,13
prescriber 188:6
prescribers 188:4 189:13
prescribing 189:10 189:10
prescriptions 162:3 300:20
presence 326:7
present 1:13 2:3 19:5 139:14 141:2 151:19 167:20 176:5 182:3 321:16 398:11
presentation 84:6 195:10 207:2 211:5 220:16 268:2 287:9,10 291:13 300:9 303:16,19 307:15 308:14,21 309:1 311:9 315:9,10 317:1,7 331:14 334:5 342:20 350:19
presentations 180:16 182:1 199:20 201:10 206:1 225:12
presented 53:9 60:19 83:3 88:21 175:15 213:20 233:6 320:9 354:14
presenting 205:1 205:14
presents 201:13
President 478:18
presiding 1:12
press 183:10 442:18
pressing 441:22
pressure 10:18 138:8,18
presumptive 28:18 28:21
pretend 184:18
pretty 30:12 77:21 84:16 92:19 123:11 126:18 127:2 132:6 162:10 163:10 204:5 206:14,22 261:18 267:3 286:6 305:10 340:2 461:18,19 464:6
prevalence 130:7 130:14 131:8 202:22
prevent 255:19
preventing 103:3
prevention 50:10 51:7 54:14 62:8 70:11
prevents 210:22 211:12 440:20
previous 64:9 76:18 203:17 492:2,6
previously 7:20 49:16 184:16
pre-college 426:12
pride 371:7 424:13
primarily 161:21
primary 73:14 77:14 108:2,7 176:18 188:7,22 189:3,7,8 271:13 450:13
principal 55:10 475:14
principles 213:6
prints 405:2
prior 10:14 17:20 18:12,14 23:6 37:19 71:21 147:1 444:18 447:5,12
priorities 173:16 173:18
prioritize 146:2
prioritizes 352:20
privacy 174:21 422:8
private 13:19,21 276:9 351:4 357:21 358:1,7,11 363:20
privilege 188:12 211:22
proactive 103:17
probably 5:22 15:9 30:11,12 35:2 46:16 64:9 74:4 80:7 102:21 106:20 110:8 155:7 161:16 162:10 171:15 172:3 179:19,19 207:4,6 224:6 225:11 249:22 251:3 256:6 267:12 273:12 332:13 335:14 345:12 347:10 368:22 375:8 398:14 401:22 431:10 448:22 472:21 491:8
problem 10:16 14:17,21 15:1 21:22 24:6 25:20 26:14 27:2 28:20 29:1 30:4 33:16 33:20 39:1 40:5 43:4,9 46:5 67:10 87:1,3,11 124:19 141:2 193:16 204:12,19 223:12 273:14 315:20 336:11 340:10 347:21 397:1 418:2,4 424:20 432:20 436:7,8 469:3 471:5 475:20
problematic 270:21 359:9 436:19
problems 8:6 9:21 14:3 19:4,19 22:11 28:19 29:3 37:6 39:15 42:18 45:15,15 88:14 94:4 110:11 123:17 131:16 151:18 174:18,19 223:10 246:19 256:12 258:20 259:12 271:20 323:21 340:5 347:16 365:11 419:7 429:14,19
procedure 84:21
procedures 164:22 165:3,22 183:21 382:4
proceed 47:10 309:3 392:16

395:5
proceeding 5:2
process 9:1 16:8 17:10 25:16 26:3 27:15 28:4 29:21 30:5 34:11,14 35:5 36:15 62:19 81:5 91:22 119:6 158:13 169:19 188:9 219:13 245:20 248:1 250:12 257:13 261:11 264:11 265:22 266:5,6,11 266:20 273:20 289:5 290:2 331:20 345:18 383:8,18,18 385:18,20 388:13 390:18 393:15 394:10 395:3,5,10 395:12 396:20 397:6 398:15 399:10,16,22 400:2,6 401:11 402:3 415:7,8 416:22 417:4 418:9 420:19,20 430:20 434:16 435:8,13 436:2,13 438:5 439:17 440:9 445:22 446:1,14 451:15 455:5,5 469:17,21 471:2 475:15,17 476:11,11 477:14 478:8,16 479:4,5 479:11 480:10 481:21 486:20
processed 392:2
processes 8:13 18:20 19:18 28:13 40:11 49:21 62:21 209:3 261:20 289:18 290:4 354:2 390:9 394:2 482:9
processing 73:8 78:13 135:16 139:5 140:9 141:17 142:5 144:12 149:15 160:12 163:20 165:13,14,16,22 168:3 169:3 181:10 187:5 190:8 191:4 268:16 354:14 397:10 398:8 475:11 478:17 479:8
processors 19:16
product 328:20 338:14 378:18 454:1
production 397:19
productive 425:21
products 49:3 54:20 419:17
professional 112:18 368:8 431:18 435:15
professionals 134:11 143:15 159:12 160:10 162:18 271:15
profile 17:11
profiles 429:18
profound 77:6 132:6
profoundly 54:17 76:16
program 3:13 33:18 60:7,15 61:8,8,10 62:1,7 62:20 63:8,11,14 63:20 66:21 67:9 69:16 74:6,8 80:3 82:13,18 83:14 94:22 101:7,12 102:1,5,6,10,15 107:10,14 109:12 111:21 116:6 129:10 149:11 155:21 170:20 176:17 177:22 187:19 189:2 199:10 207:14 208:2 212:1 230:14 233:11 235:19 236:11,20 238:17,18 239:1,8 243:20 244:13 245:11,17,19 247:7 259:8 263:5 264:17,20 265:1 266:3 273:6,21 279:21 280:5 281:13 283:2 286:17 290:18 292:4,8,20 306:6 328:9 332:22 336:19,20 367:4,9 367:15 370:6 373:16 376:15,16 389:5,11,12,22 399:2 403:4,4,21 410:3 411:3 423:16,22 425:15 426:2 428:6 430:4 432:3 443:18 444:20 445:15 450:22 451:2 457:10,19 458:10 459:9,14,19,21 468:7 481:12 487:10
programmatics 147:2
programming 348:6 351:6,14
programs 59:21 60:3,5,10 61:11 61:12,16,17,19 62:8,13,17 63:3,6 64:2 66:3,15,18 66:19 67:2,3,7,12 69:8 70:11,14 74:4 75:6 78:22 79:3,5,7,8,22 94:12 99:4 100:1 100:21,22 101:4,9 101:10,14,16,20 102:7,19 116:3 147:7 150:18 171:20 175:2 176:19 187:3 188:22 207:18 212:2,3 235:14 237:12 261:9 273:9 361:17 366:8 369:3,9,15 378:11 429:6 484:2,19 489:17
progress 52:5 62:1 92:2 105:13 194:12 276:6 337:6 339:4
project 7:6 303:5 329:12
projected 71:8 155:15
projective 70:20
projects 60:16 61:3
proliferation 309:13
prolonged 73:7 78:12 87:4,6,16 88:7 135:16 139:5 140:8 144:12 149:14 163:20 164:5 166:3 167:15 169:3 181:9 190:7 191:3 268:14
promise 282:3 367:2
promising 61:19
promote 60:12 73:15 104:18 147:3 463:1
promulgate 62:10 82:4
promulgated 76:8
promulgating 80:15
propensity 253:5 253:14,18
proper 24:18
properly 400:19
proportion 224:16 269:17
proposals 115:15
propose 47:22 392:21 473:1
proposed 60:17 200:1 235:16 236:12
proposition 55:3
proprietary 282:15 283:11 296:10 305:22
prosthetic 369:13 370:11
Protection 60:19 99:22
protein 91:11
protocol 87:14 170:16
protocols 72:9 97:1 97:21 189:20 256:2
proud 368:4 369:17,19 371:1 373:15 375:7 386:3 387:22
proudly 372:11
provide 31:13 49:22 54:20 55:1 58:14 59:4 62:12 65:19 66:9 69:14 77:6 96:19 108:10 109:21 141:12 152:17 154:9 155:19 157:13,13 157:20 158:15 163:13,14,21 164:1 186:11 189:8 191:21 196:11 199:2 207:17 230:20 232:2 234:14 237:3,6 273:8 284:20 286:19 298:14 315:14

317:13 343:3 385:15 396:7 433:2,2 446:12 450:22 452:1 462:19 470:15,17 471:6 482:5 486:10 489:5,10
provided 48:4,19 59:8 63:9,21 78:10 96:9,9 101:1,15 151:22 159:22 193:8 218:5 278:3,6 283:6 393:8 440:14 445:19 455:22 456:16
provider 24:5 34:21 107:10 150:4 152:1,4,6 190:16 193:12,14 195:16 196:13 225:16 226:5 234:5 259:10 278:16 315:3 323:14
providers 15:18 34:5 52:17 53:8 75:19 78:4,11 83:18 97:12 107:3 107:8,20 108:1,7 108:19 109:9 150:1,8,11,16,21 151:2,4 152:9 157:18,19 158:22 159:6 161:3,12,20 161:20 163:3 172:20 176:17 183:15,16 184:7 185:15,18,19 186:7,10,14 187:12,22 192:3 192:10 193:1 199:13 223:18 230:14 232:4 257:10 276:20 295:21 352:2 356:19 357:21 358:1,11 364:9,11
provider-focused 277:9 289:8
provides 136:4 141:22 231:4,11 231:20 234:17,22 378:20 385:8 396:18 400:4 450:11 473:8 483:13
providing 47:5 79:17 81:6 156:1 161:21 169:9 274:4 297:20 401:8 405:12 463:4 478:10
proving 218:10
provisionally 206:7
Prozac 189:14
PRP 249:11,16,21
pseudo-rest 76:20
psych 52:10 104:8 154:7 155:6
psychiatric 28:20 124:6 125:12 186:17 207:16
psychiatrist 88:4 177:13 181:12 184:17 188:8 197:12 205:8 214:14 215:10
psychiatrists 77:13 152:14 223:22 271:14
psychiatry 183:18 188:14
psychological 2:7 47:4 49:14 54:13 99:8 154:8 198:14 207:15 242:10 243:19 267:15
psychologist 205:8 232:4
psychologists 101:12 107:18 152:15 223:21 231:7,15
psychology 78:3 97:6 185:17,20 230:17 231:1,4
psychotherapies 73:4,5 184:14 191:12,16 195:8 198:7
psychotherapy 78:2 136:10 137:16,21 152:17 160:19 162:6,8 190:17,21,22 268:13 269:1
PTS 64:15 224:8 227:20 248:15 373:13 408:6 428:14 441:1,11 441:16 442:4,7
PTSD 3:8 50:21 52:12 53:1 69:21 70:2,13,17,22 71:7 72:15,17,21 77:12,17 78:8 86:19 87:4,21 91:22 97:2,8,13 100:14 107:1 110:2 113:19 114:17 118:7 121:16 122:10 123:5,11 124:11 124:13,18 125:3,6 125:15,16 126:10 126:18 127:22 128:1 129:11 130:7,14,20,21 131:3,7,14,22 132:10,11 133:18 133:19 135:13 137:15,18 138:11 142:16 146:7 149:18 158:9 160:7 162:20 172:8,22 173:5,17 174:13 178:13 179:3,12 180:22 181:20 183:3,5,5 184:20 190:8 196:6 198:14 199:19 200:2,11 201:13,22 202:10 202:16,22 203:21 204:6 206:7,8,10 207:7 208:7,20 210:17 211:1,12 218:2 219:3,5 220:22 221:12,19 221:21 222:8,13 224:8,21 228:21 229:8,12 232:5,11 232:15,21 234:10 234:20 239:13 245:5 248:3,12,14 248:17,18 249:9 249:16 250:10,15 250:19 251:5 254:6 255:7 256:14,18,21 257:20 258:5,15 259:19 260:3,8,9 260:16,19 262:9 265:6 267:7 269:15 270:2 271:3 409:10
public 178:9 283:22 372:22 426:16 466:9
publication 51:5 129:13
publicize 261:1
publicly 286:18
publish 259:4 306:8 358:3
published 143:12 217:22
pull 156:19 225:10 225:13 227:9,13 227:14,20 259:17 356:13 409:14 411:6,9 485:3
pulled 82:17 127:9 127:11 160:16 162:14 178:5,8 252:7 376:2
pulling 315:1
pulls 220:21 355:20
pulse 120:11
punch 469:20
pure 86:19 123:11 126:2 180:22
purely 214:9
purist 200:8
purpose 49:7 59:22 62:14 213:12 225:2 237:10 283:12
purposes 224:1
purse 387:10
pursue 42:14 460:14
purview 434:12
push 10:19 11:13 17:12 445:11
pushed 11:10,11 25:18
pushing 10:21 442:6 443:13
put 4:18 23:20 35:4 36:18 50:14 56:20 63:12,13 85:3,4 111:13 112:5 126:16 163:15 164:20 166:15 176:11 177:1,10 179:22 184:4 186:22 190:13 220:2 261:9,20 295:7 296:8 299:18 301:8 314:9,13 329:18 342:14 347:17 351:11 359:22 367:1 368:13 380:10 381:4,8 386:2 393:15 398:6 410:1 411:4 417:15 426:17 429:22 449:12 473:4 481:6
puts 23:11,12
putting 82:7 126:18 176:8

230:7 325:8 351:10 399:6 412:6 465:2
P-R-O-C-E-E-D-... 4:1
P.K 1:17
p.m 272:21,21 273:2 365:19,20 461:11,12 493:8

Q

quad 63:22 82:5 104:7,8,10
qualified 347:12
quality 49:2 100:12 100:15 148:14 400:16
Quantico 368:14 477:8
Quantico's 425:12
quantify 15:1
quantifying 472:17
quarter 6:14 142:21 165:4 193:9 339:15 410:2,8 418:11
quarterly 6:7,10 410:2
question 5:12 12:13 14:10,15 30:17 33:21 38:8 44:6 59:13,15,15 59:16,20 62:2 68:16 69:18 72:2 72:3,15 77:9 78:6 81:9,16,19 93:3 94:10 100:17 103:1 105:19 106:22 114:11 120:2 122:9 123:4 135:11 145:3 149:16 154:1 158:9,17 162:12 163:7 173:11 195:18 201:8,16 201:17 210:13 211:6,6,20 219:18 221:12 239:3,17 242:19 243:9 244:21 245:14 249:7,13 251:2,8 257:3 259:18,20 260:11,14 262:7 264:5 307:13 311:3,13 318:2 327:10 334:13,20 341:13,22 346:2 347:16 348:10,21 349:7 353:5 355:16 357:10 358:14 359:4 375:20 376:8 390:4,22 391:9 392:21 393:22 401:2 402:7,19 435:2 436:12 439:22 452:2,4 462:15 467:3 473:3 476:10 480:6 486:6
questioned 417:21
questioning 431:7
questions 3:7,12,14 3:17,19,21,23 6:22 10:5 48:4,5 59:7,10,17,19 62:5 69:9 72:11 85:7 98:16,20 110:10 129:5 130:1 143:19 158:1 163:15 164:4 177:18,21 179:4 183:14 191:22 192:13 193:10 198:4 221:8 222:19 228:10 235:10 252:1,2 256:1 259:21 263:17 264:2 273:12 279:5,9 289:11 304:10,11 327:12 349:16 364:22 366:13 374:21 389:21 393:6 402:17 409:1 410:13 414:18 415:13 434:12 437:18 447:18 448:2 461:5 462:1 477:21 481:3 488:9 490:11,19
quick 52:15 82:11 126:3 130:5 141:16 145:3 242:17 289:10 311:3 405:1,7,9 453:2 461:19 467:5
quickly 28:11 149:12,22 158:1 172:18 203:6 304:13 305:11 347:8 448:9 477:4 479:3 481:10 489:13
quite 5:1 20:3 63:10 79:20 84:19 104:9 106:7 107:19 109:8 126:1 138:6 154:11 208:11 254:21 346:9 381:8 439:18,19 444:22 455:2 488:8
quotes 35:4

R

R 366:14
racial 71:10
radical 288:12
radiological 324:22
raise 16:8 42:6
raised 346:12
rallying 466:13
ramps 271:19
Ramstein 236:13 237:3
ran 17:9
RAND 61:14 68:22 69:1,7,12 100:21 101:2,3
random 163:1,16 264:21
randomized 142:20 153:7 265:2,17 267:19
randomly 159:20
range 83:3 130:16 236:2 237:14 238:19
rank 253:9
rape 202:21 222:7
rapid 285:10
rapidly 282:10 329:5
rate 131:8 138:15 159:7,9 202:22 222:13 225:9 226:8 228:16,18 228:21 261:13 433:21
rated 155:1 271:22
rates 130:14 157:7 178:15 204:5 213:21 220:22 224:8 225:14 239:10 255:10 261:5 263:11 265:6
rating 218:2 385:19 447:4 479:18
ratings 238:18
rationalize 120:3
RCC 384:9 385:13 385:22 396:22 403:4,19 404:20 405:11 410:11 412:12 417:9,12 420:5 435:13 460:13 483:9,10
RCCs 374:18 385:12 388:17 404:11 409:7 410:8,15 411:4 412:2 416:22 418:4 428:3 433:2 443:2 454:16 482:3
RCP-SS 403:15 404:10 487:13
reaccomplish 257:1
reach 85:5 103:21 189:22 227:3 230:15 232:2 234:4 374:19
reached 190:4 332:8
reaches 90:20
reaching 52:20,21 408:17 431:7
reacting 125:1 172:14
reaction 124:15 238:13 247:20
reactions 134:16 156:12,22 247:1 267:15,16,16,17
reactive 208:15
reactivity 138:20
read 18:10 38:21 141:21 154:2 169:14 205:16 241:5 294:1 381:6 381:7
readily 10:22 446:17
readiness 14:2 99:22 274:10 416:14
reading 243:1 426:15
readjustment 108:10
reads 281:11
ready 88:1 280:8 352:7 366:20 493:1
read-well 419:17
real 46:7 52:15 76:20 82:11 87:20 88:11 102:2 126:3

172:18 242:17 311:3 347:8 348:9 364:15 436:11 453:1 466:2 485:13
realistic 74:16,22 211:4,7,8 306:17
reality 30:14 39:5,9 78:16 115:16 116:3 144:7 209:1 232:19 316:5,16 348:21 363:3 446:11
realize 197:8 421:19
really 8:19,19 12:7 18:18 21:14 25:16 26:4,8 34:22 35:16 37:17 38:8 55:8 67:1 76:14 76:19 77:5 88:4,5 88:9 89:9 90:13 91:3 97:10 103:13 107:10 109:7 110:19 112:16,22 114:10,16 117:14 118:5 120:4 121:10 122:19,21 127:10 131:11 132:3 134:12,15 136:18,19,19 137:1 138:1,2,9 142:19 144:1 145:13 148:4,8 149:6 152:5,8 171:21 172:13 173:14 174:9,10 174:21 182:11 203:12 204:13 209:10 210:9 211:2 216:22 220:11,21 221:13 222:17 223:8 225:19 229:15 232:20 236:20 238:4 241:11 244:4 248:4 251:14 254:21 255:5 256:13 259:4,7 260:22 261:15 266:13 267:5,8,14 268:9 269:12 270:14 272:14 274:1 278:19,22 280:1,2 281:17 282:5 285:8,22 298:3 301:7 302:2 306:17,22 307:22 308:5 309:17 320:13 321:10 322:11 333:19 335:4 337:9 338:22 342:10 344:22 346:1 347:1 350:5 351:2 352:18 354:15 360:20 364:16 403:5,8,22 404:21 408:18 409:21 410:4 411:20 412:5 414:9 415:14 416:4,6 418:4,10 448:11 448:17 457:16 458:20 465:20 467:18 475:18 479:22 485:4 487:3 489:13,20
real-time 358:20 486:11
real-world 58:9,12 153:9 456:6,12
reason 81:8 140:16 183:17 250:1 259:7 279:3 346:14 348:11 424:12 427:5 453:11 455:15
reasons 130:22 131:4 134:5 145:5 145:9,14,19,20 197:10 320:21 353:9 354:16 409:3 422:8 427:6 439:20
reassess 217:12
reassessment 27:16
reassurance 156:7 156:10
rebuild 14:13
receive 153:13 167:4,6 188:5 205:8 233:17 234:9 258:2 391:2 404:15 451:4
received 160:11,17 164:21 165:2,5,19 165:20,21 166:5 184:12 186:8 218:2 229:5 233:15 273:5 332:3 366:5 391:20
receiving 160:3 163:5 165:8,8 173:5 262:12 263:3 366:7 391:17 416:22
recertification 188:13
recess 128:5 365:19 461:11
recessed 272:20
recharter 280:21
rechartered 280:20
rechartering 281:10
recognition 18:19 28:3 34:11
recognize 447:9
recognized 298:5
recognizing 194:8 194:9
recommend 13:7 413:21 472:13
recommendation 13:1 40:19,20 41:3,11,18 64:14 104:16 105:20 136:16,17 142:12 351:16 427:7 447:19
recommendations 3:16 26:9 62:12 62:16,19 63:2 66:17 67:6 79:11 101:15 104:13 393:1 418:14 491:19 492:22
recommended 136:22 167:6 433:19
recommending 17:6
reconditioning 389:12 423:16,22
reconvene 272:21
record 131:4 162:19 164:12 167:20 190:15 259:11 275:8 276:11 277:4 280:19 297:3,8 319:10 323:18 327:20 328:1 358:2 373:1 399:14 434:5,7
recording 164:10 164:10 167:21
records 159:20 281:1 314:14 327:2,12
recount 167:19
recounting 164:6
recounts 164:11
recover 268:21 269:15
recovering 1:4 171:20 327:13,18 366:7 371:5 372:19 391:15 398:13 403:1 481:1
recovery 76:7,12 79:19 80:20 137:20 140:21 142:4 144:4 171:16 239:13 268:20 369:5 370:4 376:15 396:10,14,16,21 397:2 403:10,16 405:13 406:19 412:7 415:5 421:11 435:10 439:9 451:15 480:8,9,16
recruiting 273:20
recut 28:16
red 119:9,9,18,21 226:15
reduce 55:16 219:14 288:7 310:10
reduced 67:2 266:7
reduces 138:19
reducing 115:21 239:12 271:8
reduction 138:10 147:11 265:7
reductions 147:17
redundant 33:14 33:14
Reed 129:14 145:12 198:8 368:3,7,15 371:22 372:1 422:3 426:14 453:16,19
reevaluation 263:7
reexperience 180:3
reference 183:9
referral 16:3,7 19:4 24:18 31:5 42:3 401:12
referrals 8:9 9:18 24:2 363:20
referred 395:2 400:19 440:8 445:22 475:22 480:14
referring 111:20 119:14 189:18 196:4 327:6
reflect 174:16

reflection 338:7
reflects 287:11
refractory 202:17
refreshing 338:8
reg 249:15 256:4
regard 321:3 393:19
regarding 49:13 60:6 65:20 76:9 77:12 78:7 86:13 98:16 103:5 104:14 106:5 128:9 205:6 390:4 427:13
regardless 277:14 323:8 378:13
regards 13:1 43:8 112:13 327:10
regiment 366:4,6 375:13 377:1 378:22 379:5 381:4 384:22 395:15 409:8 422:12 423:11 429:16,20 430:1 430:18 431:14 433:16,21 434:3 435:2 436:6,7,20 437:21 438:8,10 451:11 453:9 455:7 480:20 481:13,21
regimental 130:12
Region 368:2
regional 102:13 383:13 394:15,17 449:6,11 450:14 450:19
regions 190:1
regs 249:21
regular 74:14
regularly 240:22 241:1
regulation 379:6 450:17
rehab 94:12,21,22 95:4 443:11,14,18 444:4 445:7,18
rehabilitation 49:10 50:11 57:3 70:13,22 95:1,6 95:15,16 96:3,9 96:18 111:6 114:15 424:6
REHBEIN 1:19 44:21 46:16 108:17 145:2,5 166:13,20,22 201:8,16,19 202:2 204:21 210:13 211:13 259:22 260:6 356:15,22 358:10 360:16,19 361:1 364:5 422:5 422:21 423:3,10 477:22
reinforce 230:6
reintegration 50:11 220:9 235:19 237:4 243:19 246:19 247:21 248:1 255:6,20 264:9,13,16 265:21 266:6,11 266:20
relapses 202:18
relate 197:13
related 25:22 72:11 73:18 75:3 99:3 117:17 138:11 154:2 164:4 198:16 201:21 202:20 214:11 456:6
relates 62:2
relating 52:2
relation 168:5
relationship 30:19 31:7,10 58:13 131:16 132:8 167:14 194:7 327:22 376:12
relatively 80:16 130:19 424:3
relax 113:18
relaxation 140:5 164:16
release 35:13
released 17:21 101:3 349:4 393:2 404:22 451:13 458:10,12
relentless 339:17
relevance 182:22
relevant 181:2
religiously 92:9
remain 126:10 257:22 338:5
remained 199:17
remarks 449:1
remember 25:21 91:7 232:17 247:12 263:15 348:13 361:8 386:4,14 486:1
reminder 127:21
reminders 111:7 114:15
remote 109:21 433:6 474:4
remotely 241:4,9
remoteness 429:9
remove 218:9 450:1
renewal 373:11
rep 198:9 262:15
repeat 184:11
repeats 491:22
repetitive 220:9
replace 280:18 297:5 328:18
replicate 255:4 380:17
report 7:11 18:21 37:20 39:7 66:12 69:3 71:15 99:17 101:2 104:5 172:21 217:22 226:2 227:15,19 254:16 303:6 330:11 393:2 396:18 397:1 429:11 448:3 492:2,6
reported 144:6 160:6,10 164:15 192:6
reporting 226:12
reports 41:21 293:22 294:2
report-generating 395:18
repositories 353:19
repository 294:12
representative 159:13 160:8
representatives 82:6 380:16
representing 210:19 380:2
represents 439:5
reps 261:7
requalify 251:20
request 446:16
requested 244:12
require 16:20 325:18 338:3
required 98:5 99:16 227:20 404:11 405:19 445:2 449:21 450:16 479:16,18
requirement 36:19 218:9 433:7 444:17 445:11 450:3
requirements 17:18 18:2 36:7 98:4 289:18 290:1 290:17 309:8 320:4 324:6 331:22 484:6
requirements-ba... 36:4,13
requirement-bas... 17:15
requires 16:4 451:5 469:21
resay 32:20
reschedule 6:1
research 50:4 52:5 52:6 56:12 57:18 57:21 65:6 86:16 86:16,22 88:10 90:12 97:19 104:21 113:12 114:12,20 115:14 115:15,18 122:3 129:13 134:6 143:11,21 145:12 146:17 148:15,18 182:20 184:6 202:6,14,15 211:2 211:20 221:19 454:11 488:15 491:14
Reserve 12:18 13:10 14:14,22 15:11 22:9,18,21 23:12 26:21 28:10 38:14 39:14 40:9 41:4,9,12,16 52:19 53:16 64:21 240:11 437:18,19 438:4,7,11,18,19 439:14 478:6
Reserves 13:18 437:22
Reservist 20:12 44:13 440:4,10
Reservists 34:4 276:4
Resick 141:18,18
residencies 208:7
residency 177:22 231:8
resident 418:1,6
residents 185:1 231:2
resilience 51:6 52:2 62:8 65:7 74:3,7 176:15 210:16,20 211:16 212:3 213:1
resiliency 102:6

264:15
Resilient 118:5
resolution 41:19
resolve 203:5 248:16
resolved 22:12 440:7
resort 143:17
resource 78:3 172:20 211:13 378:6 456:7
resourced 30:6,8
resources 30:12 81:20 82:18 85:4 126:16 298:2,2 336:5,16,17,18 442:21 455:18 462:22 463:2 481:15
respects 141:12 208:20
RESPECT-Mil 51:8 102:7
respond 59:6 133:15
respondents 160:6 254:7
responder 133:21
responders 159:10 159:19 162:17
responds 87:4 122:11
response 17:14 124:15 159:7,9 179:17 202:13 229:20 238:5 379:7 392:22 397:21 447:19 467:6
responses 134:21 254:12 332:3
responsibility 13:22 85:14 215:15 273:19 328:11 416:18
responsible 14:7 19:22 80:14 139:22 280:3 406:2 437:1 469:13 484:13,17
rest 76:7,12,15,20 77:6 80:20 90:2 91:13,15 150:4 156:7,20 242:13 247:5 285:5 288:15 389:21 489:11
restrictions 471:8
restrictively 249:22
restructuring 136:12 139:19
result 227:1 259:5 352:2
resulted 77:6 142:3 146:8 258:6
results 62:14 239:15 303:11 488:13
resume 456:14,17
resumes 456:18,18
retain 440:6
retention 144:19 169:21
retire 447:13
retired 129:18 262:10 297:6 438:16
retiree 277:16
retirement 392:12 392:14
retraining 288:8
return 10:9 13:3 108:13 157:7 258:3,16 259:14 262:4,9 263:11 369:21 370:5 425:15 469:12,14
returned 13:13 99:12 157:9 427:21 442:13
returning 12:18 117:18 150:22 440:21
reuptake 75:14
revamped 210:7
reveal 263:4,9
review 21:8 42:16 42:18,20 43:13,22 52:5 64:14 72:22 97:18 102:3 105:14 193:7 246:5 256:4 257:12 439:2,14 479:7
reviewed 177:10 193:10 218:1 455:2
reviewers 418:22
reviewing 431:6 441:2
reviews 20:8 184:5 199:12 236:11
revolutionized 399:6
rewarding 425:4
re-engineering 329:11
re-evaluation 449:20
re-exposure 73:6
RFI 332:2
RFP 332:3
ribbon 390:8
rich 31:18 32:6 464:15 465:1 470:14
RICHARD 1:20
Richmond 84:15
right 11:16 12:15 14:3 16:15 22:3 24:20 29:10,14 32:8 33:2 36:2 37:10 40:2 46:3 47:9 49:5 55:18 82:21 83:15,22 84:8 85:17 86:6 89:6,11 92:22 106:3,11 107:7 109:9 110:9 113:17 116:10 117:1 152:9 154:10 155:16 161:18,19 162:16 163:8 169:19 192:21 202:1 212:22 227:16,17 228:1 236:5 241:12 242:16 247:14 249:14 250:6 251:18,22 251:22 252:19 256:2 258:4 259:9 261:3 264:1 266:21 270:9 278:6 287:4,6,15 287:19 288:2,3,11 288:18 292:10 293:5 295:1 297:9 302:8,14,14,17,21 304:4,6 306:8,21 309:11,12 312:3 312:17 313:1,3,11 314:12 316:10,13 317:1,8 320:17,20 321:13,18 322:16 323:18 324:12,16 324:19 328:2 329:20 330:6 334:11 336:20 339:1 340:4,9 341:7 342:7,19,20 343:19 344:9 345:8 346:5,12 347:1,3 348:7 349:17,20 350:3 350:13 351:22 352:14 353:3 355:4,9 356:10,11 357:13,22 359:3 359:14 362:11,20 364:14,16 365:1 365:15 371:11 372:6 374:7 375:5 376:1 379:13 382:1 384:13 386:13,14 388:5,8 390:4,18 402:13 402:14 411:19 415:17 419:11 423:9,13 424:14 426:9 430:3,13 432:4,5,16 436:4 436:4,17,21 441:15 443:3 446:10,18 447:1 447:17 448:21 451:7 452:3 453:1 456:2 457:8 462:4 463:16 466:21 467:2 468:2 473:6 474:2,6,13,21 475:2,3,7 484:12 485:11,18 486:5,6 487:12,14 490:10
rights 403:15 485:6
rigor 218:16
rigorous 73:12,12 158:13
ripe 55:6
rise 444:7
risk 29:5 37:2 131:22 227:6 235:8 241:2 330:11,14 408:13
risky 131:16
Ritalin 133:1
road 216:21 344:8
robust 79:20 83:14 230:14 322:11 354:3 403:21 410:5 411:14
rock 271:11 448:5 489:16
Roger 292:14 294:4
role 57:13 72:10 98:15,18,20 103:18 219:2,3 385:18,19 416:14 417:1 423:18 436:12 450:13,19 483:12,16 484:6
roll 334:12 439:11 489:16
rolling 268:9 333:1

333:5,20 482:21
Rolls 399:3
roll-out 124:7
roof 271:10,19,20
room 31:6 141:21 185:5 194:9 198:2 214:19 224:6 277:20 298:8 343:11 428:13
rooms 325:2 416:6
roping 353:8
Rory 459:17
Rosemary 2:18 3:10 128:19 175:7
Ross 473:13,14
roster 401:9
rotating 438:14
rotation 244:14
rotations 244:16
rough 5:3,7 173:3
roughly 251:11
routine 107:1
routinely 425:6
row 101:14 371:13 372:6
Royce 399:3
RPA 241:21
ruled 250:16
ruling 93:8
run 37:1 74:14 87:7 104:10 116:21 118:16 119:4,5 230:18 286:5 302:19 316:9 318:9
running 27:9 32:17 36:12 157:22 303:2 320:12 379:15 425:1 430:3
runs 27:18 28:2
rush 39:18
RUSSELL 1:22
RxNorm 283:14 357:17
R&R 236:9

S

S 488:19 489:1,5,11
SABO 479:6
safe 41:5 137:7 193:1
safety 300:1
sailors 178:14 190:2
saliva 118:18
Salt 331:18
sample 253:14 255:1,1 413:14
samples 118:19 424:4
San 116:5,9 176:22 186:1 199:6 483:18,19 489:3
SAPERP 319:22
sat 463:21
satellite 441:20
satellites 90:17
satisfaction 148:14 149:8
satisfied 205:2
saved 389:12,14
savvy 343:21
saw 11:15 45:16 46:2 182:18 222:21 231:18 236:14 255:2 279:4 334:11 354:9 368:17 388:6 407:3 408:12 420:13
saying 21:18 22:10 22:20 23:22 28:7 95:7 106:16 115:8 141:10 166:14 179:6 197:10 212:18 219:1 257:18 335:21 363:18 383:5 408:16 424:11 431:8 463:19 466:19 468:16 469:1
says 36:14 87:15 113:2 190:19 323:16 363:12 367:5 402:19 416:1 417:20 421:1 477:5 488:6
scale 339:19 360:3
scaled 346:22
scales 348:20
scan 93:2,2
scanned 345:13 363:12
scans 93:6
scared 364:7
scenarios 354:2
scenes 315:22
schedule 7:5,17,19 10:14 33:10 342:14 484:11,14 484:21 485:3
scheduled 62:1 233:16
schedules 5:14
scheduling 307:10 332:18 421:3 484:9 487:21
schizophrenia 206:13
scholarships 467:11
school 150:20 180:14 370:6 391:4 420:2 452:16 459:15 477:8
Science 232:10
Scientist 2:11 128:13
scope 242:2 328:10
score 94:19 253:6 253:14,19
scores 412:15
Scott 176:4
scout 370:3,20,21
scratches 39:22
screen 51:9 87:1 287:13 314:10,15 315:8,13,14 330:7 343:4
screened 86:20
screening 70:12 120:2 254:13 261:9,20
screens 315:4
scrutinized 218:17
se 183:7
SEALs 121:7 182:14
seamless 357:18 382:5 421:4
seamlessly 286:6
SEAN 1:17
search 53:22 76:3 375:4 457:1
second 18:4 19:2 35:8 86:12 149:16 154:1 242:19 249:7 252:2 254:8 260:2 303:19 372:20 386:21 390:13 452:12 456:4
secondary 122:8
secret 320:11
Secretaries 275:17 280:15 283:1 294:2 339:14,16 346:4
Secretary 71:17,17 218:9 293:2 379:9
section 154:20 246:16 374:18 378:3 403:16 404:2 405:6,12 406:1 412:12,19 420:13 428:3 435:11,19 460:13 481:18 484:17
sector 52:22,22 161:5,7,11 215:13 276:9 358:1,7 363:20 451:22
secure 192:3
security 226:14 354:3 358:11 466:12
see 6:17 7:17 18:17 26:3 31:18 33:9 39:9 41:15 47:9 52:2 56:5 65:12 68:12 83:13 88:19 95:1 109:3 121:4 134:2 142:17 143:5,6 182:7,13 182:13 184:22 190:16 200:5 201:19 202:3,6 203:17 206:6,12 206:18 207:3 209:10 212:9 214:4 217:6,10 223:11 225:8,15 226:9 228:14,16 229:3 239:15 244:19 251:6,10 254:14,22 260:14 260:19 261:12,15 261:18 268:22 269:1 271:21 272:6 275:10 278:10,12 285:20 286:1 287:12 288:5,15 292:6 297:21 298:9 299:3 300:18 302:1 306:1 310:5 316:22 323:17,19 334:22 335:1 336:9 340:18 341:4 342:9,18,22 342:22 363:18 367:22 368:16,20 370:10 371:10,17 372:4 378:19 385:17 387:2,4,12 387:18 393:10 396:4 403:17 404:3 405:7 418:17 421:5 422:3 426:14 436:7 443:16 444:6 448:10,20

460:2 464:3 466:3 468:16 473:18 475:9 477:13 478:16 486:13,22 487:2 489:21 491:6 493:3
seeing 10:6 40:3 42:19,22 43:8 44:7 45:22 199:12 214:10 220:10 242:11,12 288:2,3 299:5 304:1 308:14 315:13 343:22 377:12 412:4 413:18
seek 130:22 131:1 194:20 216:9 401:4,18 481:6
seeking 197:2 454:18
seemless 324:11
seemlessly 324:7
seen 9:17 15:21 27:20 41:17 45:14 84:3 94:6 130:9 136:6 143:13 146:14 190:2 204:3 229:10 237:10 247:15 263:6 282:19 329:22 362:19 377:7 400:1 408:20 428:5
sees 122:18
Segall 116:14
Segall's 118:1
segment 77:9 85:9
select 22:9,18 23:13 153:8 159:21
selected 88:10 102:22 304:17
selecting 75:14 256:6
selection 274:1
self 234:9 259:12 465:10
self-aid 234:12
self-esteem 373:11 389:17
self-report 215:4
self-reported 214:18
self-select 121:8
semantic 356:9
seminars 426:14
semper 367:5
Senator 36:18
send 82:19 115:8 246:9 392:5,6 449:16 463:8 468:3,8
senior 2:11 99:17 103:18 128:13 129:11 298:17 431:18
sense 8:7 12:17 141:15 165:11 170:9 213:3,11,13 221:15 224:10,11 237:11 241:11 249:19 477:11
sensitive 259:2 344:4
sensitivities 196:22
sent 60:21 83:10 159:5 439:2 455:10
separate 302:13 311:7 348:16 409:1 447:12
separated 175:20
separately 72:16 280:17
separating 445:20
separation 258:2 392:12 444:19 445:14 447:6
September 112:6 458:13
sergeant 78:5 374:14 375:21 437:10 438:16 465:17
serious 16:15 41:19 179:16 254:9 301:7
seriously 401:21 408:11
serotonin 75:14,15
serve 192:3 358:17
served 359:11 478:18
server 316:9
servers 316:17
service 2:15 15:12 29:5 37:5 39:21 44:3 52:21 54:11 58:2 63:22 78:21 80:1,14,17 82:5 90:2 92:4 96:20 96:22 104:7,8,11 107:12 109:13 129:15 130:11,19 133:13 134:2 139:20 140:18 142:16 146:2 156:5 158:21 160:15 166:9 167:13,16,21 168:7,11 172:4,6 173:4 181:4 182:3 186:7 206:9 218:6 226:16 230:12,13 238:22 250:22 257:6 271:9 282:8 285:13 286:8 307:16,20 312:3,5 312:19 331:12 342:7,13,21 350:9 361:19 378:16 400:5,12 403:1 407:7,8,9 414:16 414:18 451:15,19 471:22 472:19 479:16,20 480:5
services 19:22 21:10 31:13 43:1 55:17,21 58:1,5 58:14 64:1 71:11 74:3,14 79:8 82:6 83:3 91:2 100:1 103:21,22 108:11 127:5 128:3,18 131:7 146:17 158:15 168:22 205:3 220:10 222:17 223:9 224:15 227:9,20 228:5 229:3,10,12 237:19 241:19 243:14,22 250:21 252:21 253:1 256:7 260:12 261:7,16 335:19 336:1 390:10 395:2 414:14 438:3 458:19 460:7 482:16
services-oriented 324:13
service's 344:21
service-oriented 285:12 337:9
service-specific 79:3
serving 326:8
session 42:9 148:20 194:16 265:21 267:13 318:13 417:19 493:5
sessions 123:12 125:8 134:4 144:11 153:16,17 153:20 167:16 171:14 199:17 267:13 425:6
set 10:14 15:13 96:2 101:6 216:18 227:21 232:17 243:13 259:11 275:18 282:22 310:6 320:8 328:20 330:7 332:7 334:10 348:2 349:9 351:5 411:22 466:14 484:18
sets 252:20 307:6,8 307:12 312:15 329:10 332:18 342:5 347:20 348:2 392:13
setter 435:14
setting 77:20 93:7 147:20 174:21 177:14 229:22 265:11 459:9
settings 76:11 195:17 196:17
settle 273:4
settled 13:8
setup 236:13 391:3 452:10,13,17
seven 81:12,12 180:9,10
severe 90:11 93:8 95:22
sexual 201:22 202:9,9
sexy 284:22 285:7
share 197:22 276:18 282:19 298:2 329:16 358:8 484:8,9,21 485:5,10
shared 362:20 484:16
sharing 272:14 275:1,2 280:13 384:3 484:11 485:7,13 488:3 490:14
sharp 444:7
sharpen 54:8
sheer 9:16
sheet 379:3,3 400:2 401:16
sheets 229:18 377:22 446:22
Shield 214:6
shifting 174:10
shine 340:8 365:9
shiny 319:20
ship 387:14
shoot 33:6 261:16

short 72:6,17 76:1 199:11 217:3 229:6 354:19 358:15
shortchange 276:17
shorter 319:1
shortly 332:4
short-term 411:15 411:18
shot 133:1,1 222:20 246:18 343:4 370:13 475:1
shove 415:13
show 136:5 194:17 243:5 246:18 265:13 306:14 307:7 314:19 351:15 376:1 381:1 389:3 429:4 461:16 488:12 489:22
showed 141:19 260:2 264:18 265:3,8 269:1 489:13
showing 138:9 266:17 399:19
shown 227:11 353:22 406:6,17 413:11 442:10
shows 65:10 191:17 252:3 255:5 367:6 489:16
shrift 354:19 358:15
shut 133:4,11
side 24:11 52:20 83:9 137:14 257:19 258:4 292:13 336:20 387:3,4 388:8 394:6 399:21 421:1 460:10 475:12 484:14
sides 287:11 289:21 339:12 418:21 421:5
Siemens 296:1
sights 233:11
Sigma 290:2
sign 332:15 391:5 452:9
signature 92:1
signed 102:18 332:9
significant 12:17 14:21 25:20 55:20 131:13 138:9 142:8 167:1 200:13 201:21 224:15 265:4 269:21 275:18 308:5
significantly 136:20,21 178:19 226:11 228:15 229:1 274:21 397:14 446:4
signs 453:4
sign-on 314:8
SimCoach 102:16
similar 80:5 86:4 107:16 161:4 186:9 191:9 196:11 204:5,10 205:4 209:2 211:6 221:9 236:13 239:8 244:8 245:3 245:8 268:22 345:12
Similarly 168:2
simple 29:12 76:16 145:22 148:13,14 317:15 364:6 429:3
simply 14:11 197:10 242:12 315:3 348:12 423:7 463:10 476:15
simultaneously 441:18
Singapore 288:19
single 66:12 202:19 296:20 297:8,14 301:15 314:8,15 318:17 332:15 375:20 380:15 406:20 410:8 412:13 428:19 439:11
singular 181:21
sip 387:19
sir 6:19 8:16 10:11 22:6 23:5 26:12 35:21 37:16 40:8 43:11 44:8 47:11 47:12 52:13 64:11 64:16,22 66:5 68:2,10,11,19 69:3,13,13 83:6 88:21 105:21 112:13 126:3 129:9 145:2 151:7 160:22 162:11 166:21 170:18,19 195:20 203:12 211:21 217:14 221:2 242:17 244:17,21 259:21 260:5 301:1 309:4 317:22 324:3 327:4 347:11 366:3 376:7,7 419:11 422:4,19 425:11 427:5 433:12,13 434:7 435:9 436:22 437:16 440:2 444:15,21 446:5 448:21 457:20,21 462:2,4 463:15 467:12 468:4 470:12 472:13 474:3 488:11
sit 59:12 185:4 263:18 491:16
site 32:20 113:1 191:19 303:12,19 331:19 377:8 378:19 379:5 386:7 387:14 406:5 446:7 457:11
sites 10:6 77:12 81:3 94:12,14 186:1 230:12 232:17 346:15 441:20
sits 404:20
sitting 16:5 374:6 474:19
situation 12:9,16 222:2 302:3,5 325:12
situations 180:1 463:14
six 7:18 13:3,13 25:4 44:13 62:7 81:12 163:22 175:17 180:10 230:22 290:1 387:13 395:22 399:3 406:9,15,17 465:19 484:19
sixth 265:21
size 254:17,19 430:16 432:5
sizes 265:11
skepticism 338:7
skills 161:13 163:13 411:5,5
skipped 368:22
sleep 77:2,2,3,3,3,4 132:2,5 138:22 156:14 174:18 246:20 271:20
sleeping 185:9
sleeve 482:21
sleeves 268:9 439:11
slide 47:16 48:7,16 49:4 55:22 164:19 186:11 224:22 225:3 228:12 235:6 257:16 281:18 282:4 291:12 296:22 310:5,7 378:19 430:9 449:9 451:9 459:5 461:16 477:21 480:6 481:4 488:9
slides 152:21 155:8 177:3 213:22 223:15 250:18 281:1,2 299:2 461:19 488:13,14
slight 80:7
slippery 322:9
slope 322:9
slow 353:15
small 130:19 202:11 218:20 219:9 229:1 245:21 254:17 265:10,15 326:17 413:14 424:4 444:3 464:7
smaller 79:9 186:4 234:3,5
smallest 9:18 10:2
smart 110:1 111:5 115:12 265:20 383:4
SmartCard 360:8
SME 180:13
smells 233:11
SMMAC 103:18
smoother 388:21
snatched 459:10
sniper 370:3,6,20 370:22
snipers 370:8
SNOMED 283:14 322:3 357:17
snow 46:12,18
SNRIs 137:6
social 131:13 134:19 152:15 171:15,17 205:7 223:21 231:1,7 486:8,9 487:9
societies 53:14

Socks 469:19
SOCOM 377:9 462:18
software 295:11 296:3,9,10 298:20 305:19,20,21,22 306:2 316:8,8 342:4
soggy 88:18
soldier 10:12 11:1 51:10 74:6 213:5 254:16 402:5
soldiers 12:1 15:11 24:14 27:14 137:9 151:15,17 156:12 173:20 211:9 270:19
solid 92:20
solidify 491:2
solution 40:21 41:3 41:11,16 102:15 283:11 313:15 321:11 344:2 449:13
solutions 199:10 295:22
solve 425:2
solving 323:21
somebody 18:20 20:21 28:21 38:16 63:4 195:2 222:6 222:8 251:4 320:17 347:11 363:5 384:8 473:22
somewhat 56:1 80:6 124:10 202:15 246:16 318:2
son 477:7
song 489:16
soon 32:1 102:22 386:10 392:9 453:22 458:12 476:15
sooner 33:7 333:6
SOP 417:8
sorry 45:11 73:18 88:20 151:11 166:3 204:22 220:13,17 227:13 304:5 366:2 390:14 440:19 444:15 480:8
sort 29:2 47:17 58:6 65:4 66:6 69:17 95:7 106:15 107:19 111:7 115:17 119:11 121:13 122:9 124:15 125:14 132:1 149:13 218:16 266:4,22 267:17 274:16 275:3 276:10 277:5,6 279:3 280:12 281:11,19 282:5,11 284:10 285:11,22 288:10 288:12,22 291:1,2 291:6 292:15 293:7 294:8 295:3 296:18 297:1 300:10 301:16 302:6,7,22 308:2 310:10,17 325:3 330:1 337:11 340:3 346:20 350:11 353:13 359:21,22 361:14 362:17 403:2 416:3 458:19
sorts 60:7 106:6 266:5 270:19 278:8
sought 402:9
sound 152:5 212:6 284:22 285:7
sounds 76:14 168:6 233:11 240:15 245:8,9 247:12 345:10
source 54:16 295:6 349:3,6 351:3,7 351:21 354:8,10 355:21 363:6
sources 57:5 296:5 356:14
South 187:6 469:19
Southern 65:8 79:14 368:1,5,16
space 91:4,6 288:22
span 353:12
Spanish 85:18
spans 309:18
spare 465:11
spawned 397:16
speak 47:12 244:7 312:7 388:10 390:12 425:22 438:16
speaking 93:1 249:19 280:5 385:1 415:2 426:16
speaks 65:5 84:9,12
special 79:14 226:17 243:3,11 243:16,21 458:7 479:8 491:9
specialists 337:1
specialties 251:21
specialty 16:4 24:3 24:17 159:13 201:2 251:14,17
specific 69:21 71:10 75:20 78:22 96:10,11 98:21 99:3 101:6 129:5 136:9 144:21 158:8 160:2 161:13 163:14 165:13 166:12 173:7 186:21 209:10 219:20 231:20 235:14 242:7 257:4 267:14 269:8 321:9 366:13 374:21 437:8
specifically 48:3 59:6 61:22 71:13 99:6 101:9 158:7 158:17 188:19 207:7 208:20 210:10 224:17 227:5 233:22 244:11 262:8 376:21 382:11 419:6 440:16 448:2 457:6 481:14
specifics 69:7 367:17
specified 200:13,19 207:9
spectrum 207:5 251:9 324:4
spectrums 298:15
speculate 249:20 260:6
speed 210:7 306:15 336:4,15,15 337:10 353:5 355:6
spend 89:15 224:19 229:8 236:7 241:14 281:15 291:3 345:3 349:21 350:20 389:20 390:6
spending 310:21 350:16 353:2
spent 352:15 353:14 425:19
spirit 369:6 380:7 405:18 421:12,13 432:10 489:18
split 65:14
splits 95:11
spoke 7:7 53:13 232:18 393:12 396:21
spoken 422:8
spokesman 466:9
sports 380:4
spot 17:7 50:19 55:17 349:15 350:4,12
spotlight 365:9
spouse 171:1 214:22 254:9 417:7
spouses 170:21 171:1 431:21 467:7,10
spouse's 468:1
spread 111:17 345:7 379:3
spring 90:19
squad 407:14 425:8
squadrons 425:2
SSRIs 137:3 189:15
stabilization 331:5
stabilize 28:22 370:13,15
staff 25:22 26:11 56:18 84:5 176:10 177:1 187:17 388:18 423:2 437:21 438:11,17 451:1 465:17 488:14,15
staffed 106:1
staffing 398:10 481:17
stage 326:13 404:2
stakeholders 49:3 103:15
stale 324:18
stand 63:16 338:21
standard 20:13 22:5 79:22 83:19 164:2 206:22 207:19 229:11,16 230:4,5 233:1 288:22 305:17 329:19 330:3 384:10 402:21
standardization 86:4,5,9 94:7 179:4 402:20
standardize 94:1 97:16

standardized 86:8 98:8,11 100:11 205:13 384:18 390:8 481:12
standards 54:17 55:12 205:4 207:21 283:13,17 283:18 284:2 286:16 308:21 320:3,8,19 321:4 321:15 322:3,15 323:1 331:20 358:5 362:12 363:4 377:17 402:16 445:4
standard-based 358:4
standing 51:6
standpoint 205:6 212:12,12,13 274:6 278:9 288:6 298:4 354:20
star 455:21
stars 371:3
start 15:14 25:8 35:12 39:17 40:6 42:3 67:20 70:6 77:12 90:17 138:15 142:22 169:18 237:7 243:6 247:22 281:7 304:1 314:1 320:4 345:18 346:16 351:18 357:11 385:3 391:3 392:6 407:6 407:7 411:14 415:17,19 416:6 416:10,10 417:1 426:11,13 461:8 464:7 465:7,15 473:15
started 37:19 102:10 124:6 201:1 204:15 269:20 384:19 397:7 410:16 452:16,16 465:18
starting 93:16 148:17 290:11 426:10 444:7 488:1
starts 38:5 144:15 261:16 383:7 415:18 422:18 475:21
state 15:7,22 18:16 18:18 19:8,13,16 21:11,14 24:14 29:22 70:17 81:6 82:2
stated 81:11 100:18 340:5 398:4
statement 8:1 177:10 318:4 319:8,12 326:20 413:6
statements 54:9
states 1:1 3:9,10,11 40:15 357:2 366:3 368:17 371:18 453:6
station 8:7,15 14:14 17:20,22 18:15,22 19:14 35:2,10,13,19 36:1,9,12 37:3,7 109:17 230:1 453:13 469:5
stationed 287:17 327:15 471:21
stations 34:15 45:16 102:12 368:12 426:20
statistic 225:19 262:6
statistical 124:8 159:16 182:22 205:10 254:5
statistically 142:7 265:3
statistics 64:18 130:7 178:4 220:19 225:11,14 226:1,6 227:10 256:11 257:4 475:16
stats 300:13
status 250:11 262:12 366:5 440:7,13 450:2,4 469:10
statute 279:20 294:1
statutory 280:11
stay 140:20 144:9 167:5 173:13,13 189:13 194:1 310:22 369:22 428:21 450:3 452:6,15 453:11 453:19,21 472:3 476:22 477:9 480:20,22 481:2
stayed 36:5
staying 270:12 357:3
stays 9:11 276:12 277:21 439:7
step 35:7 277:18 361:4 395:11 412:10 455:5,12 456:3
stepped 395:5
steps 16:3 360:21 385:17,21 399:9 403:22 404:16 413:7,10
step-by 455:4
Steven 1:15,18 45:8
Stewart 9:2,5 11:6
stick 298:9,18,19 323:16
sticking 406:15
sticks 432:9
stigma 143:12 146:13,13 147:10 147:11,17 245:7 251:2 257:16 258:18 260:1 265:7
stigmatizing 131:3
stock 465:2,9 468:22 473:19
stomach 373:9
Stone 1:20 4:9,9,22 5:11 6:20 7:7 17:8 23:17 25:16 27:15 32:8,13,16 33:1 34:7 35:14 36:2 46:9 89:15 92:6 93:10,13,18 203:8 204:22 220:5,17 263:14 264:4 330:9,14 332:21 333:16,19 335:19 338:6,11 338:19 360:20 429:8 472:13 473:2
stood 104:4 238:7 240:4 279:21
stop 66:15 236:2 284:16 320:2,3 335:7 352:8 353:2 448:17
stopper 194:17
stopping 66:17
stops 351:17 476:1
stopwatch 308:10
store 363:13 374:8 374:11 375:3
stored 312:21 364:3
Storm/Desert 214:6
story 26:10 168:13 185:9 214:16 274:13 289:11 304:8 429:4,5
straight 334:19
strategic 40:21 41:3,10,15 48:19 191:14 192:5 198:5,10 274:4 339:7
strategically 103:15
strategy 49:1 52:4 58:22 76:5 99:1 191:14
streamlined 219:13
street 1:10 34:17 468:8
strength 294:18 478:3
Strengthening 102:1
stress 27:21 73:10 73:21 117:19 119:8 128:11 136:12 140:3,4 155:9,18 156:15 156:22 157:9,12 157:18 160:13 175:18 176:7 178:16 184:15 198:12 214:16 219:14 221:6 225:6 226:12 229:20,21 238:9 242:11,12
strictly 258:7,9
strides 381:22
Strike 292:7
striker 115:7
strong 53:15 132:8 136:15 154:17 171:18 194:6 291:22 334:17
stronger 221:20
strongest 171:16 221:1
strongly 143:19 146:15 394:9
struck 26:13 467:17
structure 31:17 62:20 296:13 338:22 340:4
structured 64:7 468:14
structuring 111:9
struggling 18:19 64:20 438:3

Stu 116:13 118:1
stuck 25:10 343:11 372:6
students 370:12
studied 97:11 143:10 266:14
studies 86:16,16 121:7 143:11 153:18 252:4 264:10
studio 116:12,14
study 61:14,16 65:7 68:22 69:1,2,7,12 69:15,19 70:2,5,6 70:9 100:19,21 118:5,6 141:18 142:8 158:8,20 159:8 212:9 219:22 255:3,4 371:12 398:20,22 478:12
studying 65:15
stuff 12:20 45:19 66:22 89:8 95:8 103:10 115:17,17 120:8 121:10 127:16 172:7 246:8 282:1 298:20 301:8 302:21 315:19 322:19 325:6 329:17 348:19,22 349:3 350:15,16 350:21 353:7 359:6 362:18 374:4 384:16 407:11 412:16 413:2,16 464:18 464:20 465:14 484:14 488:10 490:6
subacute 29:3
subbed 376:19
subject 129:11 230:20 323:3 364:16
submitted 71:16
submitters 418:22
subpopulation 243:10
subpopulations 125:13 240:3 241:16
substance 125:10
substantial 8:6 269:14 429:18
sub-questions 72:4
succeeding 255:21
success 83:20 264:6 369:8 412:1 472:9
successes 83:21
successful 6:14 51:15 394:2 398:20 474:1 482:1
sudden 87:14 205:19
suddenly 168:6 325:13
suffering 260:7,9
sufficient 26:20 137:2 144:10 218:12,14
suggest 137:19 141:8 318:21
suggesting 31:19 472:19
suggests 134:7 148:16,18 202:14 202:16 269:3
Suicide 51:6
suited 194:11 197:9
summaries 393:19
summarize 93:21
summary 172:18
summer 381:19
sunset 333:13
sunsetted 312:10 313:6
sunsetting 307:4
supersede 437:12
supervision 158:12 191:21
supervisor 395:21
supply 111:10 296:5
support 2:5,14 3:18 62:19 100:7 106:11 128:18 129:2 142:2,2 150:4 151:10 154:9 155:20 156:2,10 157:20 161:21 171:15,18 175:3 203:9 224:17 226:20 234:16 236:22 369:4 378:16 386:1 388:17,18 400:9 416:17 425:8 426:2 433:3 443:7 482:7
supported 72:7,18 76:2 135:12 212:14 229:7 480:8,15
supporting 103:20 388:14
supportive 141:22 154:14
supports 100:9
supposed 49:18 165:3 199:22 445:4
supposedly 35:10
sure 5:1 7:14 9:7 12:5 17:5 20:3 22:2 23:18 80:10 85:1,6 88:2 92:14 98:9,13 100:3 109:13 110:14 111:1 117:22 130:6 146:11 148:10 161:10 166:14 170:8 188:3,16 189:12 190:15 192:10,21 194:1,2 195:5 206:14 208:1 212:16 216:6 217:17 227:3 228:9 233:18 240:2 242:18 245:13 259:19 261:6 263:6 279:12 286:8 291:22 293:4 299:12 322:12 324:17 338:1 344:13 353:19 355:11 357:8 413:21 419:18 422:15,17 423:2 428:6 443:19 455:1 483:10
surfing 369:13
surgeon 2:13 7:10 11:19 20:1,6 21:9 21:10 23:15 39:13 128:15 129:20 175:9 275:10 339:10 438:12 441:9
Surgeons 39:14
surgery 95:10,12 175:8,13 187:3,20 212:3,13 394:6,12 394:16
surprised 82:15 182:11
surprises 451:9
surprising 8:20 9:19
surreal 266:22 267:4
surveillance 50:9 347:9 348:22 349:11 354:4
survey 145:15 158:21 159:5,19 160:5 162:22 163:12,15 172:21 191:8,10 256:9,10 256:15 257:1,2 393:3 488:13
surveyed 73:2
surveyists 482:17
surveys 145:8 148:14 199:11 221:4 481:6,9
survive 330:22
survived 331:7
survivors 276:4
suspect 53:7
suspicion 30:10
Suzanne 1:12,14 3:2 461:21 492:11
Suzanne's 341:14
Sweat 469:19
sweated 465:5
sweating 138:16
sweet 50:19 55:17 349:15,15 350:4 350:11
switch 348:1
symbol 375:14
symptom 75:20 119:1 132:16 206:1
symptomatic 65:13 65:16
symptoms 65:10 110:2 114:17 115:21 119:20 132:19 138:10 146:7 179:9 180:17 181:1,7,15 182:2 185:3,12,13 194:19 196:11 198:16 203:18 205:2,15 209:20 209:22 214:18 216:1 217:2 221:6 225:7 226:12 237:13 248:15 253:12 254:6 255:7 265:6,7 269:9,18 270:3,4 271:8
syndrome 319:20
Syracuse 467:10,11
system 8:10 10:20 10:22 13:6,10,21 14:1,9,12,14 15:12 16:11 19:7

19:11 20:22 24:10 24:22 29:15 30:1 44:5 50:6 54:18 56:21 57:12 61:9 62:17 84:10,11 85:6 88:12 90:5 90:14,20 92:13,20 98:14 104:3,4 105:9 107:3 111:10,10 120:18 149:7 158:11 171:18 191:5 198:6 219:12 272:7 278:1 282:15,21,21 283:6 285:21 292:7 295:2 297:4 297:4,9 298:6,10 298:11 299:17 314:19 315:4,11 316:6 317:18 318:14,14,18 319:19 320:5 325:17 326:6 329:3,13 331:6 333:22 338:17 349:3 351:11,12 351:13,15 358:12 361:3 370:19 382:15,16,21 383:1 385:14 393:17 396:6,10 396:11,13 402:6 419:13 432:14 433:5 435:16 440:9 450:11 471:9 475:22 479:15 482:20
systematic 158:4 161:11 211:19 267:9
systematically 143:11 266:14
systems 33:14,15 78:17 100:11 275:4,6,6,8,21 277:3 281:21 282:12 283:8 284:11 288:14 298:13,22 302:12 304:3 311:7,11 313:3,5,21 315:22 316:17 325:21 333:2,5,14,22 337:6,19 338:13 344:6 358:2
system-wide 60:13
S-E-S-S-I-O-N 273:1

T

T 488:18
tab 129:6 273:10 366:14 456:20 457:5 488:18,19 489:1,5,11
table 4:19 6:13 41:19 286:2
tables 136:6 387:7
tackled 17:4
TACP 226:17,18 236:17
tactical 113:18
tag 119:14 150:22
take 7:16 11:22 12:2 15:17 21:14 28:13,15,22 33:15 34:18 36:8 37:4 60:2 72:4 90:11 105:10 106:15 118:8 150:12 184:9 188:15 216:6,11 217:18 221:11 235:2 247:9,10 248:21 273:18 274:15 281:18 284:4 289:15 290:11 296:3 298:8 305:14 307:1 308:16 317:20 326:4 330:1 357:15 371:6 374:6 384:2 398:17 422:16 426:15 434:4,7 448:4 461:4,9 464:22 466:4,6 470:18 477:2 480:3,7 490:11
taken 23:9 41:18 202:7 270:18,18 338:21 360:20 370:11 396:8 404:5 449:22
takes 25:6 28:4 39:21 339:6 341:1 350:1 370:15 373:10 446:1 458:2 483:18
Tal 91:11
tale 71:1
talk 4:19 5:4 20:4 23:16 34:1 35:7,8 37:18 39:6 41:9 48:1,13 53:16,18 54:5 59:18 69:6 84:11 86:14 108:18 111:19 112:18 128:2 130:3 138:2 139:15 158:7 168:14 169:12 171:22 172:5,6 178:14 179:3 181:20 185:5 187:10 227:6 235:3 238:8 247:17 249:1 264:12 275:14 278:17 279:8 280:22 285:8 294:6 302:13,17 318:6 320:18 321:8 322:18 327:17 350:6 356:15 367:14 369:7 380:5 381:9 383:14 385:10 386:18 407:9 412:11 414:2,4 415:21 416:10 417:10,11 420:21 421:7 426:7 431:17 438:6 442:20 454:4,4,8 454:19,21 483:20 490:15
talked 43:12 48:20 49:6 90:8 92:12 97:3 100:22 173:9 178:7 183:18 220:6,8 234:7 235:7 278:16 280:2 304:4,13 364:16 382:8 395:13 416:13,14 421:15 423:20 431:16,19 434:19 442:19,21 443:7 463:18 467:6 468:11 482:10
talking 5:7 6:4 12:22 33:13 67:11 84:12 127:16 147:22 168:13 179:2 180:22 181:3 188:19 234:13 241:15 246:12 247:1 257:5 258:18 297:11 300:8 304:2 308:5 314:1 314:7 317:4 320:4 321:20 327:1,11 369:20 373:21 375:18 382:6 389:22 402:5 407:6,7 409:22 414:15 424:2 430:10 441:14 460:12 462:7 463:21 464:6,9,15
talks 193:19 210:10 307:16
TAMP 20:10 21:19 22:2 27:18 33:17 33:21 34:3,6 35:7 35:12 36:19 37:2 37:9 38:5 39:20 108:14
tan 225:4
tape 167:20,21 448:20 488:12 489:13,15
targeted 227:2 237:13
targeting 255:7 267:10
targets 340:19
task 1:3,9 3:16 47:6 48:9,12 59:7 61:2 75:4 89:2 104:14 128:8 276:22 365:4 367:17 393:1 398:14 419:22 428:17
tasked 61:6 62:22 70:19 97:12 99:5 99:6 463:4
tasking 103:8
taskings 224:18
tasks 281:22
taught 180:14 368:11 370:7 420:16 465:11
Tavern 386:22
TBI 3:6 49:10 50:2 52:12 54:16 55:11 59:21 64:14 69:21 72:16 76:1,3 77:8 77:8 78:19,22 79:7,8,22 80:19 81:7,11 82:17 83:3 91:2 92:10 92:17 93:7,9 94:10 96:5 97:22 104:8,10,17 126:10 208:21 234:12 373:13 408:6 409:9 466:21
TDRL 258:2 262:1 262:9,12,19 479:6
TDY 237:3 392:16

469:10,18 477:2
teach 213:6 411:5 459:18 468:18
teaches 420:2
teaching 465:12,15
team 39:4 44:19 45:4,12 47:10,16 54:22 90:13 133:9 155:11 231:19 237:19 238:2 245:18,19,20 275:5 280:6 289:20 292:19 293:22 300:11,11 326:12 339:7,11 344:11 365:7 366:17 380:7 385:6,6 389:17 393:10 399:3,9 403:10,16 405:13 412:7 419:16 435:10 439:5 454:13 465:6 466:11 482:15 485:1 490:15 491:7,14
teams 130:13,13 151:1 155:9 157:9 157:13 238:21 239:1 300:12 329:5 353:11 466:6
tears 389:9
tech 304:5
technical 254:16 277:19 293:21 330:19 331:1 344:2 354:20 364:16 377:18 418:19 419:1
technically 38:13 200:10
technician 155:12
technicians 150:5,6 151:12,13 186:17 186:18 223:19
techniques 142:1 144:22 158:19 163:14 164:16 165:9,13 166:6,11 173:7 411:12
technological 335:3
technologically 291:15
technologies 322:10
technology 56:7 109:20 110:6,13 110:22 111:5 112:14 113:11 114:8,21 115:20 115:21 282:7 328:17,18
techs 151:10 186:16
teeing 54:1
tele 78:15
teleconferences 394:19
Telehealth 113:11
telemental 109:20 233:15
telephone 401:16
Tele-Health 56:7
tell 28:9 63:19 88:3 99:10 111:4 118:4 136:18 143:10 167:15 170:1 188:21 194:4 197:4 214:8,20 216:8,12 272:3 274:13 305:14 330:14,15 357:16 364:21 375:17 379:14,19 380:22 409:21 415:15 421:17 422:22 432:19 441:5 443:12 457:15 463:17,20
telling 25:19 370:12 374:2,5,10 375:2 379:11 410:16 412:4 428:7 480:18 482:11 483:22
tells 75:21 214:15 281:8 364:3
templates 456:15
temporary 249:10 249:17
tend 181:21 213:10 213:12 297:2
tendency 34:19
tenfold 213:21
tense 139:14,14 141:2 167:20
tension 204:19
term 14:17 94:4 262:18
terminal 392:17
terms 35:11 43:8 48:18 50:19 53:22 54:9,20 55:3,7,18 57:2 58:22 59:2 63:11 66:22,22 74:11 75:10 77:21 78:1,19 79:17 81:5 82:7 84:10 92:8 94:7 98:22 103:9,22 106:8,9 106:18 111:9 113:12,17 114:13 130:18 135:10 137:3 138:21 159:9,13 162:5,7 173:16 196:18 213:21 220:22 221:19 222:12 223:9,16 224:5,7 226:11 228:15 231:21 244:2 249:15 254:4,21 257:11 305:18 316:1 327:17 331:9 348:3 349:4 353:11 363:2 393:16 397:3 409:20 491:11,18
terribly 238:16
terrified 124:22
terror 124:16
test 91:18 286:22 306:10 342:2,8,15 347:22
tested 265:1
testify 177:13
tests 93:2 118:18 183:20
Texas 232:9 465:8 473:16
text 487:7
textbook 205:16,21
texting 487:5
thank 46:19,19 47:20 64:8 89:13 127:8,13,17,19 128:3 129:8 163:9 175:4 176:2,10 177:16,19 228:8 244:20 272:12,15 272:19 322:1 365:2,3,13 366:16 434:9 490:16,17 490:20 493:3
thanks 82:10 152:18 263:16 272:9,18 275:14 365:16 450:9 490:13,14 491:9 493:6
theater 18:13 23:5 51:11 56:22 76:17 77:2 79:2 89:21 93:11 94:2 98:2 155:20 157:20 218:11 276:9
theirs 244:15
theme 11:8
theory 319:9
therapeutic 110:5 142:1 194:7
therapies 73:7,14 73:19 78:7 91:13 91:13 96:4 97:15 181:9 184:14 191:18 192:12 193:6 194:4,10 195:15 196:2 199:13,16 251:15
therapist 109:16 141:22 196:22 198:3
therapists 78:1
therapy 16:22 24:15 25:8 72:21 73:8,9 78:12,13 87:5,7,16 88:2,2,4 88:7,7 91:15 94:15 97:4 109:14 114:16 122:13 123:14 125:6 126:1 135:17 139:3,6 140:2,9 140:19,20 141:17 142:13 143:7 149:15 154:15 160:12 163:20 165:13,15,17,22 166:3 167:16 168:3,8,9 169:3,4 169:7,17,18 174:6 179:7 181:10,14 181:17 184:15 185:3,14 187:5 190:8 191:4 194:1 194:12 195:2,6 196:7,19 197:9 251:9 268:4,6,16
thing 12:7 17:16 18:4 19:20 26:13 31:14 33:12 42:7 42:9 45:12 50:8 52:8 55:2,20 58:2 60:11,14 62:4 65:6 69:17 75:22 80:19 85:17 87:18 95:16 107:19 110:5 111:8 117:12 119:22 122:8 124:16 133:6,12 140:18 141:6 155:6 157:12 164:6 170:8 172:15

173:15 180:18 193:22 203:4 207:3 218:22 219:3 220:20 232:7 237:17 240:10 242:9 245:6 246:3 248:4 261:1 285:1 293:20 297:10 303:4 304:21 312:4 314:6 317:2 320:19 321:19 323:15 337:11,15 340:8 343:7 361:6 361:14 362:2 363:2 364:6 369:3 370:17 371:17 372:14 377:11 379:12,13 384:6 386:9,19 387:13 387:15 388:6 401:7 408:11 416:3,12 422:5 425:21 426:1 432:9 444:6 456:4 470:9 483:17 486:2,10 487:8
things 4:5,6 6:2 7:21 9:2,10,13 10:2 11:14,19 13:9,16 21:13 26:4 30:16 42:21 50:7,13,15 51:2,4 51:22 52:1 53:17 54:7,21 55:4 56:11 60:7 62:11 63:7,13 68:17,21 75:3,8 79:16 80:18 81:21 83:7 83:17 85:13 94:6 94:9 95:13,17 98:7,21 100:4 101:14 103:6,9,14 106:14 111:7 112:12,19 113:21 115:16 121:13 124:9 135:4 139:20,22 143:9 145:22 147:1,2,6 154:13 158:5 163:22 165:17 168:9 179:7 184:6 185:10 189:14 191:11 192:2 194:5 195:5 198:1 199:7,18 203:2 206:3 215:3,14 217:7,11 221:18 221:22 222:17,21 223:4 224:2,4 225:10 226:2,21 233:13 235:3 239:21 240:17 241:17,18 242:14 243:1 246:20 248:6 253:4,12 259:8 274:4 276:14 278:2,9,14 279:1 282:9 286:18 287:14 288:8 292:9 299:13 300:1 302:16 306:15 307:14 310:3,9,9 310:13 316:12,21 316:21 321:4,22 324:1 325:1,3 326:14,18 327:18 329:21 330:1 331:11 332:12,19 342:22 346:10,21 347:3 348:4,7 351:10,15 353:16 355:8 356:1,9 357:11,12,14 358:16 359:8 363:3 365:10 387:8 391:12,19 403:11 409:4,6,17 410:3,17 415:14 423:17 427:19 428:16 434:11 439:7 443:12,12 445:2 446:6 448:8 448:16 459:2,11 460:3 462:5 463:2 466:14 471:10 491:18,21 492:1
things/all 49:13
think 5:10,11,15 9:15,17,19 10:16 11:2,15,19 12:6 14:13,22 20:10 21:4 22:1 23:6,7 26:17,18 27:2,11 27:15 29:6,10 30:2 34:6,13 38:4 43:2,7,17 44:1 45:3,21 46:2 51:3 51:17 54:19 55:2 55:6,20,22 57:12 57:14 58:20 59:12 63:3 64:9 67:2,5,8 67:17,19 70:3 80:11,12 81:16 82:14 84:8,18 85:14 86:9 88:21 92:7 93:20,21 94:5,16 95:5 98:1 103:7 107:15 110:19 113:17 118:9 121:8 123:6 125:1 130:2 132:1 132:1,7,12 134:10 135:4,13 138:1 140:17 146:18 147:16 148:12 149:6 152:22 154:3,22 155:13 155:14 157:2,4,6 160:7 161:9 162:5 162:10 163:22 164:18,19 167:13 172:3,4,16 173:17 174:5,7,8,22 179:2 183:2 191:11 197:21 199:1,22 200:22 204:7 205:13 208:10 209:5,13 209:15,17,18,20 210:7 211:4,5,17 211:19 212:19 213:22 214:14 215:9,19,20 216:3 216:10 217:5,9,21 218:3 219:9 220:19 222:16 223:7,9,10 224:6 229:4,9,13 230:13 231:18 235:4 238:12 239:17 241:18 243:10,21 245:8 247:13 248:3,5,6 249:13 250:13,14,17 251:3,7 255:2,16 255:20 256:6 257:16 260:10 261:8,19 262:6 263:19 264:17 266:14,15,16 267:7 268:6 271:21 272:11,17 279:7,11 282:11 286:2 288:17 292:17 294:15 307:15 314:16 319:17 320:6,20 322:9,13,16,20 325:22 328:14 329:21 333:6 337:5,13,21 338:4 339:2,7,22 340:6 340:7,20 341:8,11 341:22 343:17 344:5 345:7 349:13 352:1 353:4,17 354:7,14 356:16 358:17 360:11,12,16 361:10,11,17 362:1,2 364:17,21 366:21 367:12 381:13 398:13 405:11,14 410:6 416:11 421:22 422:19 424:1,15 425:5 428:2 430:9 432:5,7 433:9 434:10,19 436:14 438:2 440:2 442:5 442:12,17 443:4 444:5 445:1 448:1 448:6,16,20 451:9 452:20 457:17 459:10 460:10 461:2,15 465:13 468:19 473:6 475:5,18,19 477:19 481:19 485:8,9,12 487:7 488:5,12,17 489:19,20 490:18 492:9,18,18,20,22
thinking 42:2 168:4,15,16 200:6 249:8 267:17 320:2,3 352:1 426:17 491:20 492:5
thinks 58:7
third 142:21 151:6 152:8 165:21 167:12 223:3 236:3 249:2 254:11 356:17 361:7 372:6
third-country 266:2
third-location 266:15
third-party 215:11
thorough 49:7 50:2 365:13 406:12
thoroughly 25:1,1
thought 30:1 92:19 161:8 162:13 168:17 187:22 268:2 302:5 339:6 344:10 358:21 410:18 431:8 461:17 471:2
thoughts 58:8 146:22 185:7

264:13
thousand 16:10 228:18,19
thousands 52:12 361:12
threats 179:16
three 13:12 25:7 31:13 42:4 56:6 102:4 108:12,13 146:8 157:10 180:6,9,9 205:2 231:15,16 245:10 245:15 253:17 254:5 317:4,5 341:5 366:18 375:19 389:7 420:1 441:19 456:2 463:19 491:11
threw 486:6
thrilled 389:20
throw 44:11 63:15 114:1 300:17 326:17 408:4
thrown 215:2
THURSDAY 1:6
tie 470:4
tied 28:1 425:7
tiered 227:2
ties 471:16
tight 58:20
tightly 282:15,20 282:21
Tim 376:13,14 385:12
time 4:17 5:19 6:13 6:15 13:2,8,11 15:18 23:9 26:16 26:17 27:5,9,10 27:22 28:13 30:18 33:11 36:14 38:15 39:12,21 41:7 71:7 72:5 106:15 110:8,9,10 112:3 127:20 157:21 164:11 172:13 179:8 182:19 190:10 192:18 199:14 200:1 201:5 214:15 217:9 220:8 224:19 226:10 228:17 229:4,9 237:16 241:15 245:11 249:4 250:13 251:17 255:16 269:8 281:16 289:3 290:3,10 291:4 301:5 303:8 304:9 305:4 306:16 308:19 310:12,21 311:15,19 319:1 325:21 337:7 338:21 343:12 349:17,21 352:5 352:16 361:22 364:18 382:13 383:21 388:9 397:8 404:17,19 406:17 409:22 414:1 416:8,14 425:20 429:19 432:21 435:21 436:4 445:13 446:4 448:4,20 449:21 458:3 461:3 462:12,16 464:8 465:11 470:20 475:16 476:6 477:10 478:21,22 488:17 491:17
timeline 26:14,19 26:22 27:11,13 304:16 305:1 334:11 476:18
timelines 476:4
timeliness 25:6
timely 37:1 478:9 479:12
timer 420:9
times 14:4 16:21 86:2 147:17 181:18 201:12 205:15 215:2 216:13 252:13 268:3 270:13 271:13 305:4 348:18 378:15 428:11 472:6 475:11
time-based 36:13
time-wise 26:6
timing 5:4,5,8 106:22 112:8 445:10 448:11
tiny 265:12
tip 314:21
Title 40:18
TMA 38:22 106:6
today 4:14 7:17 8:3 46:18 47:2,21 92:4 273:6 274:13 277:1 280:22 282:7 286:10,14 287:18 297:13 298:14 312:9 313:1 314:8 324:15 328:15 348:22 349:6 356:4 358:9 364:19 386:7 405:10
Todd 369:10
told 8:1 9:20 116:20 279:17 353:9 386:4 421:16 424:19 437:9
tolerate 181:16
tool 51:13,16,18 52:17 53:6 63:21 64:3 69:16 89:8 100:8 111:8 192:21 247:21 384:3 402:22 403:8,9,10 405:15 407:10 408:19 410:4,5,22 413:21 413:22 414:1 454:5,14 487:17 487:17,19
tools 100:7 109:22 111:17
top 17:1 113:17 125:12 173:17 226:15 285:18 385:9 460:11
topic 127:10 128:12 140:1 285:7 382:1 451:8 479:15
Topics 185:20
total 51:5 186:10 186:14 240:11 396:9 421:11 430:14
totally 10:2
touch 408:15 438:2
touchy 323:2
tough 32:15 211:4 211:7 249:4 420:6 425:4
tougher 211:8
tour 370:4
tower 58:7
town 432:1 474:15
to-day 308:1
to-head 268:12,17
to-peer 196:21
track 12:4 50:14 257:9 382:18,20 382:22 383:6 412:14 450:7
tracker 435:14
tracking 119:16 165:11 198:21,21 257:12 278:7 299:12 340:17 365:8 388:13 396:11,12 397:7
tracks 395:16
trading 468:6
traditional 110:5 444:1 464:11
traditionally 10:10 288:13 416:16
traffic 6:22
trail 12:8 265:2
trailer 118:15
train 52:11 83:18 87:7 150:14 155:4 185:1,15 191:17 213:15 264:5,14 264:16 384:7
trained 77:16,21 78:4 133:15 134:22 150:8,17 151:3 177:22 191:20 192:11 207:21 209:14,15 209:17 215:6 232:1,12 403:20 417:9 424:8
trainer 74:21
trainers 192:3
training 52:9,18 53:4 63:11 73:10 73:22 74:3,7,15 74:17,22 77:18 78:10 80:15 85:3 102:6 121:1 124:22 133:14 134:22 136:13 140:4 150:13,18 155:7,21 160:11 160:13 161:12 172:17 173:1 179:20 185:18,22 186:8 187:5,11,11 187:18 188:5 189:6 205:5,9,12 206:20 207:13,17 208:2,5 210:16,20 211:7,8,16 215:10 215:19 230:14,16 231:3,11,13,20,22 234:9,15,18 236:8 237:4,11 246:5 255:20 257:9,12 264:8 265:10,22 267:10 297:17 384:5,18,20 385:1 385:6 403:21

411:3 412:2 418:12 420:4 440:11 443:2 444:8 446:13 448:22 449:4 451:1 481:11,12 484:20 485:21 489:1,3,6,8,9
trainings 151:5 230:21
train-up 151:1
trajectory 268:20
transfer 80:2 390:21 452:14
transferring 354:13
Transformation 454:13
transition 1:4 6:5,6 8:8 32:11 36:20 36:21 51:11 102:14 204:14 267:9 317:8,19 333:12 382:1,3,5 388:15,21 390:16 400:12 411:8 445:12 455:10 457:3 460:5,5,10 476:5,8,13 480:18 481:22 482:2
transitional 20:11
transitioning 57:2 57:17 438:21
transitions 388:7
translate 344:1
translator 455:3
transparency 341:10 397:5
transparent 62:18
transportation 433:7
trauma 133:19 156:16 160:18 162:5 201:22 202:20
traumatic 2:9 47:1 47:4 49:14 50:21 54:14 76:5 89:18 90:7,11,21 91:8,9 91:19 95:21,22 117:19 128:11 133:16,17 139:11 141:20 154:10 156:6 164:6,8 167:18 175:20 179:14 180:1 218:10 229:19,22 428:14 441:16 480:2
trauma-focused 73:6,19 136:10 139:3 162:8 174:6 184:14
travel 89:2 427:16 469:4,13 474:8
traveling 32:19
Travelocity 286:12
Travis 231:17
treat 70:18 94:10 125:4 185:11,12 202:17 203:1,5 210:11 300:19
treated 9:13 125:19 157:9 162:20 163:3 276:7 323:9 423:6 427:14
treating 129:15 160:7 166:9 172:12,22 215:5 224:14 232:5 233:1 395:7
treatment 3:8 49:9 49:19,20 50:11,21 55:19 56:13 57:3 69:21 70:12,15,21 71:11 72:3,7,18 72:21 75:9 76:2 77:11,11,15 78:20 79:1 82:3 94:2 95:7,9 97:8 98:17 99:4,13 122:15 126:13 128:10 131:1,1,12 134:3 134:4,6 135:11,15 135:18,21,22 136:1 137:18,21 139:7,10,18 140:10 141:3 142:5,15,16 143:1 143:16 144:4,6,7 144:9,10,12,14,15 144:19 145:1,14 146:1 149:13,18 149:20 153:1,4,13 153:14,18 154:21 157:14,20 158:3 158:15,19 160:4 160:18 162:4 163:5,18 164:10 164:14 165:10 166:1,5,18 167:2 167:4,5,7,10,11 169:9 170:4,5,11 170:16,22 171:1,3 171:7,13 173:5,10 173:13,14 174:2 181:3 184:3 197:6 198:22 199:9 216:18 224:21 229:5,7 230:11,12 231:3 232:14,16 233:7 251:12 256:3,6,17 257:8 257:10 260:17 261:3,22 269:5,16 269:20 276:8 294:13 334:4 395:22 401:10 438:1 441:12 442:3,6
treatments 72:13 78:15 86:15 95:18 135:13 136:14 138:5 140:6 166:12
treats 270:8
trees 318:7,8,9
tremendous 29:5 123:8 482:19
tremendously 176:11
trench 322:11
trend 241:19
triage 151:14
trial 94:20 265:18 267:19 268:12
trials 142:20 153:7 153:12 268:17,18 379:16,16 386:8 389:6 427:22 428:1 464:10 489:14
tribunal 272:13
TRICARE 13:2,14 15:9,10,15,20 16:2,4,6,13,14,18 19:11 20:13 22:4 22:8,18 23:12 24:10,18 33:17 34:2,5 37:19 38:4 38:19 356:19 358:8 364:9,11
TRICARE-appr... 20:22
trickles 126:14
tried 42:14 49:18 120:22 150:22 294:17 389:3,4 434:14 437:4 453:8
tries 343:8
triggering 254:12
trip 44:11 46:15 446:7
triple 367:22
Tripler 303:17 344:16 345:5
trips 464:17,19
Troop 252:18
troops 126:9,9
trouble 17:9 21:1 41:2 87:14 364:8 472:22
true 144:18 184:21 243:13 250:20 405:13 416:20 419:15 436:5 475:3
Trujillo 482:12
truly 33:17 418:10
truncated 492:20
trust 143:14 147:22 216:7 340:12,15 487:18
trusted 54:16
truth 421:18
try 6:9 31:16 33:8 44:4 68:14 85:14 166:15 170:10 171:10 183:12 216:6 259:3 263:4 263:5 271:18 276:14 281:20 289:10 293:4 295:9 300:15 340:11 349:19 351:14 363:14 381:6,9 385:18 387:11 392:8
trying 13:17 17:12 18:21 41:5 49:11 49:13 53:16 59:1 81:13 82:4 83:17 84:9 93:16 94:3 98:7 110:4,15 112:9 121:1 124:5 127:7 148:4 189:12 196:19 201:3 213:6 239:22 251:4,20 258:12 260:17 267:18 275:20 283:7,16 284:19 296:14 302:1 307:7 311:3 313:2 318:8 319:1 326:17 336:1 348:9 349:22 350:21 351:12 355:1 360:2 372:3 403:7 414:4 470:4 471:6 473:15
Tuesday 491:7
Tun 386:22
tune 481:19

turn 30:13 57:9 138:11,22 219:16 249:20 434:2
TURNER 1:22 4:13 14:19 23:14 30:2 38:11,20 39:8 146:18,21 249:6 259:13 309:4,6 324:3 325:16 336:7,10 343:3,14 347:7 349:13 353:17 355:9 433:12,14 433:18 434:1,9
turnover 331:8
TV 428:21
tweak 13:6
Twentynine 65:9 118:2,16 120:12 427:9,20 429:9 430:14 433:5 434:13,18 451:21 462:15 474:12 491:5,6
Twitter 486:11
two 10:6 29:13 40:15 43:6 44:17 81:3 82:4 99:3 101:22 104:13 128:2 129:18 134:4 135:17,21 137:4 146:5 152:21 155:13,13 156:20 157:10 160:21 167:1,3,9 167:11 169:6,9 180:5,11,12 208:22 238:10 254:3 255:12 264:7 266:20 275:4,17,21 277:3 277:6 279:19 280:15 283:1,8 285:16 287:19 290:9 292:12 293:12 294:2 298:13,15 300:16 302:8,12,16 304:3 306:20 311:6 315:17 323:5 324:15 328:13,22 331:4,15,22 334:22 335:17 339:15 340:10 341:19 342:16 346:4 348:12 356:15 361:1 368:19 380:12 404:14 406:14 408:22 422:8 443:12,12 447:14 452:20
two-thirds 10:7 12:19 165:5
tying 470:11
Tyler 368:1,15
type 10:8 31:14 131:20 173:6 181:9 183:10 188:18 196:8 199:18 203:3 215:3,14 227:9 258:15 270:17 316:12 375:10 425:15 428:14 439:9 440:12 441:17,20 444:1 459:2 464:11
types 73:6 101:10 118:22 125:18 143:18 154:13 180:17 196:5 199:13 222:21 233:12 242:4 253:1,12 257:4 456:17
typically 174:14 190:6 226:19 481:1
T2 56:6 113:11 114:20
T2's 114:7

U

U 279:21
ubiquitously 324:10
UCSD 118:6
UIC 106:10
UK 235:22 245:2
ultimately 57:2
Um 333:18
unavailable 46:11
unaware 444:20
uncomfortable 318:2
undergoes 222:7
underlies 328:17
underlying 209:3 310:18
underneath 106:20
understand 22:3 59:11 63:12 86:22 98:13 114:22 132:13 166:14 172:12 184:13 279:12 285:3 305:17 306:5 327:16 354:9,10 385:18,22 393:18 423:14 436:21 443:20 475:21 484:1
understanding 61:11 124:2 125:2 172:8 262:16 298:4 444:9
understands 24:11
understood 25:1 29:22 91:10 149:1 162:12 203:15 362:13 391:9
Under-Secretary 293:3
unfair 251:8
unfortunate 471:4
unfortunately 248:8 252:14 256:8 271:6 470:1
unified 338:17
uniform 58:5 168:22
unique 302:2,5 437:20
uniquely 55:13
unit 5:21 6:5,16 18:1 22:21 32:11 36:5,8,11,21 182:5,6 237:20 238:2 266:10 424:7 425:7 432:11,12 435:3 436:6,9,19 439:1 451:3 469:12
United 1:1 3:9,10 3:11 357:2 366:3 368:17 371:18 453:5
units 6:6 12:18 31:1 45:14 75:1 107:8 108:20 117:18 132:4 152:2 156:2,2 226:19 242:4 450:20
universe 100:20
University 116:8 187:6 232:9 426:11,12,18 459:13 467:9
unmanned 309:12
unprecedented 241:12
untracked 10:2
update 3:6,15 47:6 101:1 273:9 366:7 367:11 486:16 489:1,5,8,10
updated 404:16
updates 191:17 486:11 489:11
UPenn 213:5
uploading 409:8,9
uptake 75:15
upward 261:16
urgency 8:7
urine 118:19
usability 113:13 115:10
usable 114:4
usage 418:20
use 13:19 14:12 19:6 32:21 34:5 35:1 62:18 75:19 91:13 110:1,5 111:5 113:8 115:12,15 119:8 137:8 183:16 184:8 192:12 195:7 229:10 233:20 245:2 252:12 253:6 254:11 255:8 256:5 272:4 282:8 284:5 315:14 333:9 344:15 345:17 370:14 383:20 402:22 411:12 412:3,14 415:19 416:10 420:8 477:1 487:20
useful 38:3 115:10 210:22 219:22 405:15
user 285:19 287:8 300:9 308:1,12 344:7
users 309:22 344:14 348:19 363:7
uses 233:11 360:9 370:16
usual 491:11
usually 30:7 36:15 142:21 153:17 157:10 177:13 374:8
utilize 4:18 93:2 146:16
utilized 11:7 60:1 144:22
utmost 372:16
U.S 104:21 318:19

V

Va 10:13,20,22 11:11,18 53:11 56:13 70:2,21 71:17 81:4 89:16 91:2 92:6,7,13 99:21 103:5 168:21 205:3 217:20 218:9 219:22 263:3,7 272:8 275:1,6 276:8,18 282:21 284:3,4,9,13 288:2,3,13 290:6 292:14 293:14 294:8,14,20 296:18 298:10,17 298:18 306:11 309:6 311:17 315:17,18 316:22 318:18 321:20 323:11 325:7 326:1 331:17 336:3 340:22 344:11 345:14 361:9 374:3 383:2 383:11 388:15,22 391:21 394:12 443:10 445:17 469:22 476:1 485:10 486:17
valid 19:4,10 206:11
validates 450:3
valuable 11:20
value 5:2 55:1,3 210:16 211:15,19 297:21 424:10
values 54:19
value-added 107:19
variability 55:16 208:12
variables 222:12
variation 123:22 206:19
variations 80:7,8 80:17 205:22 206:6
varies 77:19 153:18 269:12 270:14
variety 79:15 391:19 439:20
various 51:2 56:15 57:5 64:2 65:10 65:10 70:14 74:3 79:1 80:21 90:6 94:12 95:2,19 99:18 113:14 139:4 143:11 185:22 209:22 460:2
vast 67:10,11 231:6 429:13
VA's 108:9 295:2
VA/DoD 76:4 229:10 230:3,5
VCAs 329:9
vehicles 309:12
Venn 330:6
venue 290:16
veracity 359:19
version 281:16 373:19
versus 10:20 11:11 83:10 84:15 96:7 202:10 203:10 262:10 326:17 352:22 353:7 356:9
vertical 287:5
vessel 205:19
veteran 92:16 169:2 218:6 276:2 277:16,22 379:21 473:16
veterans 54:12 56:9 81:2 108:12 169:4,11 271:9 272:4 459:22 468:8
victim 124:12,12
victims 133:16,18
video 490:3,4,14
videos 246:17
Vietnam 203:11,21 204:1,4,10,12 214:6
view 131:2 197:11 293:8 319:13 325:10 405:1,7,9 408:9
viewing 403:15
violation 222:6
violent 222:7
Viper 118:2
Virginia 1:10
virtual 78:16 115:16 116:3 117:4 118:1 232:16,19 233:4 327:22
virtualization 316:6,18
visibility 19:17 390:11 396:18 400:4 474:16
visible 340:17
vision 47:1 54:8,15
visit 4:7 5:11,17 6:17 7:1,2 31:18 81:10 89:3 148:15 434:13
visited 10:5
visiting 437:13
visits 6:10 25:21 26:15 121:14 122:13 239:6 377:8 406:5 408:19 422:7 446:7 472:16 491:13
VistA 275:6 280:17 295:2,6 297:6 311:17 312:8 314:11,15 328:19 333:21 347:18,19 348:6
VLER 321:22 328:7,17 329:2,5 329:9,10,22 330:5 330:7,8 360:13
Voc 443:10,14,18 444:4 445:7,18
vocational 424:6
voice 434:15,21
volume 9:21
VOWS 468:7
VTA 395:15,18 396:8
VTC 233:16,21 394:14 426:20
VTCs 234:2
VTC-wise 468:18

W

Wainwright 267:21
wait 31:14 201:9 341:5 371:13 458:1,15
waiting 392:1 451:17
waives 33:18
waking 138:17
walk 17:3 31:3 34:17 168:1 274:16 277:11 279:2 281:3,18 298:7 396:2 417:2 448:16
walked 478:20
walking 10:15 76:21 318:13 416:20
Wall 468:8
Walter 129:14 145:12 198:8 368:3,7,14 371:22 372:1 422:3 426:13 453:16,19
want 6:15 15:17 20:3,6 21:6 22:17 22:17 31:17 32:20 34:19 42:19 45:22 47:22 54:4 56:19 58:18 60:4 76:13 101:18 112:12 113:8 131:3 141:1 141:4 158:7 167:18 169:12 170:3 176:1,10 177:16,19 181:19 184:7 186:15 191:6,6 194:18 197:20,22 200:8 200:20 206:13 212:16 215:21 216:14,16 235:2 252:9,10 260:1 261:3,4 276:17 278:11 279:12 281:17 287:12,13 289:3,9,16 295:13 295:16 302:19 304:9 306:17 308:4 309:16 316:4 318:6 319:6 319:11,13,21,22 321:8 326:22 341:5 343:7 344:2 346:13 349:20 350:20 351:2,16 353:19 354:19 359:7 362:9 372:2 373:19 379:19 386:18 390:21 407:9,12,17 408:10,22 413:6,9 413:17,17 417:18 417:20 425:16 426:1 428:11,12 432:14 439:22 441:3 443:19 452:7,14,15 453:19 463:20 464:7,16 466:18 466:22 467:19 468:14,18 470:18 476:22 480:21,22 486:19 492:7
wanted 29:7 42:10 48:13,21 49:22 50:12 54:7 59:4,6 224:4 244:19

291:21 293:15 302:22 319:7 379:14 380:21 385:16 408:4 432:2 455:20 489:10
wanting 217:16 485:5
wants 306:12 392:6 411:7 417:16 425:17 448:3 481:1 488:6
war 34:12 83:1 92:1 132:3 203:10 203:13 204:17 208:14 245:4 260:20 326:9 353:22 459:4,7,21
warehouse 348:14 349:1,10 355:22
warfare 204:7
warm 19:15
warrior 6:4,6 32:11 36:20,21 61:1 262:15 263:5 366:4,6,8 373:12 373:12 374:20 375:4,11,13 376:5 376:17,18 377:1 378:11,22 379:5 379:17 384:7,16 389:11 398:13 401:9,13,17 406:8 406:19 409:8 415:6 422:11 423:11 430:18 431:14 432:22 437:14,21 438:7 438:10 451:11 453:9 455:7 471:15 480:19 481:21 485:22
warriors 93:4 102:1,2 110:14 132:15 135:6 174:12 210:11 327:13,19 379:20 379:21 380:8 382:14 387:1 427:13 443:22 457:7 463:5 464:2 464:9 468:6
wars 178:20 203:17 204:20 214:3
Washington 1:10 115:4
wasn't 81:14 124:21 235:15 258:9 295:4 335:22 345:6 406:16 410:22 436:7 447:12
waste 38:10
watch 366:19 373:4 428:21
watching 490:8
watered 280:11
wave 372:7,11
waves 307:8 308:17
way 13:18 15:6 30:2 40:22 50:9 50:10 54:21 56:1 56:21 58:10,11 60:5 64:6,6,7 66:21 70:18 85:1 85:5,16 86:21 87:11 88:21 92:6 95:11,14 96:19 100:19 102:5 103:21 105:18 110:8 111:2 119:11 120:4,5 125:2 132:22 141:4,5 144:17,20 159:21 161:11 163:1 168:16 170:1,2 174:11 180:5 184:22,22 210:5 219:18 231:12 236:1 242:19 243:2 244:1,1 253:16 256:15 272:6 275:3 276:14,15 282:7,10 285:10 288:4,13 289:14 290:12 291:17 292:3 295:16,19 302:11,18 303:10 304:9 310:14 312:2,22 318:16 320:8 321:17 322:5 323:4 327:13 328:5 329:19 334:2 335:5,6,7 339:12 342:10 344:8,8 349:18 350:12 352:19 353:16 357:1 358:17,21 362:17 364:13 367:4,14 373:8 382:8 383:8 386:21 388:13 393:17 396:1 402:13 403:18 408:14,20 419:20 420:12 421:21 423:5,6 427:10 439:3 472:4 487:4 488:5
ways 100:5 135:3 135:21 139:4,9,15 140:13 141:13,14 142:12 144:16 154:12 158:6 168:18 169:10 180:4 203:14 204:9 253:2 340:14 348:5,12 358:18 359:11 418:8 430:13 466:13 484:9
weak 143:13 146:14
weaker 221:20
weapon 222:20 233:12 370:12,14
wearing 215:17
web 324:13 343:20 344:21 356:9
website 101:18 114:2 200:4 378:22 454:15
websites 455:22
web-based 109:20 187:11
week 16:21 32:5,17 32:18 33:4 48:11 65:13 87:17 119:3 119:17 162:21,22 266:7 374:22 375:20 380:3 389:6 390:6 430:6 444:3 459:18 491:6
weekly 232:3
weeks 154:3 404:14 420:5
weigh 222:12 260:12 354:21
weighing 159:15
weird 86:17,18
welcome 3:2 127:15 128:8 291:5 365:21
well-accepted 210:21
well-aware 130:6
well-defined 430:17
well-equipped 110:21
well-implemented 97:15
well-integrated 460:11
well-known 123:6 368:2 431:10 436:1
well-received 63:10 109:8
well-said 341:11 419:12
well-trained 430:4
well-understood 123:5
Wennergren 2:21 3:14 273:6,14,15 278:7 301:4 302:4 305:8,13 309:5,9 311:5,12,18,21 312:2 313:17 314:12 315:7 316:10,14,20 317:22 318:5 319:4,7,11,15 322:4,7,13 323:12 323:17 324:9 325:19 326:21 327:4,7 328:2,5 330:13,18 333:3 333:18 334:1 335:22 336:9,12 336:18 338:9,18 339:5 341:20 342:6 343:5,16 345:8,20 346:1 347:10 349:14 351:8 352:9,12 354:5,12,18 355:11,15,18 356:2,5,8,12,20 357:4,7 358:13 360:18,22 361:5 361:10,15,20 362:4,7 363:16 364:14 365:1,3,7 365:14,15
went 40:15 88:10 107:10 110:8 117:18 180:13 246:13,17 279:20 330:11 370:6,17 376:19 377:13 381:12 418:11,12 423:19 479:1
weren't 163:17 252:14 256:18,20 339:3
West 80:10 190:3
we'll 251:6 263:18 333:9 444:12
we're 14:6 26:6 27:9 32:12 52:2

85:18,19 110:14 124:9 145:12 293:5 299:12 308:5 311:6 345:8 349:19 442:18 447:20,21 468:3
we've 28:7 42:11 87:8 88:11 105:15 114:1 309:17
whatsoever 339:4
wheelchairs 371:14
whet 379:1
white 19:13 91:4,6 487:9
wide 79:15 83:2 130:16 173:1 251:8 324:4
widely 62:11 144:5 271:2,7
wife 87:13 172:11 249:3 374:15 389:13
Williamson 3:18 3:22 378:9 392:10 394:4 401:6 405:16 440:2 445:16 446:10,18 446:21 447:2,7,17 449:8 450:8,13 458:4,6 469:3 471:13 472:21 475:5 478:5 485:19
willing 16:6 31:12 169:13,14 260:8 336:16 485:16
willingness 146:16 148:5 173:19
Wilmont 7:9
win 369:15,16 427:2 429:6
winded 279:4
wine 387:15 486:1
winning 469:1
wire 240:21 241:1
wireless 325:4
Wisconsin 46:13
wish 261:17 467:14
witnesses 222:9
wives 375:19 389:8 389:9 463:19,21 464:2
woman 117:9
wonder 31:9 45:17 220:5 406:22 422:10
wondered 42:10 239:7
wonderful 123:14
wondering 31:15 64:12 116:20 117:3,16 122:2,19 304:16,18,22
Woo 448:14
Woodson 53:10
word 11:16 86:9 280:22 281:16 403:6,6 408:4 421:4 460:8 491:1
worded 256:16 280:1
wording 136:9,9 257:3
words 33:19 42:17 123:10 138:14 192:2 195:16 207:5 281:3 304:5 324:11 373:19 399:12 473:5 476:14 491:22
work 3:20 5:13,14 31:20,20 33:9 44:12,22 45:2 54:22 73:18 82:5 91:3,17 93:22 97:19 110:12,18 110:20 112:16 129:14,14 131:13 139:19 143:16 145:11,11 146:1,2 168:11 171:11 175:8 176:22 179:8 181:14,17 191:19 194:4 195:3,8 212:18 213:16 226:18,19 231:1 241:10 254:10 268:10,10 271:7 276:21 279:11 282:17 285:5 286:9,21 288:7 289:8 290:2 295:20 299:1,9 300:16,19 301:14 301:16 304:1 314:17 316:1 321:2,2,18 322:11 325:14 326:10 328:17 330:8 340:11,12 341:17 343:1 345:17 348:5 349:6,8,11 350:12 351:6,18 351:19 360:2,13 370:5 375:16 387:5,19 396:1 422:2 425:15 432:19 433:4 439:10,14 451:2,8 451:8,16,22 453:10,17 454:4 454:13,18 457:1 460:6 462:1 468:15 482:7,22 491:14,17 492:20
worked 20:4 90:13 249:5 301:19 335:15 339:13 439:19 483:9
worker 205:7
workers 152:16 223:21 231:7
working 29:20 34:4 54:3 68:21 88:18 97:5,6,16 98:6 100:7 103:14 104:6,20 105:16 107:14,22 112:14 121:1 127:7 190:11 289:5 294:9 299:8 300:6 301:22 303:2 322:17 329:6 347:19 351:20 388:19 391:5 406:7,10 409:15 413:22 414:1,3,5 418:3 457:3 459:2 467:9 468:3 471:7 471:14 473:10 482:13 492:14
works 94:13 141:8 176:13 212:9 252:3 268:4 270:6 282:7 286:6,13 287:2 289:14 292:3 295:19 306:14,15 308:11 312:3 318:18,19 325:13 342:18 375:14 400:1,2 414:7 481:21
workshop 468:2
work-up 118:14
world 203:10 208:3 276:13,15,20 277:3 279:16 282:12 284:19 286:13 288:16 293:6,7 297:13 326:11 328:6 357:9 362:19 377:11 442:15 484:1
worldwide 326:6
worried 305:6 364:7
worry 38:16
worse 195:3
worst 167:17 477:5
worth 29:6 30:18 179:2
worthwhile 238:18
wouldn't 279:7 280:16 384:12 466:10 473:21
wounded 1:4 2:15 2:19 61:1 128:21 175:11 262:15 263:5 366:4,6 367:7 369:21 371:16 373:12,12 374:20 375:3,11 375:13 376:5,16 376:18 377:1 378:22 379:5,17 379:21 382:14 384:7,16 389:11 396:12 401:9,13 401:17,21 406:8 406:19 409:8 422:11,12 423:8 423:11 424:21 427:12 430:18 431:14 432:22 437:21,22 438:7 438:10 443:22 444:17 451:10 455:7 457:7 464:2 464:9 471:15 480:19 481:21 485:22
wow 371:16
WRAIR 2:13 3:9
wrap 126:4
wrestled 479:4
Wright-Patterson 231:17
writ 303:13
write 141:20 169:13,14,15 206:16 246:8 285:4 372:22 375:3 451:18 487:9
writing 139:12 426:16
written 10:18 249:22 378:2 407:1 420:10
wrong 27:4,5 243:2 310:5 346:6 423:4 428:22
wrote 17:15
WTU 9:12 10:20

WTUs 9:4 10:21 11:12
WWCTP 404:22
WWR 3:15
Wyden 36:18

X

X 345:2
Xeroxing 399:13

Y

Y 121:8
Yeah 8:21 10:4
year 13:4 17:8 39:12,17,19 40:4 40:6,10,14 42:10 43:5 48:8 51:4,12 70:6,9 82:15 100:18 104:15 106:21 111:14 112:7 116:4 146:5 150:16 159:2 174:16 175:14,16 182:19 231:8,10 256:10 273:4 274:12,20,22 275:17 280:10 301:7 302:9 303:22 313:7 330:9,12,16 333:11 337:17 343:2 346:20 347:6 365:8 367:8 384:17 386:4 416:15 418:15 429:20 434:13 454:6 458:11 471:3 492:7
years 42:5 43:6 44:13 67:14,17 76:18 83:1,4 91:7 108:13,13 122:18 129:17,18 132:3 146:5,5 174:15 180:15 183:3 184:5 188:15 204:14 230:22 235:6 253:17 260:20 264:6,10 266:2 276:16 287:19 291:10 295:4 301:2,2,2 301:22 303:3 307:3 308:16 312:11 315:18 317:5 330:22 331:4 335:4,11 337:15 338:2 341:5 420:8 447:14 478:20 485:22
year's 41:21 274:14 393:3
year-old 411:9 466:20
yellow 119:9,20 293:6
yesterday 4:19 5:5 7:2 8:2 11:20 13:17 21:16 28:5 41:2 42:12 43:13 46:22 401:2
young 428:9,11 433:18 459:8 464:1 466:2,17 467:9,16 469:16 471:21 480:1 487:10
your's 409:2

Z

Zinder 482:14
Zoloft 137:4 157:16 184:19 189:14 268:14,15,19 269:7,22 270:16 270:19
zone 119:11,15,17 119:18,18 131:20 132:5,21 133:8 218:13

0

01 178:10
08:30 45:9
09 458:9

1

1 18:12 59:15 218:7 383:16
1st 477:6
1,000 180:22 186:19 223:20 373:13
1,200 432:3
1,400 302:20
1,900 223:18
1:00 272:18
1:04 272:21 273:2
10 40:18 71:21 83:1 91:7 101:11 102:21 105:20 106:22 113:15 123:12 125:7 132:3 146:5 174:15 182:18 188:15 232:17 236:18 264:6 337:17 346:8 387:12 410:9 448:12 459:18
10,000 107:4
10-year 188:13
10:00 127:22
10:07 128:6
100 21:19 33:19 38:13 92:3 94:8 94:14 161:17,22 162:6 164:21 170:6,7,10,14,15 184:1 318:16 349:21 383:17 397:10,14 398:5 426:22 476:4 477:18
100,000 51:19
101 63:8
101st 145:16
11 79:12 89:20 178:10 260:20 382:2 479:2 481:22
11,000 51:18
110 3:7 162:19 163:3
12 144:11 153:16 153:21 167:16 333:22 334:5,8,10
12th 32:4
12:17 272:21
120 27:19 65:16,17 119:5,5,20 383:18 476:4 477:18
129 3:9 185:19
13 81:3
13th 32:4
13,000 253:15
14 36:16 218:3 373:1 386:13
14th 31:19 386:12
14,000 432:7
144 397:12
15 37:16 130:15 165:20 263:15 279:8 365:18 368:7 448:12 461:9
15th 31:19 458:13
150 27:19 37:8
16 37:16
16.35 279:22
16:30 387:21
17 37:16
175 3:10 379:20
18 52:3,4 60:16 66:3,18 306:20 323:10
180 20:13,17 21:19 22:7,12,16 23:1 23:10 27:17,18 28:2,15 29:12,17 34:10 38:14 42:2 64:10,20
19 232:12 411:8
190 397:11
1980 203:22 204:2

2

2 56:22 59:15 69:18 258:2 259:13
2,000 107:2 118:9 218:1
2,300 159:5
2,400 150:9 151:4
2:12 365:19
2:27 365:20
20 21:17 28:7 61:22 67:3 100:22 101:21,22 129:17 150:15,17 174:15 204:14 279:8 351:19,20 411:9 427:1 466:20 477:2
2001 213:20
2005 261:10
2006 217:22
2007 60:18 185:19 217:21 478:21
2008 60:18 279:22 280:7
2009 107:4 198:18 301:19 447:10
2010 37:12 69:22 159:3,4 213:21 228:20
2011 36:17 37:11 48:2,14 54:4 61:14 69:2 100:22 101:3 105:12 108:9
2012 1:7 48:3,15 54:6 57:16 343:1
2013 105:4,22 200:1
2014 71:4
2015 303:6
2016 307:2,2,9 311:15 331:8 333:1,14
21 32:8 37:7 44:12 165:4
21st 33:8
211 101:5,20 102:20
214 388:9 390:19 391:2,11,15 392:10,14

22 32:8 44:12 429:19,22
223 3:12
23 1:7
24 7:11 67:3 132:5
24/7 187:10 242:15
249 3:12
25,077 178:12
27 52:4 99:2
273 3:14
28 233:16 444:19
280 430:5
284 232:1
295 475:17 476:18

3

3 57:1 72:2 130:10 131:6 158:1 162:12 387:16,17 387:21
3M 283:12
3rd 486:3
3,000 236:19
3,500 150:2,7
3:59 461:11
30 37:7 159:7 204:14 341:6 384:21 392:14 469:11 470:9 471:4 472:3 476:16
30,000 334:17
300 302:20 429:17
300,000 213:16
305 3:14
365 447:5
366 3:17
390 3:17
392 3:18,19

4

4 3:2,5 100:17 158:1 291:12
4:14 461:12
4:15 461:10
4:50 493:8
40 144:16,18 268:22 269:1,3
400 186:6
401 3:19
404 477:13
43 430:14
45 12:21 29:19 35:17 190:20 476:7,9 477:4
451 3:21
454 3:21
47 3:6 90:4
475 3:22
48 233:14
480 3:23
481 3:23
493 3:25

5

5 103:1 137:8 157:16
5,400 149:22 152:8
50 143:3 190:20 218:2 267:6 379:20,21 479:22
500 159:18 162:16 162:17 470:15
51 466:18
543 159:7

6

6 130:10
6,000 386:6
60 78:21 187:17
610 397:9,11
65 89:18,19
69 481:19

7

7 228:22
7,000 78:4,10
70 251:11,12
75 257:21

8

8:00 1:11
8:01 4:2
80 67:12 144:7,8,18 160:10 162:9 165:19 238:19 337:16 427:22
80-20 21:17 22:9 23:13 25:11
800 252:6
84 160:6 161:3,14 162:8

9

9 104:16 153:21 187:9 198:5
9:53 128:5
90 65:16 67:12 119:5 173:4 238:19 337:16 388:16 477:1
900 223:19
901 1:10
91 27:17
93 160:16 162:13 163:4,11 164:15
95 157:7
96 157:8
97 157:8
99 479:3

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: 02-23-12

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