U.S. DEPARTMENT OF DEFENSE

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TASK FORCE ON THE CARE, MANAGEMENT AND

TRANSITION OF RECOVERING WOUNDED, ILL AND
INJURED MEMBERS OF THE ARMED FORCES

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BUSINESS MEETING

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WEDNESDAY
MAY 16, 2012

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The Task Force met in the Commonwealth Ballroom of the Holiday Inn & Suites Alexandria-Historic District, 625 First Street, Alexandria, Virginia, at 8:00 a.m., Lt Gen Charles B. Green, DoD Co-Chair, and Suzanne Crockett-Jones, Non-DoD Co-Chair, presiding.

PRESENT
LT GEN CHARLES B. GREEN, M.D., USAF, DoD Co-Chair
SUZANNE CROCKETT-JONES, Non-DoD Co-Chair
CSM STEVEN D. DEJONG, ARNG, Member
RONALD DRACH, Member
CAPT CONSTANCE J. EVANS, USN, Member
LTCOL SEAN P.K. KEANE, USMC, Member
MSGT CHRISTIAN MCKENZIE, USAF & SOCOM, Member
KAREN T. MALEBRANCHE, RN, MSN, CNS, Member
STEVEN J. PHILLIPS, M.D., Member
DAVID REHBEIN, M.S., Member
DENISE F. DAILEY, PMP, Executive Director,
ANNE SOBOTA, Alternate Executive Officer

ALSO PRESENT

MICHAEL A. PARKER, Wounded Warrior Advocate

COL JOHN L. MAYER, USMC, Marine Corps Wounded

Warrior Regiment

CONTENTS

Page

Public Forum 4

MGAGCC (Twentynine Palms) 15

Break 54

Task Force Recommendation Development: Review of Non-Medical Case Management 54

Break 130

Task Force Recommendation Development: Review of Non-Medical Case Management (continued) 130

Task Force Recommendation Development: Review of Wounded Warrior Units and Programs 162

Lunch 219

Task Force Recommendation Development: Review of Medical Care Case Management 220

Break 296

Task Force Recommendation Development: Review of Services for PTSD TBI 306

Task Force Recommendation Development: Review of Centers of Excellence 347

Task Force Recommendation Development: Review of Interagency Program Office 351

Meeting Adjourned 377

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

2 8:00 a.m.

3 CO-CHAIR GREEN: Okay. Good

4 morning, ladies and gentlemen. We'll begin
5 today with our public forum section. The
6 items, which can be found in Tab H, include

7 written submissions.

8 And with us this morning, I

9 believe, is Mr. Michael Parker. Is Mr. Parker

10 here? Welcome.

11 MR. PARKER: Thank you, sir. Good
12 morning. At the last meeting, I discussed
13 Petty Officer Daniel Kinberg's disability
14 case.

15 He was found unfit for both

16 ankylosing spondylitis and PTSD, but the IPEB

17 stated these conditions preexisted service

18 despite the fact that VA service connected and
19 rated these conditions.
20 Because these conditions were
21 deemed preexisting, Petty Officer Kinberg was

22 to be separated without DoD disability

benefits.

As an outcome of raising this issue, the Navy PEB ordered a quality review of this case to be compliant with DoD procedures.

This resulted in finding that these conditions did not preexist service. However, the new IPEB findings stated the PTSD was not unfitting despite two VA PTSD ratings of a hundred percent.

Petty Officer Kinberg is scheduled for a formal PEB on 24 May to challenge his PEB results. This case illuminates many of the DES or Navy DES concerns, and I will keep you apprised as the case progresses.

Another case discussed last month was that of Cory McDonald. His PEB found that his nerve condition preexisted service, resulting in separation without disability benefits.

He recently underwent the very first enlisted Disability Review Board, which

concurred with our position that his condition was aggravated by service. And they granted him a 40 percent disability retirement that backdated to 2003.

There are many more Cory McDonalds out there, and we need to get them fixed. I have provided a link to get further details on his case, which is in the statement.

Due to time constraints on public statements, I have attached emails with details on two very recent cases the exemplify how Department of Navy continues fit but unsuitable discharges.

My intervention in Petty Officer Kyle Sisson's case resulted in the PEB granting him a formal board dispute his fit finding.

This case parallels in many respects to the case of Petty Officer Sandy DeMunnik, who briefed the task force in February. She recently submitted an update to the task force on her situation.

1 I have not received a response
2 back yet on the PTSD case described in the
3 second email. This case illuminates how the
4 Navy avoids recent legislation to prevent
5 administrative separations and denials of re-
6 enlistment due to conditions deemed fitting by
7 the PEB.
8 This technique simply involves not
9 submitting the individual to the MEB/PEB as
10 required. The Navy avoids the new laws by
11 simply avoiding a PEB fit finding, and this is
12 unjust.
13 Do you have any questions?
14 CO-CHAIR GREEN: Just one. Are you
15 finding that the review process is not
16 catching these? It sounds like the review
17 process is catching these cases.
18 MR. PARKER: No, because the review
19 process is not part of the process. It's me
20 acting as an individual raising these cases
21 directly to points of contact I have within
22 DoD and Congress.

1 It is not being caught internally.
2 It's from outside intervention saying this
3 isn't right, it's not following the rules.
4 And in the case of Daniel Kinberg,
5 I think what's most telling is you have a
6 statement from the PEB saying, go back, redo
7 it, and this time follow DoD procedures.
8 So, how many more are out there, I
9 don't know. Whether or not this is going to -
10 they're going to do that forward or if
11 they're just going to fix the ones they had
12 illuminated, I can't tell you because I don't
13 have access to all the data.
14 CO-CHAIR GREEN: And are all the
15 cases preceding the IDES program and the new
16 review board that's available, the joint
17 review board that's available on the IDES
18 system?
19 MR. PARKER: I'm sorry, what was
20 the question again, sir?
21 CO-CHAIR GREEN: Are all the cases
22 you're bringing up, are they all pre-IDES and

1 pre-the joint review board?
2 MR. PARKER: No. Kinberg's case is
3 ongoing. Sisson's case is ongoing.
4 DeMunnik's case is ongoing. Cory McDonald's
5 was within that range of the PDBR, if that's
6 the board I think you're referring to.
7 However, the PDBR specifically states they
8 will not review cases that are deemed EPTS.
9 The law says you have to have a
10 disability rating of zero, ten or 20 and those
11 found unfit. But EPTS get no rating
12 whatsoever, so they're excluded from the PDBR
13 process.
14 That is why I went back to
15 Congress and said we need to expand the
16 Disability Review Board to enlisted members,
17 which they did in the 2011 NDAA.
18 DR. PHILLIPS: I have a question.
19 When a servicemember is denied based on
20 preexisting conditions, what's the process to
21 investigate those preexisting conditions? Are
22 there health records available, or is there

1 recruitment -
2 MR. PARKER: That's an absolutely
3 good question. Yes, all the records are
4 there.
5 This has been an issue for a long
6 time. The VA, since 1944, had a presumption
7 standard that said if a condition is not noted
8 on your entrance physical, it's presumed to be
9 service connected. And even if it is PTS,
10 it's presumed to be aggravated.
11 And to overcome that, you have to
12 have clear and unmistakable evidence to the
13 contrary.
14 Well, the military was not
15 following those procedures. They had a much
16 less standard for deeming something EPTS. In
17 the 2009 NDAA, Congress changed it so both
18 were on the same presumption standards.
19 So, how do these things get
20 reviewed? I don't know. I mean, Kinberg's
21 case is a great case. How in the world they
22 came up that that was EPTS, you know, is

1 beyond us.
2 But the problem is, and this was
3 stated in the letter that we got back from the
4 PEB, is that they on the quality review were
5 required to do what they should have been
6 doing all along.
7 And that is, if you're going to
8 say it's EPTS, you must provide clear and
9 unmistakable evidence that it preexisted
10 service, and clear and unmistakable evidence
11 that it was not aggravated by service.
12 And because they couldn't do that,
13 you know, then they said, well, you know, if
14 that's the standard, then it's not EPTS. And
15 that was the correct way to do it.
16 A big problem on this is the
17 Reserve and National Guard. And you guys had
18 quite a bit of discussion with them yesterday
19 and I talked one-on-one with one of the
20 National Guards from the Air Force or Air
21 Guard.
22 What's happening there is folks

are on active duty, they're having service-connected conditions. The LOD is deemed yes at the unit level, at the higher headquarters, but then reverted to EPTS by the regional command, I guess it is, for the Reserves.

They are not following the clear and unmistakable standard. These folks are having these conditions service-connected by the VA, while the Air Force Guard is telling them it's not service-connected.

That's a dichotomy. You can't have the VA say it's service-connected, and the military saying it's not, given they're supposed to follow the standard, but it's happening all the time.

And because these folks aren't going through the MEB/PEB process, then it's not illuminated, it doesn't get even a chance to be reviewed under the fit but unsuitable - or, I'm sorry, the clear and unmistakable standard.

DR. PHILLIPS: This morning I

didn't have a chance to really read through it. There are, I guess, more than 200 additions being proposed for NDAA. And I assume a lot of them are not related to health, but I'm just alerting you to that. There may be some interesting things in there.

MR. PARKER: Well, and I haven't looked at the 2013 NDAA. I have been - MOAA has been very active in doing that and they talk to me every once in a while. And I talk to them about what's coming up.

The issue we're fighting or finding is that anything that requires money on offset is a no-go.

The issue with CURSEC, people are not getting the proper amount of CURSEC. DoD knows the problem. Congress knows the problem. And they said, we know about the problem, we want to fix it, but we can't find the money.

Well, because they can't find the money, there are combat-wounded veterans out

there that are being shorted their CURSEC. It's a well-known problem. Legislation has already been canned as how to fix it, but they can't find the offset. So, that's the problem we struggle with.

The one simple solution, I believe, on this one, that probably wouldn't require money and perhaps is a recommendation this board could make if it's not done sooner, is that under law you are not allowed a formal board unless you're found unfit.

So, in the case of Kyle Sisson, he was said you're fit. He asked for a formal board, said that doesn't make sense. I've got heatstroke. I can't work outside in more than 80 degrees heat. How in the world am I fit?

Sorry, you can't have a formal board to dispute it, because the law doesn't provide it. They can do it if they want, but they just said, no, you can't have it.

And that was, I think, the low-hanging fruit takeaway that we can just have

1 the law change that says, if you are found
2 fit, you can have a formal board as well.
3 Because what's happening is these
4 guys are being dismissed because they can't
5 reenlist or they're told they're unsuitable
6 and it's still ending their career, but they
7 don't get all the rights to a full and fair
8 hearing because of this flaw in the law.
9 MS. DAILEY: Thank you, Mr. Parker.
10 MR. PARKER: Thank you. I
11 appreciate it.
12 CO-CHAIR GREEN: Okay. So, I guess
13 the next thing is for us to do a site visit
14 review. We're talking about the Marine Corps
15 Air Ground Combat Center at Twentynine Palms.
16 General Stone could not be with us
17 today, and so our co-chairman, Ms. Crockett-
18 Jones, will lead this discussion. She has had
19 the opportunity to visit the Marine Corps Air
20 Ground Combat Center at Twentynine Palms
21 twice, along with Sergeant MacKenzie.
22 The Command Sergeant Major DeJong,

was new to the task force as of last May. So, he did not see it the first time, but was able to make the follow-up visit.

And so with that, I'll pass this to my co-chair. Thank you.

CO-CHAIR CROCKETT-JONES: Thank you, General Green. At this time, I would like to ask Colonel Mayer to come forward and take a seat and -

COL MAYER: Good morning, folks.

CO-CHAIR CROCKETT-JONES: Good morning.

COL MAYER: Do you want me to sit here, or do you want me to stand behind the podium?

CO-CHAIR CROCKETT-JONES: Wherever you're comfortable.

COL MAYER: Can you all see? I might end up standing.

CO-CHAIR CROCKETT-JONES: Well, I want to start things off by saying, you know, I'm glad you came to talk to us again.

1 We have finished up our cycle of
2 installation visits and we were - found our
3 visit to Twentynine Palms interesting enough
4 to want to talk with you.
5 It's the only time we - it's our
6 only repeat installation visit. We went last
7 year and this year. And we recognize that
8 it's not like other Wounded Warrior Regiment
9 detachments in that it doesn't have a major
10 treatment facility, military or civilian. But
11 that as a major deployment platform, there
12 will be wounded, ill and injured there for as
13 long as it is functioning.
14 And we understand the premise of
15 keeping wounded, ill and injured near line
16 units as a way of keeping the morale going to
17 help with healing, but we would hope that
18 there might be some more integration of the
19 Wounded Warrior detachment that is there with
20 the functioning - there seems to be a little
21 bit of separation in the sense of have and
22 have-nots out there.

1 And we'd hope that you put a
2 little sight on that kind of - on the
3 interaction between an awareness of line unit
4 command with what's going on at Wounded
5 Warrior detachment.
6 We were also concerned that the
7 wounded, ill and injured in the program are
8 not getting enough robust job training,
9 placement assistance and career guidance.
10 Because of the distance issues, it
11 might take some very special coordination with
12 VA to bring those resources to them. They
13 have a nationwide VR&E program that is very
14 robust and would be very helpful, but there's
15 an access issue for those folks because of
16 their remote location.
17 Another non-medical issue that
18 came up for us is that the section leaders
19 sometimes did not have any combat experience.
20 And we found across the board that this can be
21 sort of a culture clash issue, that it's a
22 difficult job, the non-medical guidance of the

1 recovering folks.
2 It's a balance between discipline
3 and compassion. It is a very difficult job
4 that's being asked to be done to pull people
5 along to know when you've got to push and when
6 you've got to, you know, have more compassion
7 and when you've got to go back to pushing.
8 It's not an easy job and it's, I
9 think, harder maybe for folks who have never
10 been in combat, to relate to what some of the
11 wounded, ill and injured are going through.
12 So, we were hoping you can take a look at
13 that.
14 On the medical side, we were
15 concerned about the Marines going through
16 IDES, who are basically going through IDES at
17 a different location, like Balboa or
18 Pendleton. That that's where they get
19 referred for their nonfit and that becomes the
20 location of the process, but it's very remote
21 from Twentynine Palms. And it can be -- you
22 know, that process is not short.

1 So, we were hoping that a more
2 robust program for IDES could be pushed out to
3 Twentynine Palms. Once again, this might
4 require some coordination to get VA resources
5 out to them. Because of the longevity of the
6 situation, because they're going to be there,
7 this shouldn't be something that is impossible
8 to coordinate.
9 And we were pleased that the -
10 sort of the understanding and the - of
11 transporting people back and forth that there
12 had been some - that had been a real obstacle
13 for some of those folks. And we did notice
14 that Twentynine Palms has really stepped up to
15 do more transport, specialty care.
16 They have also been boosting their
17 behavioral health resources. They have been
18 better at moving folks into the detachment who
19 really need to be there.
20 So, they really did address some
21 of the concerns we had after our first visit.
22 We're just seeing some persistent issues and

there are things that still need to be done.

I think it's sort of along the lines of recognizing that this detachment is not going to go away. This is not going to be - as long as you have - you are deploying Marines from this in significant quantities, there are going to be units that are having to use the Wounded Warrior detachment for the recovery of their Marines.

Anything you want to jump in on here?

COL MAYER: Ma'am, I'm always ready to jump in. So, am I on?

CO-CHAIR CROCKETT-JONES: You are on.

COL MAYER: All right. So, you can hear me in the back. Thanks.

Twentynine Palms, everybody loves Twentynine Palms. The reason I love it is you have a - it's a combat camp. When you go there, you feel like you're a Marine that is training for what we do. And that's we're

first to fight and we fight our nation's battle in the air, on land and sea.

So, let me answer your questions and I'll kind of go in the way I took the notes. So, your first question was the have and the haven-nots out there at Twentynine Palms.

And I took this as Marines assigned to Wounded Warrior Regiment versus those that are still in what's called Regimental Combat Team 7 out there.

Of course, we have an assignment process. And so the first thing that has to happen is the Marine has to be referred out to us.

And so the way that we do that is I talk to all the commanders when they come through, the new commanders. And then our leadership out there should be constantly working with the leaders. A small - with the operational force leaders.

So, a small camp like Twentynine

1 Palms that really houses a reinforced
2 regiment, everybody on that base should know
3 each other and be working together.
4 Twentynine Palms has - at least
5 RCT7 has its own OSCAR team. Are you all
6 familiar with OSCAR and the - let me give you
7 what the acronym stands for. Operational
8 Stress Control and Readiness Teams. So, at
9 RCT7 they have a psychiatrist and a
10 psychologist that are assigned right to the
11 regiment.
12 And then of course we have our
13 OSCAR extenders that go all the way down to
14 the squad level. And that's Marines that have
15 been trained in combating stress and
16 resilience and all that type training to
17 better recognize those Marines that need
18 additional care and to ensure that they get
19 it.
20 And so, that's very well-
21 integrated especially out there in 7th
22 Marines. As you said, it's a combat force.

1 So, I like to say that the units,
2 and you know the Marine Corps policy is that
3 we will keep Marines with their family, so to
4 speak, as long as possible. And only those
5 that are most serious would then go to Wounded
6 Warrior Regiment or to a det that's out there.
7 So, a little bit different than
8 perhaps the Army and the other services, but
9 that's the way we do it.
10 And so what I guess I'm trying to
11 say is the have, the have-nots, the regiment
12 RCT7 out there has a very good program for
13 taking care of their Marines inside that might
14 have some mental health issues.
15 And then those that are very
16 serious, they transfer over.
17 CO-CHAIR CROCKETT-JONES: This may
18 be more of a perception issue that - but that
19 perception can sort of lead to real problems.
20 And so it might just be more of - more
21 awareness back and forth between programs and
22 the understanding of what criteria really get

1 you into the detachment.
2 This might be an education and
3 awareness factor.
4 COL MAYER: Right. I agree.
5 Education is always the key. And if the
6 leaders know the assignment process of what we
7 do, how we do it, it's very good. So, I would
8 agree on the education side on that.
9 MSGT MacKENZIE: Sir, if I can jump
10 in while we're talking about this topic, I was
11 out there on the first trip as well as the
12 second. And I know on the first trip we
13 focused in a different direction and realized
14 that we missed a significant piece, which is
15 part of why we went back the second time.
16 A couple of the things that I
17 noticed and that we took a look at this year
18 was by bringing in the line leadership. We
19 had battalion commander, first sergeant,
20 gunnery sergeant from a particular battalion,
21 to ask those specific questions, you know,
22 what is your awareness, what is your

1 interaction with the Wounded Warrior regiment
2 and detachment at your location, and it was
3 minimal at best.
4 One of - the gunnery sergeant was
5 familiar because one of his Marines was
6 actually at - getting transferred over to the
7 Wounded Warrior detachment. But overall, the
8 sense from that battalion was that they really
9 had no interaction at all with Wounded Warrior
10 regiment and that detachment there and didn't
11 - I don't know if we asked the question
12 correctly, but it seemed like the perception
13 was that the Wounded Warrior Regiment
14 detachment there was not in a position, or did
15 not take the position, to brief and provide
16 them resources and guidance for their wounded
17 warriors that are in the line units.
18 And they had requested more
19 interaction with Wounded Warrior Regiment as
20 to, you know, some of the continued care and
21 work with their wounded warriors while keeping
22 them in the line unit.

They didn't want to leave them in the line unit as in the culture that you explained, which is working very well. It's just they would have liked to have had more of that interaction.

The other thing through, you know, extensive communication, you know, you got to put on that NCO thing and get a little more communication, as we all know.

Within SOCOM, one of the things that we have is a significant number of our teams that work within the Care Coalition are out of the components, you know. So, you've got all the components that are represented in SOF, have personnel that work with the Care Coalition.

And when I was talking to one of the personnel there, it seemed interesting to me, or perhaps for me to ask you this question which is, you know, do you feel that if 7th Marines had an active duty person on staff at that detachment, you know, would that provide

that additional interaction where the - it's an assumption, but the underlying tone was is the CG at 7th Marines being, you know, truly understanding what's going on with all of the wounded warriors there, and would having a member of 7th Marines or in that aspect on your staff there at the detachment, provide an additional continuity of communication and reach-back effect?

I mean, it was an interesting interaction, but I kind of - I wanted to bring that to your attention that as you guys continue to move towards bringing active duty Marines on board with Wounded Warrior Regiment that, you know, what are your thoughts on that idea?

COL MAYER: Yeah, I think there's merit to that, but, once again, at least in my opinion - and we'll look at that at your suggestion - the - it's so small out there, and Marines are Marines.

And so - and we're going to bring

- now, we got six more active duty coming on this summer. We have three there now. And the interaction between Wounded Warrior Regiment and Twentynine Palms and the units at Twentynine Palms, it should be all the time.

We should be going to their meetings and they should be - we should be providing status updates to General Smith, who runs the whole camp and also involved with RCT7.

And so, I'll make sure that that gets started. So, I don't think we necessarily need to bring a table of organization staff officer over. They just don't have any spares, but I think we can do a better job of ensuring that there is a - I won't use seamless, but a transparent communication between wounded Warrior Regiment and 7th Marines.

I mean, that's why they're up there. They're up there to support those Marines, yeah. So, the communication is the

1 important thing.

2 CO-CHAIR GREEN: Can I ask for a

3 little - I'm sorry. Go ahead.

4 CO-CHAIR CROCKETT-JONES: Go ahead.

5 CO-CHAIR GREEN: I was just going

6 to say, I need a little clarification since

7 this is the only place we visited twice.

8 One of the reasons that we were

9 concerned about this particular site last year

10 was command climate and the feeling that the

11 medical case managers were not having any say

12 in terms of people who may have needed to go

13 to the regiment, because they weren't able to

14 get to their care while staying in a combat

15 unit. That's my interpretation of what

16 happened last year.

17 And if I heard you right, Suzanne,

18 command climate issue has improved

19 significantly. And the issue with regard to

20 the medical case managers having input has

21 been resolved as well.

22 CO-CHAIR CROCKETT-JONES: Yes, both

of those have improved. I'm not sure -

CO-CHAIR GREEN: Resolved is -

CO-CHAIR CROCKETT-JONES: Resolved is -

CO-CHAIR GREEN: But it's working better.

CO-CHAIR CROCKETT-JONES: It is working better.

CO-CHAIR GREEN: From what you saw.

CO-CHAIR CROCKETT-JONES: Yes.

CO-CHAIR GREEN: And so, your criteria for entry into WWR are actually quite clear, in essence, after visiting Lejeune. Essentially, they need - it's conditions that would take them longer than six months and there's some judgment at that level.

And so I'm assuming that in the combat unit, the people who are there don't meet the criteria to come into the WWR. Is that accurate?

COL MAYER: They either don't make the criteria, or it's determined that it's

1 better to keep them where they currently are.
2 And that's why I talked about the OSCAR
3 program and then the hospital.
4 I mean, it's such a small place
5 out there that some - many units might say,
6 hey, we want to keep them within our units.
7 It's better for the recov report.
8 CO-CHAIR CROCKETT-JONES: Yeah,
9 there - we still have a little bit of a
10 concern sometimes at the amount of specialty
11 care and the travel required to get care while
12 still being in a line unit which had
13 requirements for work - daily work. That the
14 struggle is sometimes - I think it's a hard
15 call to make that it remains better.
16 And I think sometimes it's tough
17 for folks to know when to - when they got to
18 push them over to Wounded Warrior Detachment,
19 but I have to say they have increased the
20 population and they seem to be grabbing them
21 better.
22 I'm not sure they've - I think

1 that sometimes they greatly underestimate the
2 stress and the factor for travel and distance
3 that goes with getting care.
4 CO-CHAIR GREEN: Okay. And so I'm
5 not second-guessing any of the local decisions
6 on who does and who doesn't. And the OSCAR
7 teams and the embedded mental health, I think,
8 are probably a very effective way to deal with
9 some of the PTS issues that are going on out
10 there.
11 So, I guess my - the balance and
12 what I was trying to get to is, so you've done
13 some very aggressive things to get PTS
14 treatment to make sure they have what they
15 need there. That's great.
16 So, the other folks, I'm thinking,
17 are less than six months or have been
18 adjudicated that their conditions are going to
19 be dealt with and will resolve in less than
20 six months based on the WWR criteria.
21 So can you give us any idea of the
22 number of people that are in the combat units

1 that have issues that may be going longer than
2 six months and it has been adjudicated that
3 they will stay in the combat unit?
4 Do you see what I'm asking? In
5 other words, how many people might have met
6 your criteria, but was decided that they were
7 to stay in the combat unit?
8 We're just - I think what we're
9 looking here is, is there a large number of
10 people and, therefore, a difficulty getting
11 them the specialty requirements other than
12 psychiatry, which you've taken care of?
13 CO-CHAIR CROCKETT-JONES: Do you
14 have that number?
15 MS. DAILEY: I can get that number,
16 sir. I did not ask them to bring those types
17 of numbers, but I -
18 CO-CHAIR GREEN: And that's okay.
19 I just -- for me, I'm trying to figure out if
20 it's a large number or a very small number,
21 and it's a small vocal number when we're going
22 out and visiting, if you know what I'm asking.

1 COL MAYER: Right. And that would
2 be almost a medical question that - you see
3 what I'm saying? So, that would be -
4 CO-CHAIR GREEN: Not if you've made
5 the decision that, despite meeting the WWR
6 criteria, you've kept them in the combat unit.
7 You see? That's the -
8 COL MAYER: But they would have to
9 be referred first so - I mean, we wouldn't
10 know until they've been referred to us.
11 MSGT MacKENZIE: And that was the
12 point that was brought up by the battalion
13 commander, was that increased level of
14 communication would help them better make that
15 decision, because you got to take into account
16 that the Marine wants to stay with his line
17 unit.
18 So, it's not a - it's not always
19 nearly as cut and dry as, you know, this guy
20 meets the criteria and now there's this
21 discussion point.
22 I think that's what the battalion

1 commander was discussing was that there wasn't
2 a lot of cross-talk between the line unit and
3 Wounded Warrior Regiment to continue that
4 determination, as well as in one particular
5 case where one of the Marines was like, you
6 know, how can we make use of some of this
7 Wounded Warrior Regiment detachment resources
8 without actually having to push our guy over
9 there, i.e., getting him on board with some of
10 this transportation and getting some of this
11 connectivity without having to make that
12 clear-cut line unit or, you know, det.
13 CO-CHAIR CROCKETT-JONES: Well, we
14 -
15 MSGT MacKENZIE: And that was some
16 of the discussion points.
17 CO-CHAIR CROCKETT-JONES: We do
18 know that there are numbers of folks on second
19 LIMDU still in line units. And that's tracked
20 and that number is available.
21 I know that it was - I can't - I'm
22 trying to remember, but it -

1 CO-CHAIR GREEN: It's okay. What
2 I'm trying -
3 CO-CHAIR CROCKETT-JONES: But we do
4 know that it's an issue.
5 CO-CHAIR GREEN: Yeah, what I'm
6 trying to kind of drive at, I'm a big fan of
7 some of the things you were doing at Lejeune
8 to try and keep people productively engaged.
9 And so I think that keeping people in the unit
10 is actually a good idea.
11 I guess where I'm going with this
12 is, my guess is that the communication is not
13 just needed between the WWR and the RCT7, but
14 probably with the hospital that has a
15 specialist that are seeing the progress or
16 lack of progress, and not necessarily having
17 a good venue for communicating when somebody
18 is not making the progress expected.
19 Now, we would hope that the case
20 managers are doing that, but, you know, that's
21 - and since you're - that's where I think we
22 are. Am I misunderstanding the issue?

1 DR. PHILLIPS: Can I follow up a
2 little bit on that? I certainly understand
3 the culture, but I'm thinking a little bit out
4 of the box.
5 Twentynine Palms is a Marine
6 combat unit where they're preparing Marines to
7 fight a war. Because of a whole host of
8 different circumstances related to what's
9 going on in the world, we have required a lot
10 of the combat units to do something new, take
11 care of wounded warriors.
12 And the question I'm asking, are
13 we truly optimizing our resources by keeping
14 troops in a remote location with every good
15 intent to try and keep them with their units,
16 as opposed to saying, okay, you're temporarily
17 broken, we need to get you somewhere where
18 they have ever facility available to fix you
19 as quickly as possible and get you back, as
20 opposed to struggling with the command
21 authority and the combat cadre to try and do
22 another job and take their focus away from

1 what the mission is.
2 It's sort of a broad question.
3 It's do these remote bases have the facilities
4 and the ability to really do the job that
5 should be done, or should we think out of the
6 box, optimize our resources, centralize that
7 care and get these folks back to doing what
8 they're supposed to do?
9 COL MAYER: So, I mean, through the
10 - the Marine Corps' policy is to assign the
11 Marine as close to his home station as
12 possible, but the first and overriding
13 criteria always is that he can get the medical
14 care he needs.
15 So, a Marine wouldn't make it back
16 to Twentynine Palms, unless the medical
17 community felt that he could get the medical -
18 or she could get the medical care at
19 Twentynine Palms.
20 So, I mean, it's kind of - and I
21 believe in Navy medicine and all that. So,
22 the thought is that Marine wouldn't be back

1 there unless they thought.
2 Now, on the same thing is if he
3 came back with RCT7 from the combat and then
4 it became known through medical appointments
5 and all that that he needed a higher level of
6 care, then we would send him down to Camp
7 Pendleton or Balboa or wherever it would be.
8 So, I mean, that's the system.
9 It's designed to work, and I think it does
10 work well.
11 CO-CHAIR GREEN: I think your
12 system is actually designed to work. And I do
13 think that -- from what I saw at Lejeune.
14 Now, I haven't been out to the other areas.
15 So, I can't speak to Twentynine Palms.
16 But what I'm hearing is, and I
17 want to give you something concrete, what I'm
18 hearing is that there may not be the
19 communication still between the case managers
20 who should be tracking when somebody is not
21 making the progress that they need and may
22 need some additional, you know, assistance in

1 getting - whether it's appointments or follow-
2 ups or whatever.
3 And so I think that we still have
4 a problem that the case managers have not
5 figured out how to communicate that to the
6 line commander. And so that's what I'm
7 hearing.
8 CAPT EVANS: John, and I just - and
9 I'm hearing the same. I'm not sure how your
10 case managers out there at Twentynine Palms
11 are communicating between the line and back to
12 the WWR. And that's something we may need to
13 just kind of hone in on, that process, and we
14 will.
15 We'll come out there. We'll go
16 out and look at the case management process
17 and I'll go back and talk to Admiral Niemyer.
18 I think - I truly think that's
19 your link and -
20 CO-CHAIR GREEN: I do too. I think
21 the other thing that you might explore is,
22 because the case managers aren't necessarily -

1 it sounds as if they're not as tied into the
2 RCT7. It may be that your communication
3 between the WWR and the RECT is essentially to
4 have the case managers who are very tied into
5 the WWR leverage your line commander from the
6 WWR to talk to a line commander over at the
7 RCT7 when they see some issues.
8 I'm just, and I'm guessing, but
9 I'm hearing kind of a consistent theme that
10 says there's still a little bit of a breakdown
11 because the case manager should be clearly
12 identifying people who aren't making the
13 progress that they would expect.
14 And that would actually solve, I
15 think, what I'm hearing from the task force
16 members.
17 My effort here is really to give
18 you something concrete rather than just
19 perception or, you know, "we need you to
20 change something," because I think you've done
21 good work in getting command climate and
22 everything working well. And it sounds like

there's just this last vestige of how the case managers identify those people.

And the distance makes it more complex. I mean, you have to admit the distance makes it more complex.

CSM DeJONG: And it also is -- what we're hearing back from the focus groups is that the wounded Marines within the line companies want the same resources as those in the WWR.

So that's -- that communication between WWR and the line company commands and that interaction to share some of the resources, share some of the knowledge and cross-talk that, along with the case management.

CO-CHAIR GREEN: Yeah, the tricky piece is they want the same services without being in the WWR, because they want to be a Marine in a line unit.

So it's kind of the perfect match. And so now the question is how do you

1 accommodate that.

2 MSGT MacKENZIE: One of the things

3 that we found, sir, was especially when

4 they're doing - working their med board piece

5 and so forth, for the case management, that

6 case manager was handling - what - 95 cases by

7 herself and almost creating an interaction of

8 she doesn't have time for us.

9 And the case management is

10 definitely the key. And I think part of

11 bringing you up here and bring up some of this

12 Navy med stuff is you as the WWR commander

13 going, hey, Navy, I need some more support out

14 here for my Marines, you know.

15 Because we found that, although

16 when we went the first year, I think our focus

17 was a little more narrow and we looked at it

18 from a different angle, I think. And we

19 concluded this year, and I wish General Stone

20 was here because he had a very - a fantastic

21 way of presenting it, but that it was, you

22 know, it was much higher up to the support.

I mean, Twentynine Palms is going to be there forever. That detachment is doing a lot of really, really great things. And it's not a matter of moving it to a different location. It needs to be there.

But what it needs, is it needs the support across the Board which you are doing, but it's - there's two pieces here, two leadership pieces here, that need to be supporting those Marines there.

And we're just -- you know, you guys have done great with that piece, but it's - excuse me - but there's another piece out there that needs to be leveraged. And so, that's why we're bringing it up.

CO-CHAIR GREEN: Could be as simple if I just heard right about the case management that the distance which may drive more work for people to get information, that it could be as simple as you just need to pay a lot more attention to the case management ratios. Get it back to the one to 20.

1 Because it may simply be that you
2 don't have the right number of people out
3 there and they're overwhelmed trying to keep
4 track.
5 MS. DAILEY: Sorry, sir. I need to
6 get that -- kind of correct that on the
7 record. That 95 to one is the PEBLO ratio.
8 It is not the nurse case management ratio.
9 And it is within the one to 20
10 formula for --
11 CO-CHAIR GREEN: Okay.
12 MS. DAILEY: -- case management
13 with the IDES population.
14 CO-CHAIR GREEN: Sorry.
15 MS. DAILEY: So, it is not medical
16 case management.
17 CO-CHAIR GREEN: Disregard.
18 So, ladies and gentlemen, give us
19 your feedback. We've been talking a lot
20 trying to make certain that when you leave
21 here you have some fairly specific feedback
22 and things that may be useful.

1 I will tell you I was so impressed
2 with Lejeune and what you're doing with the
3 WWR that I think your system is on the mark.
4 And so, I suspect you're dealing
5 with a tyranny of distance for people you're
6 keeping in combat units. And the question is,
7 how do you solve that?
8 And I don't know that we have the
9 answer. But I think that if you guys
10 understand that that's kind of the issue, then
11 I know you will solve it because I've seen
12 what you can do.
13 I love your app, by the way. Just
14 so you know, okay. I use that all the time.
15 COL MAYER: Can I -- do I got time
16 to make a few more comments?
17 Well, ma'am, on the job training,
18 Twentynine Palms is very challenging. Same
19 with Camp Lejeune just because of where it is
20 located.
21 We have engaged with the
22 vocational rehab and we're planning to put a

1 counselor up there and add -- I think make it
2 up to three down in Camp Pendleton.
3 So, a little bit easier to get
4 folks down there, but we do expect to have a
5 voc rehab employee there working, helping
6 guide the Marines.
7 The, you know, the unit transition
8 coordinators, you know, I was asking why
9 aren't there more of those guys out there?
10 And once again, this is a leadership thing.
11 I know you all ask me, well, you
12 got combat Marines, you know, 73 percent of
13 Wounded Warrior Regiment Marines are combat-
14 wounded, injured Marines. Our section
15 leaders, though, many don't have combat
16 experience.
17 All right. So, I mean, I'm
18 looking at my staff NCOs here, is combat is
19 not a requirement for leadership. A Marine
20 wouldn't be promoted to become a non-
21 commissioned officer unless he has already
22 shown that he can lead, right?

1 So, I mean, you have a whole flock
2 of lieutenants that join and lead platoons
3 that have never lead before, but they do it
4 because they are leaders of Marines. And
5 that's been something that we've used forever
6 and ever.
7 So, the point about being a
8 leader, must have combat experience, we as
9 Marines and we as servicemembers, we wouldn't
10 buy that. Otherwise the system wouldn't work
11 the way it is. And so, the question is, is
12 getting the right leaders in the right place
13 that can lead.
14 And that's always the challenging
15 part and we do our best to assign the right
16 Marines, the right leaders out there.
17 And of course with active duty
18 ones, the ones that we have a track record and
19 they're coming, I think that we're meeting
20 that requirement.
21 I hope that makes sense to you and
22 answers that, ma'am.

1 CO-CHAIR CROCKETT-JONES: It does.
2 I just want to emphasize this is a
3 particularly tough leadership job. It is much
4 more divided than some other leadership jobs.
5 It's not always push. It's not
6 always pull, you know. It is a very -- it's
7 a very -- it's a delicate job and I think you
8 know that.
9 I'm seeing in most places you find
10 very effective leaders. I think that a little
11 review on the leadership that you've -- that
12 is functioning out there, just a good eye on
13 it.
14 Just because of some of its
15 extreme circumstances, Twentynine Palms might
16 need a little bit of special review. I think
17 you've got that.
18 COL MAYER: So, I guess my point in
19 that, ma'am, is it's for a career. So, if you
20 take section leaders at a one-to-ten ratio and
21 then you have an RCC which is trained in all
22 of the different recovery and transition,

1 perhaps not an expert specifically in the
2 transition and finding careers, but you have
3 leaders that care, that are concerned and that
4 are looking to build futures so these Marines
5 and their families know their best days of
6 their lives aren't behind them if they're
7 still to come, and then we have three unit
8 transition coordinators down at Camp Pendleton
9 that belong to the greater battalion.
10 The pathway is there for the
11 careers and education, opportunities in
12 leading the Marines into great careers.
13 And so, I mean, I think it's
14 established once again you do have the tyranny
15 of distance, but that's not any different from
16 the Marines that are transitioning out of 7th
17 Marines and going out to -- transitioning out
18 to the civilian world, too.
19 I mean, that is a challenge across
20 the board, not just with wounded warriors.
21 But at least we have the structure in place to
22 work on it.

1 DR. PHILLIPS: Just a question.
2 Are you having difficulties hiring
3 people because of the remoteness, I mean,
4 getting people on board and people
5 transitioning out because of the remoteness?
6 COL MAYER: So there's always
7 challenges in the more remote places. You'll
8 find if you talk to the medical side, too, is
9 getting civilians down to Camp Lejeune.
10 Personally, I like Twentynine
11 Palms. I'd love to go out there. So, I guess
12 you have to find the right person, but you can
13 find quality people.
14 And of course in the military, we
15 just assign them there. And so, that works as
16 well.
17 MS. DAILEY: And, ladies and
18 gentlemen, sir, if we can get you to make one
19 more point, we really kind of need to wrap.
20 COL MAYER: Right. Okay. So, the
21 IDES. Let me just say this: The IDES for
22 Twentynine Palms, I know we were asked that.

1 And I know there's a distance and the PEBLO
2 ratio and all that.
3 Right now there's 90 total
4 enrolled in the IDES process at Naval Hospital
5 Twentynine Palms. Of those, 69 have completed
6 the MEB phase in under a hundred days and 21
7 are currently working at completing it, but
8 they're under the 100 day kind of the mark
9 that's set. Only one is exceeding the
10 hundred-day goal.
11 So, across the board that is a
12 good ratio for moving along smartly in meeting
13 the current system and the standards set for
14 the IDES.
15 So, there might be distance in
16 there and all that, but I think the hospital,
17 the Wounded Warrior Regiment and the whole
18 base that provides transportation and all that
19 are working to make it possible.
20 Okay, ma'am. Are we set?
21 CO-CHAIR CROCKETT-JONES: We are
22 good. Thank you very much.

1 CO-CHAIR GREEN: Okay, folks.
2 We're getting ready to move into discussions
3 again regarding our findings this year. And
4 I'm going to take a little leeway up here as
5 a co-chair and give us a short break and then
6 we'll come back.
7 So, let's take ten so you can get
8 rid of that coffee, and then we'll come back
9 everybody fresh. Thanks.
10 (Whereupon, at 8:47 a.m., the
11 above-entitled matter went off the record and
12 resumed at 9:01 a.m.)
13 CO-CHAIR CROCKETT-JONES: Okay. I
14 think actually we can begin with the review of
15 the topic of non-medical case management.
16 Last year we created
17 Recommendations 3, 4, 6, 13 and 14 which
18 related to this topic. Effectiveness
19 documents for these topics can be found in Tab
20 I.
21 This topic falls under restoring
22 into society. So, command Sergeant Major

1 DeJong and Captain Evans and I will -- I guess
2 we're supposed to lead this. Though, I'm not
3 sure we've coordinated it all.
4 MS. DAILEY: Well, let me --
5 CO-CHAIR CROCKETT-JONES: You want
6 to give us some push?
7 MS. DAILEY: I'm happy to give you
8 all a moment to process.
9 In your Tab I you have the
10 effectiveness document. And just kind of as
11 an introductory, your non-medical case
12 management is going to include your RCCs, AFW2
13 program, the AW2 program. It's going to
14 include services such as the DISCs provide.
15 It's the Navy Safe Harbor program.
16 It is a non-medical case
17 management piece that you see out there.
18 We'll get into in the third hour, the medical
19 case management.
20 Some of the other interpretations
21 of non-medical case management also includes
22 services provided by squad leaders in the

1 Army, section leaders in the Marine Corps and
2 their chains of command are providing non-
3 medical case management.
4 And the last distinction I would
5 like to make -- but keep in mind we've put
6 units and programs in another section also.
7 So, this is going to kind of run together a
8 little bit, non-medical case management and
9 units and programs. It's kind of why we have
10 them together.
11 There is a distinction though,
12 ladies and gentlemen, between non-medical case
13 management and RCCs. In the Department of
14 Defense Instruction, an RCC has an oversight
15 responsibility. And the RCC has a
16 responsibility for the Recovery Care Plan.
17 There's a different set of
18 responsibilities for the non-medical case
19 management in the DoDI. And so in the DoDI,
20 the RCC and the non-medical case management
21 are split out.
22 We've captured them in one

1 document, but keep in mind you'll find the
2 RCCs doing a lot of non-medical case
3 management. But, in fact, they kind of have
4 more of an oversight responsibility, and they
5 also have a primary responsibility for the
6 Recovery Care Plan.
7 CO-CHAIR CROCKETT-JONES: Thank
8 you.
9 I think that we have -- we have
10 some issues under non-medical case management
11 that we've seen consistently throughout
12 installations.
13 Continuity of staffing for non-
14 medical case management, these are often roles
15 given to reservists one year at a time.
16 We hear a lot of complaints about
17 once you get to know someone, they're gone.
18 They take a long time to come up to speed.
19 This is at least the issue that we
20 see. I'm not sure if we have opinion -- if
21 you -- I want to hear opinions from folks on
22 what the resolution to that is. Is this

1 something we want to speak to in our
2 recommendations?
3 I know that we see some other
4 issues, but do we want to tackle this like
5 sort of one thing at a time, or do you guys
6 want to hear some of the other things I think
7 are issues with non-medical case management?
8 CO-CHAIR GREEN: Go ahead.
9 CO-CHAIR CROCKETT-JONES: Okay.
10 I'll keep going.
11 The other issue that I think we've
12 seen with non-medical case management is that
13 eligibility to get non-medical case management
14 seems to be inconsistent from service to
15 service.
16 The Army AW2 program relies on a
17 rating in order to qualify, which means you're
18 getting that level of non-medical case
19 management late in the game.
20 And the -- not everyone has an
21 RCC. We've just heard about definitions
22 regarding RCCs as non-medical case managers

1 that are inconsistent with what we see in
2 practice. And we've got to add Navy med hold
3 and whether they're -- and the definition of
4 "Category 2" being clear and usable as
5 something we want to tie to non-medical case
6 management eligibility, is the second thing.
7 I can probably keep looking for
8 issues for us to think about if you really
9 need me to, but there's two things right on
10 the board there that I know we've seen,
11 staffing and eligibility for this resource.
12 CO-CHAIR GREEN: So, if I can also
13 help kind of bring this together, so when I
14 looked at the ones that are associated with
15 non-medical case management. And so when you
16 pull these out based on the two, four, five,
17 six, seven, 12 or 16, five, six and seven we
18 said that they had met. And so, we were going
19 to possibly include some things about good
20 progress and ongoing.
21 Two and 16 we said were kind of
22 the issues about the standards for WTU and the

1 SFAC -- beyond the SFAC, but really how we
2 decide how many we're going to keep and codify
3 how we're going to do that. And then Four was
4 on the CTP, CRP. And 12 was on the training.
5 So, to dovetail just to stay with
6 where you started this, I think that the
7 Number 12 on training is something that we
8 could basically leverage some of the things
9 that you're talking about and we need to kind
10 of sort out. Plus, an expansion of last year
11 in terms of the training that's required and
12 the manning that the ratios perhaps even is
13 something associated with that.
14 And then the question I have is,
15 is there something that's not covered?
16 Something new that we've seen that's not kind
17 of in what we were -- what we talked about
18 last year.
19 So, how much of this is an
20 expansion of what we saw last year versus
21 something new that we want to talk about this
22 year.

1 CO-CHAIR CROCKETT-JONES: Okay. I
2 think we sort of did not look -- one of the
3 things that we missed last year though it --
4 the issue existed, was the idea of who was
5 eligible for non-medical case management and
6 how that is standardized across the services.
7 It shouldn't be that if you are in
8 one service, you get access early on to
9 someone guiding you and if you're in another
10 service, you've got to be pretty much with
11 your retirement date in hand before you get
12 those services. It seems really inconsistent
13 to me.
14 So, I think that -- I think that
15 we need to look at eligibility for non-medical
16 case management and standardizing it.
17 I think that tying it to a better-
18 defined, you know, we see it somewhat tied to
19 saying, you know, like eligibility into a
20 transition unit means Category 2 and 3. Not
21 everyone who gets in there is also going to
22 get the non-medical case management.

1 It seems unclear how whether
2 people are really sticking to the criteria as
3 defined as what is a Category 2. I mean, we
4 have to decide do we want to say this is what
5 we see, this is Category 2 and this should get
6 you non-medical case management, or is that
7 too broad?
8 MSGT MacKENZIE: Well, I think
9 we'll come up with a point on that, but, you
10 know, let me add a little bit to this.
11 Non-medical case management is a
12 critical piece in the recovery process. The
13 level of non-medical stuff that your medical
14 team knows depends upon their experience and
15 where they're at, not because that's the best
16 way to go, you know.
17 I always looked at it being at the
18 bedside and interfacing with the medical
19 folks. That was my job, you know. These guys
20 are busy trying to fix my guys. It's up to me
21 to make sure that they get the information
22 they need to make effective decisions.

1 And so the non -- I think the non-
2 medical case management is extremely critical
3 here, but we need to make it -- I do believe
4 it's, hey, across the board, you know.
5 And I know the Air Force is
6 changing their program. But it's like, you
7 know, the first time somebody sees a non-
8 medical case manager in the Air Force should
9 not be when they're going through the med
10 board, you know.
11 It should be right -- that
12 particular category should be all the way
13 through and, you know, they are addressing
14 that and they're making that change, you know.
15 We pick them up within SOCOM from
16 point of injury, you know. We've already got
17 that piece in play.
18 That's part of why we're so
19 successful, not because we give better medical
20 care. But I think that non-medical management
21 and discussion and interaction and advocacy is
22 what makes a more informed family and a more

1 informed servicemember, which is more
2 successful in the recovery process because
3 medical care is all the same.
4 It's that non-medical piece that I
5 think really provides an enhancement to the
6 recovery process.
7 CAPT EVANS: So, is it the RCC's
8 responsibility to solely manage that recovery
9 care plan so they do not provide any of the
10 non-medical care functions?
11 MS. DAILEY: According to the
12 definition of the DoDI, for example, you have
13 non-medical case management embedded in the
14 programs. It's the community readiness
15 consultant for the Air Force. They're doing
16 a lot of hands-on walking of the families,
17 getting them connected with the military life
18 consultant.
19 So, it is interpreted differently
20 in the services. I would say that there are
21 supposed to be other resources doing those
22 types of things and the RCC is overseeing

1 them.

2 Now, we all see the RCCs doing a

3 lot of non-medical case management. But, for

4 example, in the Marine Corps a lot of that

5 non-medical case management is being done by

6 the squad leader, the detachment and the

7 battalion. They come in, they talk to them

8 about their pay. Talk to them about ensuring

9 that they've got other resources available to

10 them. And the RCC is supposed to be

11 overseeing that process.

12 It is a matter of engagement and

13 the aggressiveness of the individual who's

14 doing the RCP.

15 MSGT MacKENZIE: And that CRP, is

16 that accountability tool? I mean, you know,

17 it's been mentioned before where it's a

18 documentation device by the RCC. But I really

19 see that, I believe, if I understand

20 correctly, that's always been in place as

21 accountability to make sure those things are

22 being addressed and tracked for the warrior

1 and her family.
2 And that's where I think we see a
3 huge disparity is how that recovery plan is
4 instituted across the board.
5 CAPT EVANS: I think that's where I
6 would like to recommend that recovery plan as
7 far as the RCC.
8 So, I think we really need to have
9 a better monitoring system of the warrior and
10 that recovery plan. And if the RCC has that
11 sole responsibility, then they should be -- we
12 should be able to see some feedback.
13 And the warriors, I mean, from the
14 focus groups that I attended, they had no idea
15 that they had a recovery plan.
16 So, right there I think the RCC,
17 you know, we know that they receive a
18 training. We know that's being done by OSD,
19 but there's still a gap between what we see in
20 the field and what's actually happening in
21 that training.
22 CO-CHAIR CROCKETT-JONES: I'm a

1 little concerned that if that's the job of the
2 RCC, that not everyone has an RCC who has, you
3 know, who qualifies for these programs. And,
4 you know, I think this is a serious gap.
5 If we're going to say and that
6 RCCs are the -- where the buck stops for
7 oversight of tracking that plan and seeing
8 that people are connected to the resources
9 they need, then everybody who meets the
10 criteria should have an RCC.
11 MS. DAILEY: That is the intent.
12 It was the intent of Dole-Shalala that a
13 Category 2 individual who could be classified
14 as a Category 2, they would have an RCC and
15 they would have a recovery care plan. That
16 was the intent.
17 In kind of an effort to address
18 that, we tried to get the services to redefine
19 or clarify their definitions last year. This
20 year you said you want to kind of come back to
21 the definition process. You might want to
22 narrow it down again to Category 2. Everyone

1 knows a Category 3.
2 In the non-medical case
3 management, you might want to recommend a new
4 definition for Category 2 that allows the
5 services or recommends to the services if
6 they're in this area, they're getting these
7 types of services, they get an RCC if they
8 trip these triggers, they meet these criteria.
9 And be specific.
10 CO-CHAIR GREEN: I think that would
11 be helpful. Honestly, the difficulty in terms
12 of the people who don't have the RCC, okay,
13 because they fall into that section of
14 Category 2 that doesn't get that, is creating
15 confusion, honestly, even at the service
16 levels.
17 So, do you -- when you start
18 dealing with the ill and injured, okay, in
19 particular that may fall into, you know,
20 somehow they make it into the Category 2, the
21 problem becomes, you know, are those folks
22 getting RCCs or not.

Do you have demand to that additional workload, or are you going to keep that in your historical system? And so, I can talk to the Air Force having some issues with that.

It also kind of helps define what level of non-medical case management you're going to have.

So, clearly when you go to the WWR, you have your first order of non-medical case management is actually the platoon sergeant and that -- they don't call them a squad leader, okay? Squad leader, sorry.

And then, you know, just beyond that you have -- what's the next level? It's not the RCC. There's an FRC or -- is it the RCC and then the --

(Speaking off mic.)

CO-CHAIR GREEN: But I thought there was another one besides the --

CO-CHAIR CROCKETT-JONES: Is it two in the Army?

1 CO-CHAIR GREEN: Yes, I thought
2 there was even in the Marines, I thought there
3 was another level of non-medical case
4 management. Not an FRC, but like a PRC or
5 something. No?
6 CO-CHAIR CROCKETT-JONES: They have
7 transition unit officers, I believe. They
8 have some other service-specific non-medical
9 services folks like are they FLOs or family
10 readiness folks, but they are not, like,
11 assigned to the person.
12 CAPT EVANS: It's usually the RCC
13 and the squad leader. They're usually
14 assigned together.
15 CO-CHAIR GREEN: A FLO is a good
16 example, okay. We tend to assign FLOs to the
17 wounded coming back.
18 CAPT EVANS: Right.
19 CO-CHAIR GREEN: Okay. But there
20 may be people with equally serious problems
21 that are -- that don't necessarily have a FLO.
22 And so, that, you know, those

1 discrepancies are the things that create
2 confusion in terms of how we do this.
3 CSM DeJONG: But that takes us back
4 to Recommendation 1 from last year of defining
5 "recovering warrior," defining -- how we
6 define our wounded, ill and injured. Because
7 based off of their definition, they're granted
8 certain levels of care, certain eligibility
9 for certain things that other ones based on
10 their labeling are not, sir.
11 CO-CHAIR GREEN: I don't disagree.
12 So, then the question is -- I think we're back
13 to where Suzanne started. So, most of that
14 confusing area is in that Category 2. And so,
15 should we give them some specific inputs in
16 terms of what we think actually is the way to
17 discriminate, if you will?
18 MS. DAILEY: And on Page 1 of the
19 discussion points we did try and break that
20 out for you.
21 CO-CHAIR CROCKETT-JONES: I think
22 that basically if we can be clear on what is

1 Category 2 and creates eligibility for that
2 oversight, you know, then it's not saying that
3 each person who gets an RCC needs every
4 resource that's out there or every level of
5 non-medical case management, but they need
6 someone to decide if what they are getting and
7 connected to is the appropriate level of case
8 management.
9 And as long as we've got, you
10 know, this lack of clarity and different
11 people filling all those different things,
12 there's no standard for are we getting the
13 right level of resources to the person that's
14 going to get them through the process and
15 transitioned well.
16 MS. MALEBRANCHE: So, Suzanne, what
17 I'm thinking may be the definition of the RCC
18 because if that person is skilled and has
19 oversight of the other pieces, and maybe we
20 need to define that oversight and what, I
21 mean, that's really getting kind of into the
22 weeds, but it sounds like it might be

1 necessary.

2 CO-CHAIR CROCKETT-JONES: Well, I

3 think if we are clear on the definition of

4 Category 2 and eligibility, if we can create

5 a recommendation to reword the category

6 definition, then we can basically tie it in

7 that recommendation saying that those who are

8 -- meet this, are eligible for an RCC

9 oversight to get them the -- we can include in

10 that recommendation why this -- why this

11 definition of Category 2 needs to be clear and

12 specific.

13 MS. MALEBRANCHE: Let me just ask

14 another question because I'm not familiar with

15 this, if you don't mind.

16 So, I understand the Category 2

17 being eligible for this, but what if someone

18 else wanted an RCC? Are they excluded from

19 this or, I mean, there are other folks that

20 might need one that aren't necessarily in that

21 category.

22 I thought that that was supposed

1 to be available. Is it different in every
2 service or, no, they're just not able to?
3 CO-CHAIR CROCKETT-JONES: Now, if
4 they don't meet the eligibility requirements,
5 they don't get that resource.
6 They have other -- they can access
7 non-medical resources on their own. It
8 doesn't stop them from getting, say,
9 assistance at an SFAC, but having that
10 oversight is something that is tied to an
11 eligibility requirement.
12 MS. MALEBRANCHE: So, those that
13 aren't defined in Category 2 are probably --
14 or maybe they are defined in Category 2, but
15 seen differently. They're probably doing that
16 now.
17 CO-CHAIR CROCKETT-JONES: Yes. The
18 question is, it seems that what constitutes
19 Category 2 is definitely not clear.
20 I mean, we see that in med hold,
21 in the Navy med hold that we were frustrated
22 with yesterday.

1 If they've got -- Navy med hold
2 considers those folks Category 1 for the most
3 part. I mean, at least 50 percent of them
4 Category 1, and yet they are there for way
5 more than six months. On average, their
6 number is closer to a year or more.
7 But by definition, they're going
8 to multiple appointments every week, they're
9 taking more than six months, they have a 50
10 percent chance of being transitioned out, but
11 they're not calling them Category 2.
12 The language of Category 2 allows
13 them to be very gray on this. I think we need
14 to get it very clear.
15 MSGT MacKENZIE: Let me ask this
16 question --
17 CO-CHAIR GREEN: Do we have the
18 actual language of Category 2? Based on this
19 discussion, do we have something we can put in
20 front of us?
21 MS. DAILEY: Yes, sir. It's on
22 Page -- let me see. It's in your effective

1 DISC document. Tab J. Page what?
2 (Speaking off mic.)
3 MS. DAILEY: Yes, Page 1 of Tab J.
4 And, in fact, these are congressional
5 definitions. Congress in kind of an effort to
6 get everyone, services, told DoD that these
7 would be the categories.
8 MSGT MacKENZIE: So, the question I
9 have is those folks at Portsmouth when you
10 guys were there, those folks that are being
11 considered Category 1, were they receiving the
12 services of a nurse case manager because of
13 multiple appointments, etcetera, etcetera?
14 So, I'm not saying that medical
15 and non-medical should -- each decision point
16 should be tied to one another. But it almost
17 sounds like if the person's condition has
18 accelerated to the point where they require
19 nurse case management, obviously their
20 situation has risen to the level of Category
21 2 within non-medical care management.
22 CO-CHAIR CROCKETT-JONES: I think

1 this goes back to the topic, though, that
2 we've discussed before. And that is whether
3 they're likely to be separated or not.
4 DR. PHILLIPS: Let me just pose
5 something in thinking about this. What if we
6 said everybody gets an RCC, you know? You had
7 a lot of Category 1s -- no, wait. Let me
8 finish.
9 You had a lot of Category 1s and
10 they probably would not have much work to do
11 or not at all. But if they need something,
12 they could get it. I don't know.
13 MS. MALEBRANCHE: I'm hearing you.
14 And that's one of my thoughts in looking at
15 this because we have serious illness or
16 injury, and then I don't know how that's
17 defined.
18 But also I know depending on
19 illness or injury, there are psychosocial
20 issues that complicate a person's illness
21 whether it's serious, severe or not, that can
22 make that person a very needy person of these

1 non-medical pieces and I don't know what that
2 does.
3 But, again, if it's oversight, I
4 know for, you know, heavy-duty case management
5 you need to -- hands on. But if it's
6 oversight, what if this person has major
7 psychosocial issues or, you know, family
8 living things that -- and maybe it's serious,
9 but not serious in the term of -- I'm not
10 quite sure how we'd label that. Just a
11 thought.
12 MS. DAILEY: Serious psychosocial
13 if I -- and based on the education of the
14 four, serious psychosocial would resonate with
15 commanders, would resonate with medical
16 providers, would resonate with your community-
17 family advocacy programs. And they're able to
18 plug into the resources of the wounded warrior
19 communities.
20 That does trigger these resources.
21 If someone is coming up through one of these
22 channels and someone says this is a serious

1 psychosocial, do we need a case manager? Case
2 manager then might say, I think I need an RCC,
3 theoretically.
4 DR. PHILLIPS: Well, what I was
5 just indicating and saying, sometimes it may
6 be an easy solution not to have to make a
7 decision than just simply say everybody is
8 covered.
9 And then case by case, you could
10 decide how much effort needs to be put into a
11 particular individual.
12 CO-CHAIR CROCKETT-JONES: I think
13 we'd then still be -- my concern is that we
14 would find ourselves next year saying now we
15 need to define when the RCCs provide more over
16 -- do you see what I'm saying?
17 DR. PHILLIPS: But that could be
18 good. Then we'll get feedback. I'm just
19 saying which is the path of least resistance,
20 which is easier to do? Go through all these
21 little steps to try and help the folks out
22 there decide and define and put people under

1 stress on both sides, the caregivers and the
2 needy, or just saying, okay, everybody can
3 have a shot at it and we'll revisit it in six
4 months or a year and see if it works?
5 CO-CHAIR GREEN: I guess the
6 question is that as soon as you do that, then
7 you've got to also work the ratios of RCCs to
8 numbers of people, which then drives a
9 personnel -- et cetera.
10 And so, let's not talk Wounded
11 Warrior for just a second. Let me take you
12 out of that and think about ill and injured
13 and the way we've done it in the past.
14 So, an ill and injured
15 servicemember prior to all the things that
16 have happened over the last five to ten years,
17 essentially was identified via a profile in
18 terms of what was going on.
19 If it went greater than a year,
20 okay, then typically they were -- they were
21 looked at by the system pretty much across all
22 services because one year is kind of what the

1 max extent of a profile is.
2 And then they were -- the
3 determinations were typically locally as to
4 whether or not they were subject to a medical
5 board. They had to be reviewed at one year,
6 but if they were in the year of process of max
7 medical benefit, you know, hadn't gotten max
8 medical benefit.
9 So, there are many people who stay
10 on active duty with cancers, okay, that are in
11 remission or, you know, you name the medical
12 problem, post-heart attack.
13 And so, technically the one-year
14 time frame is when they were reviewed by the
15 system as to whether or not they were really
16 qualified.
17 That doesn't always work, because
18 doctors make decisions that they haven't met
19 maximum medical benefit, they'll submit the
20 medical boards, but almost all services use
21 one year. I think that's true. Army, Navy,
22 Air Force, I think we all use one year for ill

1 and injured in terms of how it goes.
2 Now, here's the problem. So, if
3 you say that everybody needs an RCC, then in
4 essence the system that currently takes care
5 of those folks when they need that kind of
6 information, they go talk with their local
7 military personnel, flight or military
8 personnel representative on the base to kind
9 of find out, well, what are the implications,
10 what can happen.
11 Or they come to the medics and
12 they get information. They can even talk to
13 a PEBLO ahead of time. Or they go talk with
14 an ADC or, you know, the lawyers. They can
15 get -- this is, again, pre-Wounded Warrior.
16 They can call and get advice or
17 talk to the lawyer who talks with the PEB
18 lawyers and essentially getting this stuff.
19 None of this has anything to do
20 with Wounded Warrior. But what I'm trying to
21 say is that the services that you're thinking
22 that RCC only provides are available in every

service on every base, okay, to a certain extent, because that's where people get information.

So, you don't necessarily want to ignore the fact that you have something that's preexisting that does that when you say we're going to have -- inject this RCC thing, okay.

And so, the real question becomes what is it that triggers the RCC's involvement?

So, at my level if I looked at ths, I would say when the -- and this isn't -- doesn't happen today. But when our deployment -- deployability, you know, the DAWG when it meets, if those folks feel that this is somebody who's going to need an RCC, it would be nice if they could actually say this is a candidate for that, okay.

Because basically you're looking at somebody who has potential for long-term disability, and you want them to be thinking about what are their options.

1 But I don't know that that -- that
2 doesn't exist in all the services. So, now
3 come back.
4 The hardest part in this is
5 unlikely to return to duty within a service-
6 specified time. I don't know what that means.
7 I mean, that's a very difficult -- okay.
8 So, I mean, it would be easier to
9 say one year, because all services basically
10 use one year to review it.
11 And so at the time of review, the
12 review would say, yes, this person is probably
13 not going to make it back and then RCC gets
14 involved, or, no, there are still things that
15 can be done that we think will keep this
16 person on active duty, and for whatever the
17 condition is. I mean, that's what happens
18 today -- or happened even before Wounded
19 Warrior.
20 So, if we want to insert an RCC,
21 maybe the place to insert it is at the point
22 when they're thinking that they're going to

1 enter the MEB system, but I'll tell you the
2 problem.
3 A huge number of people, okay, get
4 that MEB at one year, get a review of some
5 kind, and then they are still returned to duty
6 with a -- with a -- I'll use Code C, which is
7 what we use, a Code C to identify people who
8 have a medical problem that may present some
9 restriction.
10 But still when almost, I would
11 think, I think it's like 70 -- or 70 percent
12 or greater that even in a year they're
13 retained on active duty.
14 So, do you really want to create a
15 workload for an RCC that 70 percent of them
16 are going to come back to their primary job?
17 CO-CHAIR CROCKETT-JONES: We have
18 another issue though. We've defined -- if
19 they have a transition plan, they're supposed
20 to have an RCC by definition.
21 By giving the responsibility of
22 that transition plan to the RCC, it's implied

1 that everyone who has one has an RCC and we
2 know that's not the case.
3 CO-CHAIR GREEN: And when you're
4 talking about wounded, okay, so let amputee --
5 let's use a simple -- a single-limb amputee.
6 So, they're technically going to get an RCC
7 right up front. And the reason is because
8 they have to be boarded in order to be
9 maintained on service. So, everybody knows
10 they have to be boarded.
11 Okay, but there's unfortunately
12 when you get into the ill and injured stuff,
13 it is very subjective. And so -- it is very
14 subjective.
15 MSGT MacKENZIE: One of the things
16 that I was -- and I'll go back to my original
17 thought process on this though. When do you
18 folks medical-wise say, hey, this individual
19 needs a nurse case manager?
20 I mean, when things are getting
21 complex where you get into like more than one
22 specialty where these things are getting

complex, it's obvious that it begins even on illness or injury.

I mean, is there a decision point on that?

CO-CHAIR GREEN: But even the nurse case manager -- so, if you use an inpatient stay, for instance, they may well get a nurse case manager because they've been in a motorcycle accident and have several fractures and they're also requiring some follow-up, I mean, so you're going to get a case manager.

You could even get a case manager technically because of high frequency of use, okay. And so, you know, somebody who's trying to help you with utilization so that you're not guessing where you should be going.

So, I don't think you can use when a nurse case manager is assigned, because we do too much nurse case management that's for acute transient illness and injury.

MS. MALEBRANCHE: I guess the other thing is so it sounds like some of our

1 definitions have to be re-looked, but maybe
2 not everybody has to have the RCC. But those
3 that request it shouldn't be denied, is what
4 I'm thinking.
5 I don't know how many people would
6 actually request, but I do know that somehow
7 like some of them feel like they need an RCC
8 or an FRC. I don't know how many because --
9 but some use that person more than other. But
10 I don't think anybody should be denied that,
11 I guess is what I'm wondering.
12 I don't know what that does
13 ratios. And I know about, you know, the high
14 frequency, high volume, that sort of -- those
15 folks probably we identify them, but what if
16 somebody self-identifies?
17 That's, I guess, kind of the only
18 thing I'm thinking.
19 MR. REHBEIN: And along with what
20 Karen was saying thinking about colonel Mayer
21 a minute ago because they have Marines that
22 fit the criteria for Category 2, but remain in

1 line units.
2 Do they get an RCC? Do they have
3 a CRP and how is this whole thing
4 administered? Is that part of the resources
5 that they wish they had access to, but they
6 don't because they're in the line unit?
7 That's kind of some of -- one of
8 the questions -- some of the questions that
9 occur to me as I listen to the discussion
10 here.
11 CO-CHAIR CROCKETT-JONES: Yes, and
12 I think that that's one of the gaps we've been
13 seeing is that those in line units that are
14 really likely to transition out directly from
15 the line unit, which happens more frequently
16 than in -- wasn't it Marines that had the
17 highest -- higher -- that they had a fair
18 number of folks who go through med board in
19 the line units?
20 And, yes, the question is that
21 they seem to when we look, they don't
22 necessarily get access to good resources in

1 transition because they are not tapped into
2 non-medical case management.
3 I mean, their unit command is not
4 trained to do that. So, it would seem if we
5 define the Category 2, we might, yes, open up
6 a need for RCCs to cover folks that are still
7 in the line unit.
8 But I don't think that's a -- I
9 think that's a positive.
10 LTCOL KEANE: Marines are getting
11 RCCs in the line unit. A VSI or SI Marine
12 that comes to the casualty branch that comes
13 to Wounded Warrior Regiment, within 24 hours
14 an RCC is assigned. Within 72 hours RCC
15 either meets in person or speaks on the phone
16 with that Marine.
17 Not every Marine who is in the
18 line unit rates an RCC.
19 CO-CHAIR CROCKETT-JONES: I
20 understand that. I'm not sure -- I know that
21 that's the system.
22 CO-CHAIR GREEN: But all the Air

1 Force, I mean, because we keep everybody in
2 their line units, all the Air Force people
3 followed by an RCC are in their line unit.
4 CO-CHAIR CROCKETT-JONES: Yes.
5 CO-CHAIR GREEN: So, I mean, it's
6 not uncommon for an RCC to --
7 CO-CHAIR CROCKETT-JONES: Yes, it's
8 not uncommon. Yes, it's not undoable.
9 MR. REHBEIN: I'm just asking about
10 consistency across the board because that
11 seems to be a subject of a lot of concern
12 here. And that was a gap in my knowledge,
13 frankly. I was just looking for
14 clarification.
15 CAPT EVANS: One question.
16 RCC program started in 2008, I
17 believe. Their sole function is to manage
18 this Recovery Care Plan, which we found a lot
19 of gaps, we found not as effective as we would
20 like to see it.
21 Is there another entity that
22 manages the Wounded Warrior that can take that

1 function on?
2 Do you truly -- we have recovery
3 care plans for the FRC. We have case managers
4 that document their plan. It's a lot of
5 redundancy with recovery care plans out there.
6 Each entity if you look at the VA
7 system, they have a plan for the recovery
8 member.
9 Do you find value in the RCC? Do
10 we have to have those three redundant plans
11 out there? Is there another entity we can
12 look at to do that function?
13 CO-CHAIR GREEN: I think the
14 difference is that the RCC's job is to be the
15 overarching.
16 So, in other words, whereas the
17 medical case management is going to take them
18 so far, the RCC's goal is to make sure that
19 they don't have a gap in benefits as they get
20 ready to go to the, you know, whatever is
21 next.
22 The harder -- I understand what

1 you're saying. Do we really need RCCs? So,
2 you're actually saying is there somebody else
3 that can do it?
4 It's an interesting question
5 because, I mean, it's something that's been
6 added. And so, clearly we didn't have it
7 before.
8 And so as I started off, a lot of
9 this is done locally; airman and family
10 readiness centers, the -- I'm sorry, the --
11 what is it called? The SFAC for the Army. I
12 don't know the Navy's version of that.
13 CAPT EVANS: We have the Fleet and
14 Family.
15 CO-CHAIR GREEN: Fleet and Family.
16 And so --
17 MS. DAILEY: But, yes, and Safe
18 Harbor provides a lot of those non-medical
19 case managements and RCC.
20 CO-CHAIR GREEN: Right. So, we all
21 have those things on the bases that basically
22 now a family in stress goes to the Airman and

1 Family Readiness Center. Farm and -- I would
2 say farm and fleet, I'm sorry. My daughter
3 just drove me crazy with some of her stuff,
4 interacting with that, so -
5 CO-CHAIR CROCKETT-JONES: Well, I
6 think that we've also got to differentiate the
7 RCC is an oversight. It's not a service
8 provider.
9 The services exist. The question
10 is do they need someone making sure that they
11 connect to them.
12 I also see a secondary thing, and
13 just from hearing from Colonel Keane who said
14 seriously and very seriously injured and I
15 want to know how that relates to Category 1,
16 2 and 3, I think we've got some definition
17 issues here.
18 If people are using multiple
19 definitions, I thought that seriously and very
20 seriously injured were all under Category 3.
21 I might be wrong.
22 MSGT MacKENZIE: And there are also

1 -- but there are also medical terms that
2 change as the condition improves. And I
3 think, correct me if I'm wrong, that is only
4 upon initial injury. That status that is
5 initially assigned thereby labels that Marine
6 is requiring an RCC from the beginning.
7 Okay. It's initial point-type
8 thing because the medical folks are going to
9 change that status as that condition improves
10 so it's not one of those things that follows
11 back up.
12 But what I look at is in my case
13 as a wounded warrior within the Air Force, I
14 have an AFW2 advocate. I don't qualify for an
15 RCC, okay.
16 So there, my advocate's looking at
17 X, Y and Z on where I'm going and that kind of
18 stuff, but it's not the Recovery Care Plan.
19 It's just the AFW2 program looking at making
20 sure I'm getting those resources.
21 Which is kind of the same way that
22 the Care Coalition operates, which is the non-

1 medical management looking at it to make sure
2 all those resources are there. And it --
3 which is why we have absorbed our RCCs,
4 because it's a variable position, but somebody
5 needs to maintain that those events are
6 happening.
7 The Recovery Care Plan is a very
8 useful tool to make sure everybody is getting
9 what they need and that somebody - that that's
10 an accountable tool.
11 The question is does it rely in
12 just one area, or is this a tool that needs to
13 be a document that moves with the wounded, ill
14 and injured along the way?
15 CO-CHAIR CROCKETT-JONES: And I
16 have to say we've got a lot of behavioral
17 health folks who wind up being likely to
18 separate who would not qualify because they
19 didn't start out very seriously or very
20 seriously injured, necessarily.
21 So, and maybe those are some of
22 the folks that need the most targeted amount

1 of management. I think I just keep coming
2 back to it's a definition problem.
3 MS. MALEBRANCHE: Well, you know,
4 this is interesting Ms. Crockett-Jones brings
5 this up.
6 We at the previous OIPT, went
7 through definitions, I think, for almost two
8 years trying to come up with some.
9 And one of the things I think
10 that's not readily recognized is that just as
11 Sergeant MacKenzie mentioned, personnel uses
12 very seriously injured, seriously injured in
13 an administrative way sometimes even to get
14 orders or like invitational orders or families
15 put together.
16 In the medical field, VSI and SI
17 is very different. You report on those every
18 morning. They are not the same. So, how they
19 work -- but they do need to have non-medical
20 case management.
21 When they're very seriously
22 injured, oftentimes from the medical

1 perspective they'll have nurse case managers
2 perhaps. But because of family situations,
3 families coming in or if it's a personnel
4 activity, it accommodates certain things.
5 So, I think it is a definition
6 problem, but that is a huge undertaking. And
7 a lot of -- a lot of work I think had been
8 done. I don't know exactly what's happened
9 with all that in terms of definitions, but it
10 clearly is showing up again.
11 CO-CHAIR GREEN: Correct. And when
12 I worked with the AFW2 program because they
13 were trying to figure out what their manning
14 should be because they have all their RCCs
15 into this. They basically have RCCs for the
16 CAT 3s, and the AFW2 in large part is
17 following the ones that -
18 But the way they define their CAT
19 2 is based on this serious illness or injury.
20 They basically have to be identified on an
21 SI/VSI list.
22 And so the ones that are

1 struggling the most with there, okay, so now
2 how do I capture PTS and TBI? Because almost
3 everything else does come through someplace
4 where you actually can be listed as SI/VSI.
5 The other exception might be
6 cancer treatment because you may or may not
7 make it to an SI/VSI list as you go through
8 cancer therapies, but this is really, I mean,
9 it's a fascinating and difficult problem.
10 It's also interesting that they
11 include CAT 1, but then they leave a lot of
12 leeway in CAT 1 in terms of how we - how they
13 actually deal with that.
14 So, everybody kind of ignores CAT
15 1, okay, and focuses on CAT 2 because of that
16 thing up in that block that says, gets RCC.
17 And so, you know, that's the difference right
18 now.
19 And I don't know. I mean, I
20 honestly don't know. How are you going to -
21 do you have a suggestion for standardization?
22 I mean, we've been traveling a lot for two

1 years. So, is there something that you see
2 where there's a gap especially in the ill and
3 injured?
4 MSGT MacKENZIE: What I found, sir,
5 is just the accountability to document, you
6 know. And that's the - it was, you know, in
7 some places the document is used quite heavily
8 and quite effectively. In other places it's
9 not used at all.
10 And as a matter of fact in some
11 places it's being used, but when you actually
12 look at the document, you know, it's a very
13 ineffective piece of data in that document.
14 MS. DAILEY: You're talking about
15 the Recovery Care Plan?
16 MSGT MacKENZIE: Right, the RCP.
17 MS. DAILEY: Okay.
18 MSGT MacKENZIE: So, the question
19 is, you know, where does the accountability
20 for that document lie and how is that - I
21 think that's where the problem is, not
22 necessarily the - except for PTS, you know,

1 and some of the illnesses. But it's like the
2 document itself is in place, but, you know,
3 you can go to any location and poll and you
4 can tell that there's nobody going, hey, this
5 has to be X, Y and Z.
6 CO-CHAIR CROCKETT-JONES: I also
7 want to say that everywhere we go we see a
8 huge lack of information resources being
9 absorbed.
10 Whether it's the amount of
11 exposure or reinforcement, you know, we - the
12 more families can be drawn in, the more
13 information resources actually get connected
14 because a lot of these folks have real trouble
15 with memory and retention.
16 And I think that if we have a
17 slightly better understanding of an RCC
18 oversight, we'd get a better connection to
19 information resources.
20 I think that RCCs don't
21 necessarily have a well-defined -
22 MS. DAILEY: Well, they do.

1 CO-CHAIR CROCKETT-JONES: They're
2 not really getting -
3 MS. DAILEY: Their duties are lying
4 down Department of Defense Instruction, which
5 was pretty much the first of its kind.
6 CO-CHAIR CROCKETT-JONES: Okay.
7 Whether that's -
8 MS. DAILEY: They're required to
9 provide that information to the servicemember.
10 CO-CHAIR CROCKETT-JONES: Yes,
11 whether that - I'm not convinced it's always
12 happening.
13 CO-CHAIR GREEN: Even the footnote
14 there - so, look at the footnote under CAT 2
15 where it says, CAT 2 or CAT 3 a/k/a recovering
16 servicemember. I mean, so it's very nebulous
17 the way they've done it.
18 Maybe it's done that way
19 purposely, but essentially this because
20 they've defined it so nebulously, is making
21 everything harder to folks because they're
22 trying to find ways to exclude.

1 So, do you pick SI/VSI because it
2 says, serious injury? So, do you basically
3 identify only those that have SI/VSI and then
4 essentially try and do the exception being PTI
5 and PTS? Okay, maybe.
6 All right. So, if you're a
7 patient with breast cancer, okay, and
8 essentially you may well have to have - be
9 medically separated depending on whether or
10 not the, you know, how advanced the disease
11 is, et cetera.
12 And so with that, you'd never do
13 on SI or VSI. Do you need an RCC? I mean, I
14 don't know the answer to that question.
15 CO-CHAIR CROCKETT-JONES: And also
16 if you've got PTSD, but you have returned to,
17 you know, almost near normal functionality
18 after eight visits, do you really - and you're
19 probably going to be retained, not every PTSD
20 -
21 CO-CHAIR GREEN: Right, right. In
22 fact, it's like 90 percent that are retained.

1 So, are you going to give them an RCC?
2 CO-CHAIR CROCKETT-JONES: Right.
3 But the ones who are not going to be retained
4 whose TBI or posttraumatic stress is never
5 going - is not going to be - is going to nix
6 the retention, they do need an RCC. So, we
7 can't let them be excluded, I think.
8 So, I keep coming around that it's
9 - this definition is just too nebulous for
10 those.
11 CO-CHAIR GREEN: Right. So, maybe
12 the solution set, though, I mean, so your IDES
13 system takes roughly - the goal is what? 295
14 days.
15 And so, you're spending almost 75
16 - 45 to 75 days before you see the VA for the
17 physical. So, maybe the place to assign the
18 RCC is the point where they enter the IDES.
19 CSM DeJONG: So, that basically
20 takes us back to where I was talking about
21 yesterday at that medical decision point is
22 where you would get your RCC. And that also

1 could be the conduit into the VA.
2 CO-CHAIR GREEN: Correct. That
3 might be a very clean way.
4 CAPT EVANS: Then I think you're
5 going to go back to your confusion between the
6 RCC and the FRC, because then the FRC comes
7 into play. Same categories, but they start
8 using -
9 CO-CHAIR CROCKETT-JONES: No, FRCs
10 are only for Category 3 very serious.
11 CAPT EVANS: That's what they say
12 they're for, but they get involved with
13 Category 2 also.
14 MS. MALEBRANCHE: And see, that's
15 one of the cases where I think if someone
16 requests an FRC, I have never seen it been
17 turned down. I have never seen them turned
18 down.
19 CAPT EVANS: Right. If they
20 request an FRC, they get FRC. So, I'm just
21 again in working with the RCCs, they usually
22 get involved as soon as - so, 24 hours after

1 the patient arrives, they let them know who
2 their RCC - at least for the Marines and I
3 think the Army side too. I'm not sure. I
4 know for the Marines particularly.
5 And then 72 hours that RCC is
6 entering that room and they're starting that
7 trans - they're supposed to be getting that
8 plan and identifying any of the non-medical
9 issues that patient has.
10 CO-CHAIR GREEN: But I'll bet
11 that's for a CAT 3.
12 CAPT EVANS: And CAT 2.
13 CO-CHAIR GREEN: How do they
14 determine a CAT 2 at that point in time?
15 CAPT EVANS: Well, anyone that
16 comes in with a serious injury and likely may
17 not go back to -
18 CO-CHAIR GREEN: So, are they using
19 serious injury defined as SI/VSI?
20 CAPT EVANS: Yes, sir.
21 CO-CHAIR GREEN: Yes, see. Okay.
22 MS. DAILEY: A lot of them are

1 doing it through their incident report, sir.
2 Fire in a house, severe burns, house fire, car
3 accident, severe brain trauma.
4 CO-CHAIR GREEN: But maybe it gets
5 cleaner then because you say basically if
6 they've been identified as SI/VSI, however
7 that is done, they've been identified as
8 SI/VSI, they will get an RCC.
9 Or if they have not been
10 identified as SI/VSI at the point where they
11 enter the IDES, that would capture it all.
12 MS. DAILEY: Yes, and that is what
13 they're doing now. I wouldn't say that the
14 IDES is the trigger point, but it is a better
15 catch point.
16 The VSI/SI incident report,
17 serious incident reports travel back from the
18 AOR with some sort of medical condition as
19 triggering it. These reports are watched.
20 They're pushed down through the contractor who
21 runs the RCC program.
22 CAPT EVANS: Exactly.

1 MS. DAILEY: I think, though, one
2 of the best ways, though, to describe a gap is
3 when we bring Reserve component on Title 10
4 orders. Is that a trigger point?
5 We've now investing money and time
6 to put them in Title 10. Does that then
7 trigger an RCC and Recovery Care Plan for
8 their rehabilitation and then moving back into
9 their communities?
10 MSGT MacKENZIE: That's a good
11 point.
12 CO-CHAIR GREEN: The question being
13 are the Reserve and Guard being put out of
14 Reserve and Guard without going through the
15 IDESes?
16 MS. MALEBRANCHE: Well, from our
17 Iowa trip I would say, yes, some of them were.
18 It certainly would be a good idea to bring
19 them back in as Title 10, but not all of them
20 get there.
21 CO-CHAIR GREEN: But are they being
22 separated by the system, or are they choosing

1 to leave? There's a difference, okay.
2 And so, if they're simply choosing
3 not to reenlist or not to continue - because
4 I don't think - I'm trying to think if there's
5 a way for them to put them out of the
6 Reserves.
7 There's a non-deployability issue
8 for them. And so, do they avoid a - I don't
9 know enough about the Reserves. Can you help
10 out?
11 CSM DeJONG: This would - if at
12 that point on what Denise said if they did go
13 on to Title 10 and they got assigned the RCC,
14 I think that would help answer a lot of
15 unknown questions that a lot of our Guard and
16 Reserve members don't know the answer to.
17 Which is why some will continue down to the
18 IDES, some will choose to come off of orders
19 and go back home, thus leaving them without a
20 lot of benefits.
21 CO-CHAIR GREEN: Based on our
22 system we were told yesterday from a

1 continuity sell, that 58 percent go on to
2 separate. Forty-two percent return to duty.
3 CSM DeJONG: Right.
4 CO-CHAIR GREEN: So, maybe. I
5 mean, so basically when they come back on
6 Title 10 orders, you say they should have an
7 RCC?
8 CO-CHAIR GROUP: And so, you're
9 hoping to catch 42 percent that don't - that
10 are going to be returning to duty.
11 MS. MALEBRANCHE: Well, you offer
12 them at this point, because they don't have to
13 take, right? Or is this like a - I mean, I'm
14 thinking if you offer -- I think the folks
15 that we spoke to weren't even offered that.
16 And they would have liked that.
17 So, and that does put kind of a
18 burden back on the active component then too
19 when they're back on Title 10, which they were
20 not able to get.
21 CO-CHAIR CROCKETT-JONES: I think
22 it's a pretty - that 42 percent of the

1 Reserves who wind up back on Title 10 that go
2 and return to duty, I think that's a pretty
3 small population.
4 CO-CHAIR GREEN: True, because they
5 have to get the continuity sell first.
6 CO-CHAIR CROCKETT-JONES: Yes.
7 CO-CHAIR GREEN: True.
8 CO-CHAIR CROCKETT-JONES: So, yes,
9 perhaps I think that that is a reasonable
10 overreach to get the people that we are
11 getting missed right now. It's a net.
12 MSGT MacKENZIE: But make sure you
13 clarify either retained on Title 10 for
14 medical recovery, or brought back onto Title
15 10 for medical recovery would qualify them as
16 an RCC.
17 CO-CHAIR CROCKETT-JONES: Yes.
18 MSGT MacKENZIE: For an RCC. And
19 as the sergeant major alluded to, that would
20 certainly tighten up that information problem,
21 that poor decision-making problem, that -
22 because then the person is captured.

1 Somebody, you know, an overwatch
2 is established for that person because those
3 individuals when faced with financial, with
4 family, with geographic situations, they're
5 going to make decision whether right or wrong
6 because it's what's in front of them and they
7 got to do something.
8 But I believe that recommendation
9 is, you know, retained on or brought back on
10 to Title 10 orders for medical recovery
11 qualifies them for an RCC.
12 MR. REHBEIN: Just listening to the
13 conversation, I think attempting to tie the
14 need for an RCC together with a likelihood of
15 return to duty is something of a blind alley.
16 Because the likelihood of return to duty
17 depends as much on the personality of the
18 individual as it does on the medical
19 condition.
20 If that wasn't the case, then we
21 wouldn't see very high returns to duty in the
22 SOCOM community with the same or more serious

1 medical conditions than we see in some of the
2 other branches of service.
3 So, I tend to think that whether
4 or not they will be returned to duty or
5 medically separated, we're trying to use that
6 as a quantification of the medical condition
7 without taking into it any account of the
8 individual characteristics of the person.
9 And I think we need to tie that
10 need for an RCC strictly to the medical
11 condition and do away with that likelihood of
12 return to duty.
13 CO-CHAIR GREEN: The only problem
14 is that if you - the medical conditions are
15 very broad versus the way to capture the
16 medical condition.
17 The reason for the RCC as I
18 understand it, is to make certain that the
19 non-medical aspects of their benefits and
20 things are continuous. So, in other words, as
21 they go through their process.
22 And so, the people you would be

1 worried about any continuity of benefits are
2 people who are identified in IDES where they
3 may be separated. Or if they're in the
4 Reserves, when they come back on Title 10 or
5 are maintained on Title 10 for evaluation of
6 an injury that they may be leaving the
7 Reserves.
8 And so, again you're back to the
9 reason for the RCC is to be following the care
10 plan and making certain that benefits are
11 keeping up with what's happening in the
12 medical case management.
13 So, it does make some sense to tie
14 it to whether or not they're likely to be
15 retained. And that's why - and so, I mean,
16 what I wrote down in terms of that, just keep
17 it into fairly simple three things.
18 So, SI/VSI. So, you could
19 actually make it more specific. Has a serious
20 injury or illness. And then put in
21 parentheses SI/VSI.
22 And then the next one would be

1 upon entry into the IDES system because those
2 are people that now may have to worry about
3 benefits.
4 And finally the Reservists
5 continued or returned to Title 10 orders for
6 a medical condition.
7 Again, even in peace time, okay,
8 if you're returned, then you may have need for
9 an RCC because you may not be a Reservist if
10 as the process is evaluated.
11 So, those three things would make
12 this fairly specific. And the RCC is there to
13 just try to make certain that there's
14 continuity of benefits.
15 It would make it so all three
16 services basically know how to plan and how to
17 use these folks. It doesn't answer the
18 questions on AFW2 or some of the other
19 programs that are tracking people long term,
20 you know.
21 There's a lot of others, the DISC
22 program, I mean, a lot of things that people

1 are doing beyond what's required right now.
2 But for what's required, it would be very
3 specific.
4 MS. DAILEY: Okay. One more time,
5 sir, would you look over your notes? I just
6 want to make sure everyone's got it.
7 CO-CHAIR GREEN: So, CAT 2, the
8 suggestion for change would be has -- stay
9 with the same language. Has a serious injury
10 or illness. And then put in parentheses
11 SI/VSI.
12 And then underneath that instead
13 of unlikely to return, you'd say upon entry
14 into the IDES process.
15 And then under Number 3 where it
16 says, may be medically separated, you put,
17 Reservists continued or returned to Title 10
18 orders for a medical condition.
19 MSGT MacKENZIE: Reserve component,
20 not just Reservists.
21 CO-CHAIR GREEN: I'm sorry.
22 Reserve component, yes. It would make it very

clean.

MS. DAILEY: Okay. All right.

CO-CHAIR CROCKETT-JONES: And we have to be clear that that would be not - that the three - the three items in Category 2, any one of those things would define someone as Category 2.

Right now I believe Category 2 requires that you check all three of those blocks. You'd have to be in all - you'd have to have all of those blocks checked.

So, it needs to be worded to say "or," not "and."

CO-CHAIR GREEN: Right. So, you end each sentence with "or." SI/VSI or upon entry into IDES process, or Reservists continued/returned, yes, that would be better.

MS. DAILEY: Okay. That was an hour discussion. Very good. I mean, I know that you think you kind of ramble, but that's the process, ladies and gentlemen.

So, good - you came to something

1 that we will pull the data together. We'll
2 put our findings behind it and craft
3 recommendation very similar to that.
4 I'm going to let Jess get up here
5 and just kind of run through it one more time
6 for you.
7 DR. JAGGER: All right. So, I've
8 certainly captured where we just ended with
9 the three definitional elements for CAT 2.
10 And I'll get to those at the end, but I think
11 I wanted to go back to where we began, Ms.
12 Crockett-Jones began with two main issues; the
13 continuity of staffing particularly around the
14 issues of Reservists being assigned one year
15 at a time to perform these NMCM duties, and
16 then the eligibility to get NMCMs and RCCs.
17 And those were where we began the
18 conversation.
19 Just really quickly to summarize
20 from there, there was discussion about maybe
21 not everyone has to have an RCC. But those
22 who request should not be denied. That was a

1 point that came up a couple of times.
2 There was a problem with
3 accountability for the CRP and CTP. That
4 issue was something that came up repeatedly
5 among - in the discussion as something you
6 might want to address.
7 And then basically we came to that
8 new definition for Category 2 that one or more
9 of the following conditions be met; serious
10 illness or injury as in VSI or SI, or upon
11 entry into IDES, or a Reserve component member
12 retained or returned to Title 10 orders for a
13 medical condition.
14 Does that sum up where you were?
15 CO-CHAIR GREEN: Yes. So, just a
16 question on the continuity of staffing.
17 So, are we thinking about
18 expanding our Number 12 to basically still
19 talk to training and add to that the
20 continuity of staffing?
21 You had one other thing that you
22 said there. You said continuity of staffing

when she first started off. What was the other thing regarding that?

DR. JAGGER: Eligibility, which I believe is what we came around to with CAT 2.

CO-CHAIR GREEN: The eligibility was covered, yes.

DR. JAGGER: Yes. Yes, sir.

CO-CHAIR GREEN: I'm just trying to get as I think we can expand on the training needs, talk to their progress, but then talk to the need for continuity in that one which actually makes this a little easier.

We haven't really talked too much about the CTP, but clearly we're going to have to talk about the CTP and expansion of that. Number 4, I think it is, yes.

MS. DAILEY: We can talk about it in the units and programs, which is the next hour.

CO-CHAIR GREEN: Okay.

MS. DAILEY: They run together a little bit, but you've been relatively

1 discrete in this activity of defining Category
2 2. And CTP had some play. We can discuss it
3 in some length more in the next hour.
4 CO-CHAIR GREEN: The only other
5 thing that we usually also include here and
6 just some highlight, I think that there's some
7 best practices that we haven't talked about.
8 But I would suggest that we just as a note,
9 that we put in the DISC program. And I think
10 that the WWR app are very good non-medical
11 case management assistance-type things here.
12 There may be others, but I just
13 want to - I'll start us off with a couple that
14 I thought were very clear.
15 MSGT MacKENZIE: I think now that
16 we've defined when the RCC comes into play, we
17 can then define the accountability for that,
18 the Comprehensive Recovery Plan and CTP.
19 MS. DAILEY: Okay. And, ladies and
20 gentlemen, keep something in mind. I like the
21 work you've done.
22 There are 22,000 people in the DES

right now in IDES. Anyone do quick math on a 40-to-one ratio on RCCs? That's a lot more RCCs than what they have right now.

And I agree with you the requirements there, but someone do me quick math on -

DR. JAGGER: 550, ma'am.

MS. DAILEY: 750.

DR. JAGGER: Five. 550.

MS. DAILEY: 550 RCCs. And we have how many now?

DR. JAGGER: I'd have to look.

MS. DAILEY: Yes, we do have that data.

Now, the Army - the Army is - got a whole chain of command that they call their RCCs. And that's - we can debate that in the units and programs, but keep that in mind.

We don't want to undo the work you've done, but we need to find the delta in the current RCC population. And we need to compare it to what the requirement is.

DR. JAGGER: One-seventy.

MS. DAILEY: We have 170 RCCs right now.

CO-CHAIR CROCKETT-JONES: But we'd have to add to that the number that the Army calls accounts as far as that goes.

That includes the Army's version?

MS. DAILEY: No it does not.

DR. JAGGER: Only the 11 they told us that they have that we're unsure of exactly how they function.

MS. DAILEY: They have 11 for their Reserve component or they've trained 11. Generally the Army says, my squad leader is the RCC.

CO-CHAIR CROCKETT-JONES: And they have the largest chunk of folks in IDES.

MS. DAILEY: Out of that 22,000, they have 20 - or, I'm sorry, 17. Yes, out of that 22,000, they have 17.

We'll get there. Just we need to be - it is - it's a very good data point.

1 These individuals are transitioning out more
2 than likely with a disability.
3 CO-CHAIR GREEN: You know, I still
4 think that our definitions make sense and the
5 Army's definition of using squad leaders
6 because of their - so, basically they're
7 linking their squad leaders to somebody who's
8 overarching and providing information to the
9 squad leaders. So, I don't have a real
10 heartburn with that.
11 I would in the Air Force if they
12 wanted to designate the family - not the
13 family life coordinator, but somebody at the
14 Airman and Family Readiness Center as an
15 initial RCC for people going through the
16 disability process, that would actually serve
17 us fairly well.
18 So, I'm not sure that we can't
19 define some of these RCCs for the, you know,
20 but then we just have to make sure they're
21 trained.
22 MSGT MacKENZIE: And that's a - if

1 you look at the Care Coalition, we have RCCs
2 embedded within the Care Coalition.
3 What they do is make - not only do
4 the RCC function, but ensure that the
5 Comprehensive Recovery Plan is complete across
6 the board through our advocacy in, et cetera.
7 It enables us to expand further.
8 So, I mean, I think what we're
9 asking for here is that recovery care
10 coordinator in the Comprehensive Recovery Plan
11 and accountable intake and care of our
12 warriors, you know.
13 Does that mean that we have to now
14 hire another 400 RCCs? I don't believe so.
15 But what we have to do is make sure that we
16 are accountable and that tracking is being
17 done and our guys are being - our warriors are
18 being taken care of.
19 CO-CHAIR GREEN: And really that
20 people are being advised on their benefits as
21 they go through the process, which is what
22 we're really trying to make certain of.

1 MS. DAILEY: I think your DISCs
2 were very - the DISCs were very articulate as
3 we talked with them in transition outcomes.
4 It's not about the guys coming out
5 of the WWR. It's not issues with the people
6 coming out of WTUs when you talk with your
7 AW2s. It is about the individual who's been
8 in a line unit, gone through the IDES process
9 and is trying to transition.
10 And so, that is a population also
11 in the Army that's not in the WTUs. It's
12 outside the WTUs. So, you've got a population
13 not covered, you know.
14 Well, the Army says they're
15 picking up the AW2 function at the IDES
16 process. So, a good - I think you're on track
17 here.
18 CAPT EVANS: At some point, though
19 -- I need to probably let this one go. The
20 garrison line, they provide a lot of these
21 services.
22 So, at some point we really have

1 to look at how do we get the warrior to what
2 we pay, we pay the garrison, that's what they
3 do, connect it with what's already provided?
4 MSGT MacKENZIE: What is provided
5 as the individual resources? What is not
6 provided is the overarching advice, counsel
7 and insurance that that individual knows where
8 those resources are.
9 I mean, quite frankly if you never
10 use, I mean, I've never in my career used the
11 Airman and Family Readiness Center. I didn't
12 need it. I have no idea what they provide
13 other than now that I became a supervisor, I
14 had to know in order to help my airmen out.
15 But quite frankly I have no idea what's on the
16 base, because I don't use it.
17 What that RCC does with that
18 Comprehensive Recovery Plan, is make sure that
19 that individual is aware of the resources and
20 that those resources are brought to bear.
21 It doesn't take the place of the
22 people that we pay to do those individual

1 specific jobs.
2 CAPT EVANS: Right.
3 MSGT MacKENZIE: It's, you know, as
4 you find every single day.
5 CAPT EVANS: Right.
6 MSGT MacKENZIE: If you don't know
7 what the resource does for you, you don't know
8 to ask the question, what does this resource
9 do for me?
10 CAPT EVANS: What we found, though,
11 in the one visit, there was a huge gap in that
12 RCC providing that number, that information.
13 And so I, you know, we can go back
14 to Instruction and say, okay, we want the RCCs
15 to make sure, you know, close that gap, but I
16 would say we have folks already on those in
17 the services that can ensure that member gets
18 to what he needs.
19 MSGT MacKENZIE: I just in multiple
20 locations, I've never seen that happen whereas
21 having that one document that all that stuff
22 is in there. To make sure that they've seen

all that stuff is very, you know, and especially as you move around from base to base, you know.

None of these resources at McDill Air Force Base have called me up and said, hey, you know, have you stopped by to see us?

Okay. But my AW2 advocate goes, hey, you know, have you looked at this? You're getting ready to go two years out. You need to stop and look at this stuff.

So, having that resource to remind folks and to take them out of their bubble to address the resources that are available to them is a very needy thing and through the recovery process and the reintegration process.

But, you know, and that's why I think this is so important.

CO-CHAIR GREEN: I'm just thinking. So, what you're really saying is we need to look at the definition of an RCC and be certain that we're not overutilizing this

asset.

So, we ought to pull the DoDI language that says what an RCC is and look at that to make certain.

So, for instance, the Army is going to call a squad leader an RCC. What are the critical functions of an RCC? That's what you're really asking.

CAPT EVANS: Yes, sir.

(Off record comments.)

CO-CHAIR GREEN: I've got lots of people whispering in my ear, bio break, bio break. So, take ten everybody. Thanks.

(Whereupon, at 10:15 a.m., the above-entitled matter went off the record and resumed at 10:30 a.m.)

MS. DAILEY: If we could have everybody back? We've talked about the responsibilities outlined in the Department of Defense Instruction on the RCC responsibilities. They are up on the screen here.

1 The first one is train, primary
2 responsibility for the CRP. Ensure
3 coordination with and have access to all
4 medical and non-medical service throughout the
5 continuum of care.
6 CO-CHAIR CROCKETT-JONES: What is
7 the RT in this?
8 MS. DAILEY: Recovering warrior,
9 recovering transition.
10 CO-CHAIR CROCKETT-JONES: Okay.
11 MS. DAILEY: Recovery team, sorry.
12 CO-CHAIR CROCKETT-JONES: Recovery
13 team.
14 MS. DAILEY: So, CRPs are supposed
15 to go to family members. That's Number 5.
16 Review and update the CRP and person when
17 possible as frequently as necessary based on
18 the recovering servicemember's needs.
19 MSGT MacKENZIE: I believe that's
20 where we see some of our biggest issue is Step
21 5 being followed through upon.
22 MS. DAILEY: Step 6, can we roll

1 down just a little bit, please? Thank you.
2 Six, seven and eight, thank you.
3 CO-CHAIR GREEN: Really, the
4 toughest piece is who needs those services?
5 Because if you're going to broaden the number
6 of people that require those services as
7 defined by the DoDI, then you're going to have
8 to expand the number significantly.
9 So, have we captured it right?
10 We've said that we need them to be involved in
11 this. So, do all the people that we just put
12 into this require a Comprehensive Recovery
13 Plan? I don't know. That's an interesting
14 question.
15 So, for instance, the Reservists.
16 You brought that up. Do all the Reservists
17 brought back on active duty and may be
18 separated, do they require a recovery plan?
19 I don't know.
20 MSGT MacKENZIE: But as we look at
21 least from my perspective, I mean, I'll let
22 the sergeant major chime in on that.

1 CSM DeJONG: I don't see why they
2 wouldn't, sir, based on the fact that if their
3 condition warrants them coming back on active
4 duty or being retained in Title 10, chances of
5 them going back to a normal life or their
6 normal job or normal civilian life is probably
7 slim to none.
8 A lot of what we heard from some
9 of the reservists was the job that you do in
10 the Reserves, is also the job that they do in
11 civilian life. And once they're medically -
12 it's kind of like Workmen's Comp. Once you're
13 told you can't do this job, you can't go back
14 and do it in your civilian life either.
15 So, we're talking about a
16 significant change in their life.
17 CO-CHAIR CROCKETT-JONES: And on
18 some of them, actually their civilian jobs
19 require more physical - have more specific
20 physical requirements that they're not
21 returning to even if they're not returning to
22 - even if it's not the same job that they had

1 I the military.
2 So, I think that as far as the
3 Reserve goes, yes, we need those. Those
4 people might actually be in. I think if they
5 were returning to - if they anticipated
6 returning back to their jobs and their normal
7 lives, they wouldn't be also being pulled back
8 onto Title 10.
9 CSM DeJONG: We're also dealing
10 with a population that has less access to the
11 information and the resources available to
12 them based off of state by state than what our
13 active components do with the SFACs and the
14 other available resources.
15 MSGT MacKENZIE: And let's, I mean,
16 let's not forget, too, as well is that, you
17 know, it's the engagement of these resources.
18 It doesn't dictate an amount of time.
19 I mean, if it comes to be that
20 that individual doesn't need a long length of
21 time, it's a very quick case, you know. It's
22 meeting the need of that recovery plan and

1 making sure everything is good to go.
2 Some will require more
3 intervention and assistance, and some will
4 require less. But the fact of the matter is
5 they're at a point where they need that
6 assistance to take somebody - they need
7 someone to objectively take a look at what's
8 going on and make sure that the right things
9 are happening.
10 It's not that we need all these
11 extra people that are going to be working all
12 these extra hours. It's just that we've
13 identified the folks that need this
14 assistance, some will be long, some will be
15 short, but at least somebody is looking out
16 for them and making sure this stuff is
17 happening.
18 CO-CHAIR CROCKETT-JONES: And if
19 you look at Number 8 as soon as they've met
20 their goals or declined further support, it's
21 closed.
22 CO-CHAIR GREEN: Yes, but somewhere

in the same DoDI it says that the ratio is one to something. And so, you know, if we're talking 22,000 in the IDES, plus all the people who - VSI/SI, okay, which is probably not a lot. That's probably hundreds, but then you talk about the Reservists.

I mean, if I was the example, that's 2200 out of, you know. So, I mean suddenly you're starting to talk about, you know, a significant proportion of -

CSM DeJONG: Well, not necessarily.

CO-CHAIR CROCKETT-JONES: I wouldn't have been 2200.

CSM DeJONG: Out of 2200 LODs, they only requested seven and got three back on active duty or Title 10s that would have been seven or three.

CO-CHAIR CROCKETT-JONES: And even if we are looking at all of the IDES folks like in the Army, but not in a transition unit, if the Army wants to assign this function to someone, you know, not to

1 specifically to an RCC, but to someone who
2 does - has another job and they're willing to
3 train that person to do that for a certain
4 number within a unit, I'm not sure that this
5 is as big a change as it sounds.
6 CO-CHAIR GREEN: So, what you're
7 saying is that they just have to train whoever
8 they're going to have responsible for this to
9 the RCC level.
10 So, can you go up a little bit and
11 see what the training says? I think it just
12 says services inside the training.
13 So, uniform Corps training with
14 WWCTP right there. So, what's the - how long
15 is that training; do we know?
16 LTCOL KEANE: I believe the federal
17 training is a week. And then the Marine Corps
18 and other services have like another week of
19 specific service training.
20 MS. DAILEY: Correct. Correct.
21 MSGT MacKENZIE: I mean, we already
22 do that within the SOCOM Care Coalition where

1 we have RCCs, but our Corps advocacy are all
2 trained to that level. And we have, you know,
3 a senior RCC who makes sure that what we are
4 doing meets the needs of the CRP and that
5 those things are going on, you know.
6 The service has taken at least in
7 the Care Coalition, and I think the other
8 services are looking at it the same way, I
9 know the Air Force is looking at it that way
10 where, you know, we have our Corps RCCs, but
11 we have the other individuals that are trained
12 to that level that are working with these
13 folks that are meeting the needs of that CRP.
14 And they have that senior RCC to look upon and
15 go, are we meeting the needs, you know?
16 It's the individual service
17 branches are - have already got that ability
18 in place. It's more defining that we're
19 capturing all the folks than - and the
20 accountability piece is in play.
21 CO-CHAIR GREEN: So, Captain Evans,
22 do you think that because they define this as

1 completing a certain amount of training, do
2 you think that that would actually suffice for
3 some of the assets we have in place already to
4 do this?
5 I mean, essentially all we're
6 saying is that they'd have to have this
7 training to be called an RCC.
8 CAPTAIN EVANS: Yes. The only
9 concern, I think they only get that training
10 once, right? And so, they may be an RCC for
11 three or four years and they never -- other
12 than the service-specific training.
13 I think the gap again is that the
14 services are taking on the responsibility and
15 making sure that that RCC completes that
16 Recovery Care Plan.
17 This is a DoD Instruction.
18 Somewhere up above we need to make sure that
19 that information is being fed to higher
20 authority if that Recovery Care Plan is being
21 completed and if all the requirements for that
22 servicemember are - that they're being met.

1 And right now that's just not happening.
2 We are finding that the services
3 have taken that responsibility on and they're
4 keeping it at that service level. The
5 training occurs once a year through OSD, and
6 there's no follow-up, no higher authority to
7 say this is being completed.
8 Site visits, I'm not sure if they
9 come down to do site visits like we've done,
10 you know, going in to see what's going on.
11 So, it's just a - if we're going
12 to - I hear that it's a valuable program. And
13 so, I'm convinced, okay.
14 However, we have some gaps out
15 there that we have got to make sure that this
16 is being completed. The training occurs once,
17 but what's the follow-up that all the
18 requirements are being met?
19 MS. DAILEY: Very good point. We
20 do, you know, when we talked to the Marine
21 Corps in the February meeting and we said,
22 what are you doing to ensure your CRPs and

1 your RCCs are doing their job, they said - and
2 they stepped right into that question and that
3 gap and they said, yes, we quality control
4 these RCPs. We select four to five a month.
5 We go through it. We make sure that they have
6 a complete plan that's done in accordance to
7 standards.
8 That's a compliance program at the
9 service level. So, not all services have come
10 to us and said this is how we are in
11 compliance with it, this is our quality
12 control program for our RCPs.
13 They should be doing that. That
14 is correct, but I gave an example of how the
15 Marine Corps answered that question.
16 And they do have an inspection
17 requirement. This is WWCTP's DoDI. They do
18 have an inspection requirement in this to do
19 quality control checks. Quite frankly it's
20 very difficult because of constraints and
21 funding to do that.
22 It is in fact a Do - it is in fact

a service's IG's responsibility to ensure compliance with DoD regulations.

So, when a, you know, when an IG, service IG Army, Air Force, Navy, Marine Corps says I want to inspect or systematically do an organizational effectiveness review, this is the document they would take down to Wounded Warrior Regiment, AFW2, the RCC program at the Air Force, the RCC program at Safe Harbor being implemented by Safe Harbor and their non-medical case management.

Their IG would take this document and then run down a checklist of compliance.

CAPTAIN EVANS: So, I mean, as far as the population, I agree a hundred percent. I think we should capture the Reserve population.

A little concern with the IDES, upon entry into IDES. I think most of them are already being captured by RCC especially if they - but it's that other category of IDES that I'm worried about that if we say they

1 should have an RCC, would that increase the
2 amount of need for hiring additional folks?
3 MR. REHBEIN: I had the same
4 concern, Captain. If one of the trigger
5 points for being assigned an RCC is entry into
6 IDES, it seems to me by the nature of the
7 system, entry into IDES means the medical
8 conditions have stabilized. Because if
9 medical conditions are still in transition,
10 how do you evaluate the disability?
11 If the medical condition is
12 stabilized, what useful function does an RCC
13 and the Comprehensive Recovery Plan serve if
14 it's just being created after the medical
15 condition is stabilized?
16 CO-CHAIR CROCKETT-JONES: I would
17 think it would help with making a transition
18 plan to a new, normal - new job training, new
19 - or connection to resources to say this is
20 stabilized, you are getting out, you won't be
21 able to do X, Y and Z or you need to consider
22 other options.

1 MR. REHBEIN: I see very little in
2 here of the RCC's responsibilities to assist
3 in transition.
4 CO-CHAIR CROCKETT-JONES: They
5 don't actually assist in transition. They
6 say, you know, what is your plan? And this is
7 who you go to, to assist you with this plan.
8 They look at - they can connect
9 between the plan and assistance.
10 MR. REHBEIN: I just don't want to
11 see us creating what can be seen as an
12 inconsistency because RCC and CRP both say
13 "recovery." And that's - I believe the
14 general definition would mean medical
15 recovery, but yet IDES says the condition is
16 stabilized.
17 If everyone else is -
18 CO-CHAIR CROCKETT-JONES: I see
19 what you mean. This is a language problem.
20 MR. REHBEIN: If everyone else is
21 comfortable, I'm comfortable.
22 CO-CHAIR CROCKETT-PLAN: The Army

calls it a transition plan. Everyone else calls it a recovery plan. This is yet another area where standard language is an issue.

LTCOL KEANE: Instead of requiring an RCC be assigned at the IDES level or for when a reserve member comes back on Title 10 instead of requirement, could we say services will evaluate at these points if a member needs an RCC?

CO-CHAIR CROCKETT-JONES: How about if it was offered? My hesitancy is that they are using - that one of the things we are trying to fix here is their use of the language in the current Category 2 to not connect folks who we meet at installations who need the intervention to that resource.

So, I don't want them to just evaluate in a new way to say we evaluated and we say no, you know. I think that we'll still be seeing the same outcome.

If what we want to see is a different outcome, I think we're going to have

to at least put the - make the language that it's offered.

LTCOL KEANE: I think "offered" is better than "requiring."

CO-CHAIR CROCKETT-JONES: I'm not uncomfortable with that.

MSGT MacKENZIE: Well, I am. And I think once again if we're going to talk about definitions, there's an intake briefing that the RCCs do, you know. They go through and sit down with the warrior and go through all that information, you know.

I think that briefing should be required, and then the decision to engage as an RCC is then based on the results of that briefing, you know.

Because if you say offered, they can say, hey, do you want an RCC? They don't know what an RCC is. And if the person says no, then they're going to go, hey, block's checked.

And I'm not saying that happens

1 across the board, but I'm saying that it
2 leaves the potential for that especially when
3 I think in some cases when you look at the
4 Reserve component, they're going, you know.
5 But if you do that intake
6 briefing, the RCC or RCC, you know, the CRP
7 representative sits down with that warrior and
8 goes through that intake briefing. And then
9 there's a decision made at that point if the
10 person needs one, because you're right.
11 If I've got an illness and I'm
12 going in through a med board and I don't need
13 that person because I've got all my ducks in
14 a row, there should be an opportunity to not
15 engage an RCC because it's not needed.
16 CO-CHAIR CROCKETT-JONES: That's
17 already in the language, though, of the RCC
18 responsibilities. A servicemember can say no.
19 MSGT MacKENZIE: So, but, I mean,
20 does that coincide with what you're thinking,
21 sir?
22 LTCOL KEANE: Kind of. I just

1 think when we talk broad brush, everyone gets
2 on, I can't imagine how the services are going
3 to -
4 MSGT MacKENZIE: And that's what
5 I'm saying. If they don't need one, it can be
6 turned off immediately. But at least the
7 person responsible for that when we look at
8 accountability, that agency is accountable to
9 at least sit down with that individual.
10 And if none is needed, they can
11 say we're done. If one is needed, then they
12 can say let's do this.
13 CO-CHAIR GREEN: You're creating
14 the same confusion we have now in terms of we
15 haven't helped the definition.
16 So, the question is, is, you know,
17 at the top of that box it said RCC required,
18 okay, in that Category 2. Should we change
19 what's in there?
20 Instead of saying RCC required,
21 say, you know is it an RCC we really want
22 there for these three different categories?

1 Is it a CTP that we really want there for
2 these three different categories? Because we
3 don't have to mandate the person.
4 If you say CTP, then technically
5 the RCC is the person who oversees it, but we
6 don't tell them how the RCC oversees it. They
7 can oversee it through the Family and
8 Readiness Center. They can oversee it through
9 - the RCC is just responsible for making
10 certain that those services are offered.
11 So, instead of saying RCC
12 required, you can say that a transition plan
13 is required, okay. And then let the services
14 decide how they're going to use their RCCs to
15 oversee that function.
16 So, it may just be that we want in
17 those cases, a CRP. I'm going to say CRP,
18 because that's the more broad term. Do we
19 want a CRP to be offered?
20 And so, you know, or a CRP to be
21 utilized? I mean, that may be a better way to
22 say it.

1 CAPT EVANS: I would ask the - oh.
2 MS. DAILEY: Yes, I doubt if - I'd
3 have to ask the research staff. Off the top
4 of my head, I think that the language of the
5 legislation says Category 2s are required to
6 have an RCC. I believe that is the language
7 of the legislation.
8 CO-CHAIR CROCKETT-JONES: It will
9 be a legislative recommendation if we change
10 that.
11 MS. DAILEY: Correct. Correct.
12 Anyone back here remember is that a
13 legislative requirement? That's how the
14 legislation phrases it? Seriously injured
15 Category 2s will have an RCC?
16 Okay. Sorry, guys. I mean, that
17 is a requirement. The real issue is, yes, the
18 services are conserving resources by kind of
19 parsing the Category 2 requirements. And
20 we're trying to help them with a definition
21 that helps them focus their resources again on
22 the most needy populations which we have

1 identified as people in the IDES. But we do
2 know that we've got degrees of people in IDES.
3 So, that becomes more difficult.
4 We've focused their definition in
5 the area of other most needy populations. We
6 believe that to be the Reserve component.
7 And did we have a third category?
8 Very seriously injured. So, it was Reserve
9 component, IDES and very serious and seriously
10 injured which we already have in there.
11 So, the pieces you are adding are
12 IDES and the Reserve component on Title 10.
13 The resources are being spent to bring them
14 back on Title 10. If they're not seriously
15 injured, then there are other ways to manage
16 them. It follows that you would give them an
17 RCC.
18 So, you've got two categories here
19 that still have fuzzy edges. It's hard to
20 create a crisp, very defined, but you've done
21 okay.
22 CO-CHAIR GREEN: I still think the

1 gets RCC, so that's the DoDI. You could make
2 it so it gets RCC oversight of CTP. And the
3 RCC oversight simply means that they have
4 somebody that does the CTP. And that the RCC
5 is the, you know.
6 So, there are going to be some
7 cases where the RCC is heavily engaged, and
8 there are going to be some cases where the RCC
9 is simply going to a base to make certain that
10 they are doing a transition plan for anybody
11 who's in those categories.
12 CO-CHAIR CROCKETT-JONES: We may be
13 able to tackle this by separately talking
14 about ratios being taught, you know, being
15 mitigated with acuity.
16 I mean, we've talked about that in
17 about every case management level and every
18 assigned person in this process who is - who
19 when we talk about ratios, we've been talking
20 about making those ratios reflect an account
21 for acuity and that could be done with this
22 RCC as well.

1 Someone who needs a onetime plan
2 and information briefing is a different acuity
3 than someone who needs an ongoing intervention
4 of overlooking the process and keeping to a
5 plan that's going to take more than six
6 months.
7 CSM DeJONG: Instead of trying to
8 change legislation, do we add - do we try and
9 add to - do we add another block into this
10 table? I don't know if you want to call it
11 Category 1b or Category 2a. I don't care how
12 you want to label it, to where we can capture
13 General Green's idea about a CTP with some RCC
14 oversight.
15 Leave Category 2 alone which is
16 written in legislation and is pretty well-
17 defined, and we just add to it.
18 MS. DAILEY: Well, I mean, the CTP
19 is in legislation also. It's in legislation
20 that Category 2 seriously wounded have an RCC
21 and a Comprehensive Recovery Plan.
22 CSM DeJONG: Correct.

1 MS. DAILEY: And that is for 2s and
2 3s. So, those resources are going to those
3 categories.
4 CSM DeJONG: I understand that, but
5 we still want to somehow capture the Reserve
6 component and we want to capture IDES.
7 So, what's the easiest and most
8 efficient way to capture them without trying
9 to change too much, is what I'm asking, I
10 guess, to clarify that.
11 MS. DAILEY: I suspect right now
12 might be in the big issue in - might be in the
13 IDES, which is - and Anne brought it up a few
14 minutes ago which was, do we want individuals
15 in the IDES, do we want to capture individuals
16 in the IDES who might be there for sleep apnea
17 or - she had another good example.
18 CSM DeJONG: Asthma or something
19 like that.
20 MS. DAILEY: Yes. So, in that case
21 we might be looking - we might - that's where
22 you start a parsing function. And that takes

1 you back to seriously, very seriously, did
2 they show up on a report for - incident report
3 from their command for an injury? Have they
4 been documented and did they show up on an
5 incident report for their command for cancer?
6 That might be the definition there.
7 Now, those incident reports as
8 pointed out to me, might be short-lived. Fell
9 off a deck, broke a leg, is going to be in a
10 cast for six months. That's a serious
11 incident report also.
12 But tying the IDES back to a
13 serious incident or serious injury or illness
14 report will assist with the asthmas, the
15 apneas, the - those that are making you
16 nonmission capable, but not due to a - you
17 can't use serious, chronic or specific event.
18 CSM DeJONG: Maybe we can wordsmith
19 that.
20 MS. MALEBRANCHE: Well, the other
21 thing is could we make - maybe flip this.
22 Make a recommendation, because I'm sure IDES,

I mean, they're going to be having a hearing here in about a week or so.

Can we make a recommendation to their policy? I'm saying the reverse. Legislation just takes a while, that's what I'm thinking, I mean, if we're changing.

So, if we go into their policy, then that has the ability to maybe more quickly -

CSM DeJONG: So, you're saying going into the IDES policy and require CTP or some sort of oversight when they meet such and such criteria?

MS. MALEBRANCHE: Recommend to DoD that they use the IDES policy to put it in, which is something they can do, I think, without legislation. Just a thought.

CO-CHAIR CROCKETT-JONES: That doesn't capture reservists.

MS. DAILEY: I kind of see where that's going. I mean, IDES policy would - one of the steps of the IDES policy would be RCC

overinvolvement along with the PEBLO and MSC and a Comprehensive Transition Plan being provided.

CSM DeJONG: The Reserve component is going to end up having to be legislation anyhow to capture that.

We can capture the IDES under policy, which I do concur with that. Adding the group of reservists is going to be higher than policy. So, that one is going to take either a separate recommendation under this category, or a recommendation to somehow add that into this. That's going to be a little bit different.

It's going to be easier to wordsmith that one alone and take policy with IDES, I think.

MS. MALEBRANCHE: Aren't the Reserves, I mean, the Reserves are a huge piece of IDES.

CSM DeJONG: Yes.

CO-CHAIR GREEN: I don't think it's

an issue because we're talking about people who are brought under Title 10 orders. So, they'll be on Title 10 orders. So, therefore it's not a question since we're only applying this to the people coming on Title 10 orders.

The harder piece is trying to figure out how to not drive a huge manpower tail in terms of the RCCs. And so, I think we're back to what services do we want the three categories we identified to have.

And when you look at the RCC and what the RCC provides, do we feel they need full RCC services?

If the answer is yes, then we - then what we need to - remember, an RCC is simply defined as somebody who's gotten basically service training and a week of training. And so, it doesn't mean that the services can't do this with whatever assets they have wherever they are, but it is going to drive the CRP to be completed for all these different folks.

1 Now, I would guess that the Army
2 already has a CTP for anybody who is in the
3 IDES. So, for 20,000 of these people, they
4 should have it because, you know, the -
5 MS. DAILEY: If they're in the WTU,
6 the have one. If they're in the WTU and going
7 through IDES, they have one.
8 If they are outside the WTU and
9 going through IDES, they do not have a
10 Comprehensive Recovery Plan.
11 CO-CHAIR GREEN: Well, it's really,
12 I mean, it would solve the problem we were
13 talking about the Marines today too, because
14 they'd have a CRP that would be a
15 communication device with the folks.
16 CSM DeJONG: So, ultimately with
17 that statement we capture the Reserve
18 components - well, I would say we capture
19 National Guard, Army Reserve components that
20 go back on Title 10. Because the only place
21 that they are generally put back in Title 10
22 is into a WTU.

1 MS. DAILEY: There's some of the
2 Reserve component management, case management
3 that's putting them on Title 10 also.
4 CSM DeJONG: Correct.
5 MS. DAILEY: So, that would capture
6 them also.
7 CO-CHAIR GREEN: The Reservists are
8 actually the smallest number. The big number
9 in terms of what we did was the IDES. So,
10 maybe we should think about the IDES. Maybe
11 that's where we've gone too broadly in terms
12 of a transition plan.
13 And the hard part is how do you
14 capture the folks that are now going to be,
15 you know, who are going to be SI/VSI?
16 So, you know, I'm not sure it's a
17 big issue for our cancer population and people
18 with - it's probably a bigger issue for PTSD
19 and TBI.
20 And so, maybe we should be
21 specific and talk to TBI and PTSD that is
22 entering the IDES system if they're not

1 already captured.

2 MS. DAILEY: They've been referred

3 for that specific condition in the MEB, okay.

4 CO-CHAIR GREEN: Maybe we should be

5 specific, because that would basically tie it

6 into the things that we can't get through VSI

7 and SI.

8 CO-CHAIR CROCKETT-JONES: Yes, I

9 think that might work. I like that.

10 MS. DAILEY: Okay. So, the IDES

11 piece will be tied to referrals for TBI and

12 PTSD and will ensure those individuals going

13 through the IDES with the highest chance of

14 not returning to military service, will have

15 an RCC and a Comprehensive Transition Plan,

16 okay.

17 CO-CHAIR GREEN: That will solve

18 the numbers problem because now we're focused

19 on a specific group that we're worried about

20 that essentially are not captured in the

21 SI/VSI realm.

22 MS. DAILEY: It's 11 o'clock.

1 Let's talk a little bit about units and
2 programs. This has kind of overlapped a
3 little bit, this first piece. And it is still
4 - it's actually when we start talking units
5 and programs, we move into a different group
6 which is Colonel Keane and Dr. Phillips.
7 These are the - yes, this covers
8 the Army WTU, the Marine WWR, Safe Harbor, Air
9 Force Warrior and Survivor Care Programs AFW2.
10 So, units and programs falls in the Restoring
11 Wellness and Function Team.
12 Unit and programs effectiveness
13 document is in J. Page 19 of units and
14 programs talks about the CTP, CRP. It might
15 be a good place to start. We did want to
16 invest some time, a little bit of time.
17 LTCOL KEANE: Focusing on this next
18 session, we have Items 2, 4, 5, 6, 7, 12 and
19 16. Just going over what we decided yesterday
20 along with the Task Force recommendations,
21 which they passed out this morning, we
22 scratched out 5, 6, 7. Everybody tracking

with that? So, our focus for this next will be 2, 4, 12 and 16.

We discussed yesterday combining 2 and 16. We also just recently - we just finished up talking about 4. I'm not sure if we want to talk about 4 again.

Do you want to start with that?

DR. PHILLIPS: Sure. Do you want me to jump in on 4? Is 4 up? Can we put 4 up just so everybody can see it so I don't have to read it, but -

MS. DAILEY: I don't have it.

DR. PHILLIPS: Okay. Item 4, create standards, et cetera. I think there are two issues with 4 that we've identified, and one is a technical issue.

It's really just the inability to download and bandwidth and so forth. And I think we can make a recommendation to that that the technical aspects of the utilization need to be improved.

CO-CHAIR GREEN: Are you going to

make that specific to the CTP? Because technically the other services haven't tried to do that.

DR. PHILLIPS: Whatever. I mean, I don't know if we can make it specific.

MS. DAILEY: Yes, the Army's addressed this. And they addressed it in February. So, we kind of rolled their answer into that.

I mean, yes, they'd like another platform. It's very robust. It's on the Army AKO.

DR. PHILLIPS: So, we can skip that?

MS. DAILEY: Yes, I'm not sure going down that road again we would - we did spend some time in our findings last year saying bandwidth is tough, logging on is tough.

We've - and they tried to talk us through it in December.

DR. PHILLIPS: Okay, that's fine.

1 MSGT MacKENZIE: The question I
2 have is with some of the training deficiencies
3 that we saw throughout this year in the
4 visits, do we believe that those are being met
5 in order to better utilize the CTP with the
6 system that it's in place to do?
7 DR. PHILLIPS: I was going to
8 address that next. The second sentence as it
9 stands right now, second sentence says they
10 should clarify which members of the Recovery
11 Team, et cetera.
12 Suggest changing that "should
13 clarify" to "must identify" which members of
14 the Recovery Team or - which member or members
15 of the Recovery Team are responsible for
16 engaging the RW and Family.
17 CO-CHAIR CROCKETT-JONES: In their
18 implementation plan they said that that is the
19 RCC. So they've sort of answered us on that
20 that we'll just say again that it is the RCC,
21 I think.
22 I think that the real nut to crack

is the last sentence of that recommendation. "Ensure the plan is a meaningful tool used to create a dialog."

We don't see it being used that way and I think people not only are - from the installation visits, my feeling is that whether you're talking CTP or CRP, recovering service members are - don't know what it's supposed to do.

DR. PHILLIPS: Right.

CO-CHAIR CROCKETT-JONES: And the people in charge of them don't know how to use it.

DR. PHILLIPS: Right. Well, I had that as my next comment.

CO-CHAIR CROCKETT-JONES: Okay. There you go.

DR. PHILLIPS: It was basically to do an outcome evaluation to see, you know, how it's working.

I mean, we know verbally offhand how the response is, but maybe to do an

1 official evaluation and see how it's working.
2 MSGT MacKENZIE: I like Captain
3 Evans' comment earlier about the fact that,
4 you know, that the IG has the ability to do
5 this, but do we need to put in our
6 recommendation that this is a required
7 inspection item?
8 DR. PHILLIPS: I would say yes. I
9 mean, at least for the next go-around.
10 MS. DAILEY: I mean, DoD IG is
11 going inspections, Navy Safe Harbor just had
12 an IG inspection, the Marine Corps has been
13 inspecting their WW unit site from last year.
14 CO-CHAIR CROCKETT-JONES: Do we
15 know if the recovery plans are something -
16 MS. DAILEY: It's in that document
17 when the IG goes down, it looks at - they look
18 at them. I incorporate them in your - I
19 incorporate IG findings into your
20 effectiveness documents when I have them. So,
21 you'll see a lot in there about the DoD IG
22 inspections.

I like the idea. This is my thought about the Army's program. They briefed us on 1 December. They just put their policy in place. Training. Revamping. Updating the CTP. I think we're premature. I think we need to let it bubble out there.

I'm not trying to put down any ideas at all.

DR. PHILLIPS: It was status partially met. So, should we move it from partially to met?

CO-CHAIR CROCKETT-JONES: I don't think we know that yet.

CO-CHAIR GREEN: No, I think it's still - I think it's still partially met. I mean, so if you're looking at Number 4, I think that you can say the CRP and CTP, clearly it's delineated as a responsibility of the RCC. And that the RCC is responsible for communicating the plan to the recovering warrior. That's in the DoDI. So, that part is clearly met.

1 But when you get to the latter
2 part of it, our visits indicate this tool is
3 not yet a meaningful tool for the recovering
4 warrior and family members to track their
5 progress. I think that's the way I would take
6 this.
7 And so, the question is, are you
8 going to make it so that it is something that
9 the family members have access to, or - and I
10 shouldn't be asking the question, do we want
11 them to make it something that the family
12 members have access to?
13 Because we ran into a lot of
14 problems with that, the whole HIPAA issue, in
15 terms of what's going on. Even though this is
16 nonclinical case management, we are running
17 into people who are very sensitive to HIPAA on
18 this recovery, you know, this RCP.
19 And so, do we think it should be
20 HIPAA-protected from the caregiver? I mean,
21 that's an interesting dynamic.
22 CO-CHAIR CROCKETT-JONES: We saw

1 places where we didn't think that the
2 recovering warrior had decent access to it.
3 MS. DAILEY: Some clarity then.
4 Discrete distinction. CTP is online and a
5 recovering warrior can take his wife into the
6 computer at any time and say, here's my CTP.
7 So, it's available.
8 But the document that is not
9 available online and requires face-to-face
10 with their RCC, is the Comprehensive Recovery
11 Plan covered in this - covered in the RCC
12 DoDI. It is still a paper exchange.
13 Are you interested in kind of
14 moving DoD down the road a little bit more on
15 making that document more interactive, more
16 accessible?
17 MSGT MacKENZIE: Right. I mean,
18 even in the guidance on the RCP it states
19 clearly that it's a tool both to recovering
20 servicemember and - not or, but and
21 caregiver/family members.
22 So, I think my conflict in some of

1 these site visits was not - was they weren't
2 following the rules. They weren't bringing
3 the family members or the caregivers in on
4 reviews of this plan, which it clearly states
5 they're supposed to.
6 DR. PHILLIPS: Exactly. I agree.
7 I mean, if recovery depends or is helped by
8 family interaction, then they should have that
9 ability.
10 CAPT EVANS: Regarding the outcome
11 measurements, so that last sentence is where
12 we continue to struggle because we don't have,
13 you know, we know we have IG that looks at the
14 - they do their annual or every-other-year
15 visit. I think we want more than that.
16 And so, I think we want some type
17 of system in place other than us going out to
18 talk about - talk to the focus group to
19 provide that feedback on recovering
20 servicemember, they have a CRP or CTP in place
21 and that it's being engaged through their -
22 whoever has that function, RCC, or whoever the

1 service assign that function.
2 I think we want more than an IG.
3 We don't want to wait until IG goes out. We
4 want something provided to us that this is
5 actually being provided.
6 DR. PHILLIPS: I agree.
7 CO-CHAIR GREEN: I'm wondering if
8 saying something provided to us. So, it
9 really is what's the feedback to the RCC,
10 right? I mean, it's a question of feedback to
11 the RCC.
12 CAPT EVANS: I think RCC services
13 or some mechanism where that feedback, that
14 loop is closed, and it's just not closed to
15 them getting a survey done through the
16 Inspector General.
17 CO-CHAIR GREEN: It would be nice
18 if -
19 CO-CHAIR CROCKETT-JONES: Yes, how
20 are they accountable for -
21 CO-CHAIR GREEN: Yes, it would be
22 nice if the servicemember could put input

1 directly into the CRP, right? Okay, because
2 then you'd see it immediately. You could do
3 a screen and find out what the servicemember
4 put into the CRP.
5 CO-CHAIR CROCKETT-JONES It would
6 require them to make the CRP electronic. It
7 is not at this point. It's paper.
8 CO-CHAIR GREEN: But it could be
9 done on paper and then just have the
10 servicemember initial or sign that it's been
11 reviewed or add a comment after it's been
12 reviewed.
13 CO-CHAIR CROCKETT-JONES: Okay, I
14 see.
15 CO-CHAIR GREEN: Yes.
16 LTCOL KEANE: Can I ask a point of
17 clarification?
18 MS. DAILEY: Yes.
19 LTCOL KEANE: I believe it was
20 December when the Army was here and I spoke to
21 the CRP manager, a gentleman who was on
22 crutches. We spoke for 20 minutes.

I was under the impression that the technical problems, the bandwidth problems that the soldiers were having was for inputting to CPT. It's not. It's for the small eCTP.

So, my point of clarification is, is it the eCTP that's available to everyone, or the actual CTP? I'm under the impression that it's the eCTP.

CO-CHAIR CROCKETT-JONES: I think that the whole CTP is available to everyone for viewing. The eCTP is the only portion that is available for input, data input from the recovering warrior. That was my impression.

Now, you know, we might need clarification to find out which one of us heard it correctly.

LTCOL KEANE: I didn't think that the actual CTP was available for everyone to look at. I thought it was just the eCTP that the soldier does, and then the squad leader or

1 whatever, section leader, and then the nurse
2 case manager that are working on that.
3 But eCTP feeds the CTP, which I
4 thought was not online.
5 CO-CHAIR GREEN: Yes, what we got
6 from the squad leaders was that they're not
7 using the CRP at all, I mean, when we were out
8 at Lejeune.
9 Yet when you go to the Army sites,
10 they will tell you that they let everybody on
11 the team input into the CPT, but I think that
12 the - I think we're missing a bit of a point
13 here, okay.
14 From our standpoint, okay, our
15 visits indicate that the tool is not yet a
16 meaningful tool for recovering warriors to
17 track their progress. The CRP/CTP should be
18 accessible to the recovering warrior, family
19 and caregivers. And servicemember/family
20 should be encouraged to contribute to the CRP
21 whether electronic or paper, okay.
22 I mean, because, you know, we're

1 not trying to drive an IT solution here.
2 We're trying to make certain that there is
3 actual sharing of information and that the
4 families have input.
5 So, if I'm the servicemember or
6 the family member and I'm unhappy, I should be
7 able to say I'm unhappy right on the
8 comprehensive form, and then let people deal
9 with it, right?
10 Okay. It's a record of my
11 recovery. So, you know, whether I choose to
12 do that in expletives, or I choose to do that
13 in, you know, I need help, then it's right
14 there captured. That's kind of what this
15 thing should be.
16 MSGT MacKENZIE: Right, and then -
17 but then the other part is the accountability.
18 I mean, we keep - I mean, I find it hard to
19 believe that throughout all of our site visits
20 the only people we see are the ones - the only
21 CTPs and CRPs that we see are the ones that IG
22 didn't look at or that inspectors didn't - I

mean, there's got to be some kind of accountability.

Because to me, that's just, I mean, we've seen a lot. And the fact that the effectiveness of those documents and who's the oversight, you know, I still think that needs to be addressed as well.

CO-CHAIR GREEN: Are you sure that we want to take on the accountability for whether the RCC is doing their job?

I mean, I would think that if I was overseeing the RCCs and I saw a lot of, you know, very negative comments regarding the feedback and stuff, then I would decide whether I was going to continue that person or not because there is still some kind of an oversight.

They're still employees. There's oversight of the people. I guess - I think you're trying to take this a little farther than what we - so, for instance, if somebody puts a negative comment on an RCP - yes, RCP.

1 CRP. Sorry, CRP. I'm going to say that
2 wrong.
3 If somebody puts a negative
4 comment on that, that's not the end of the
5 world. I mean, these people should be
6 frustrated.
7 The real question is, so what does
8 the next entry say, okay? If this is a
9 communication tool, which is I think what it's
10 all about, how did the RCC deal with that
11 particular input?
12 It's not that they shouldn't put
13 it there. It's whether or not the next person
14 who looks at it is dealing with it.
15 MSGT MacKENZIE: That's just what I
16 was talking about was that -
17 CO-CHAIR GREEN: But you're talking
18 accountability.
19 MSGT MacKENZIE: Of the form and
20 the completion thereof.
21 CO-CHAIR GREEN: But first you've
22 got it to where the -

1 MSGT MacKENZIE: The person has
2 access to it.
3 CO-CHAIR GREEN: Right.
4 MSGT MacKENZIE: And then -
5 CO-CHAIR GREEN: Access and ability
6 to put things in. You're going the next step
7 thinking they're going - that nobody is going
8 to act upon what the servicemember said. I
9 find that a little hard to believe.
10 CO-CHAIR CROCKETT-JONES: Well, I
11 know you might find it hard to believe. At
12 installations, we would hear that from RCCs
13 basically saying, oh, they just use it to
14 gripe.
15 So, they - that's considered not a
16 factor. I mean, that did not reflect on RCC
17 performance if they were filled with negative
18 comments.
19 I don't think -- it's not working
20 that way in -
21 CAPT EVANS: Right. And that's
22 what so in 4, that's what we say. Provide

1 oversight.
2 So, I think what we are trying to
3 establish is oversight. Just some type of
4 oversight.
5 If they have negative comments,
6 I'm glad because guess what? That means
7 they're using that tool, Anne.
8 CO-CHAIR CROCKETT-JONES: Yes,
9 right.
10 CAPT EVANS: But I think we need to
11 define oversight a little bit more. Who has
12 that oversight and where, you know, how can we
13 assure when we go out there, we should expect
14 to now hear, oh, I know what a CRP is.
15 It may not come from the RCC, but
16 guess what? That member knows what that tool
17 is and how he's using that, interacting with
18 that tool and the family.
19 So, that's what we want to hear
20 when you go out on the site visits.
21 DR. PHILLIPS: Well, exactly. I
22 heard negative comments that were above and

1 beyond being useful. I mean, they were
2 comments - I put - shared things into my
3 response, and I got no response.
4 I mean, I've heard this from
5 enlisted and officers. So, that's why I just
6 suggested some sort of evaluation, outcome
7 evaluation to see if it's working.
8 I mean, if we feel the IG is not
9 doing enough to evaluate that, then perhaps a
10 separate evaluation, outcome, should be -
11 LTCOL KEANE: To expand on what the
12 doctor said, we had a soldier that put in
13 absurd things for eight weeks. No one acted
14 upon it. Then he stopped doing it, because he
15 thought that you weren't reading it.
16 They came to him when it was
17 coming time to leave. It was like, oh, you
18 haven't filled out your thing in three weeks.
19 That's when they were concerned was when they
20 weren't filling it out. It was more of a
21 check-the-box-type thing.
22 I'm hesitant to say that the

1 Army's CTP is a best practice. I mean, I
2 don't think it is.
3 However, that being said and all
4 the focus groups I've been in, ten or 11, one
5 of them did identify someone who was suicidal.
6 So I mean, in that case, maybe
7 it's worth - so it's only as good a tool if
8 it's being utilized.
9 More times than not it was a
10 check-the-box. Yep, he did his CTP this week.
11 He's good to go.
12 MSGT MacKENZIE: And that's, I
13 mean, we are only getting samples. I mean,
14 Camp Lejeune, for instance, I have a - the
15 captain brought me six CRPs from people who
16 had checked out of the Wounded Warrior
17 Battalion there.
18 And as we went through them, I was
19 just like, oh, my goodness. I mean, there was
20 no follow-up. There was single-point entries.
21 There was no follow-up. And he was like, I
22 don't know who to talk to about this because

1 it's like, I mean, as I look through the
2 folder after the fact, here's these things
3 that say, you know, Marine wants to go to
4 school. That's it.
5 There's no saying that anybody has
6 assisted him. There was no way of saying that
7 that form was being used. That Marine may
8 have gotten assistance, but none of that stuff
9 was - there was no accountability for the
10 document being used correctly.
11 CO-CHAIR GREEN: So, let me take
12 another try. So, feedback loops should be
13 established to ensure review of utilization of
14 this tool and that the RCC is responsive to
15 recovering warrior/caregiver inputs.
16 Because, I mean, it would be like
17 overseeing a PA, okay, or an extender.
18 Essentially I review ten percent of the
19 records to see what's going on.
20 So, you know, we basically, I
21 mean, we don't tell them what the feedback
22 loop is. But, I mean, if I was, you know, so

1 review a certain percentage and basically you
2 have a problem, or you don't have a problem.
3 So, we can basically add that to
4 Number 4, which then kind of is a
5 continuation, yes.
6 MSGT MacKENZIE: Excellent.
7 Thanks, sir.
8 (Discussion off the record.)
9 MS. DAILEY: Okay. And the Marine
10 Corps made that commitment to us in the
11 February meeting that they were going through
12 their CRPs, quality controlling them, pulling
13 out the ones that needed review at that level.
14 So, that's a good place to document it.
15 The Army had made commitments 1
16 December, revised program. The Army really
17 has a - I call it a marketing problem with
18 their CTP. It is not well-liked by the
19 servicemembers. All the perceptions you have
20 out there is correct.
21 It is a very comprehensive
22 document. It's just it's not well-liked. And

I don't know that the Army is going to be able to solve that.

MSGT MacKENZIE: But it's also not well-trained, as we discovered based on where you went. Some of the information everybody said they couldn't find, once we discovered the smart person that knew how to find it, it would then become a more useful tool. It's just the guys weren't learning all the ins and outs on how to use it. And when they were going to their squad leader or platoon sergeant, they didn't know how to get to it either.

And I think that one location where you found the one guy that knew how to do it and everybody else was like, oh, wow, it kind of changes the perception and utilization of the tool once people know how to read it.

MS. DAILEY: Correct. And again commitment is made by the Army on 1 December to fix/address those things, to increase the training, to ensure those squad leaders,

1 platoon leaders, whole staffs understand the
2 process and the meaning of that CTP.
3 We don't know how effective that's
4 going to be. I don't think they're ever going
5 to overcome the negative perception of the
6 CTP. They've made commitments to work it
7 aggressively.
8 MS. MALEBRANCHE: I think just one
9 other comment, Denise, and I don't know how we
10 would feed this back to the Army, but I think
11 the reason that the people were not receptive
12 is they saw nothing come of it.
13 So, maybe there's some type of if
14 they saw it being used in a positive sort of
15 way, then I think that would be an impetus,
16 but the people that we spoke to said it wasn't
17 being used.
18 And similar to what Colonel Keane
19 mentioned, we talked to people that had put
20 observed stuff in it and people didn't even
21 recognize it. Just they were doing that to
22 see if someone was looking at it and would

1 offer the help.

2 CO-CHAIR CROCKETT-JONES: I also

3 want to say Colonel Keane is right. What I

4 thought was the eCTP is actually part of the

5 eCTP. There are not two - just two layers of

6 the Army CTP. There are three.

7 There is a portion of the eCTP

8 that is available, then there is the whole

9 eCTP, and then there is the whole CTP. So,

10 it's even more convoluted than I thought.

11 LTCOL KEANE: Ms. Crockett-Jones,

12 during the break could you call my wife and

13 tell her that I was right once?

14 (Laughter.)

15 CO-CHAIR GREEN: The other thing we

16 probably need to decide, are we going to put

17 some of the comments regarding the problems

18 with the electronic CTP into our report, or

19 are we going to - because from my perspective,

20 what you're really looking for whether

21 electronic or paper, you're looking for

22 something that documents the interaction

1 between the RCC and the recovering warrior.
2 And the reason you're looking for
3 the documentation of that interaction is to
4 show that that communication is taking place.
5 And so, whether they do it on
6 paper or do it electronically, a lot of the
7 things that I heard is people who were walking
8 about the CTP, is simply not liking the
9 electronic and not liking the way the
10 information presented or having to learn an
11 electronic system to basically be able to
12 interface.
13 And so if you're centralized, it's
14 actually probably more important that you have
15 some way that you're getting immediate
16 feedback. But whether it's electronic or on
17 paper, you know, what the interval is, I don't
18 know that we need to define any of that. It's
19 just we're looking for a way that they're
20 documenting and showing that the
21 communications are taking place.
22 DR. PHILLIPS: Yes, I would suggest

that, I mean, I think we should address it, but very broadly. That those places that identify technical issues related to communications should look for solutions.

CO-CHAIR GREEN: Again, their CRP could even be an email chain that's going back and forth where you share these are the plans and it comes back.

I mean, there's actually a format, I think, for the CRP. I'm not - but I -

MS. DAILEY: Yes, there's a format outlined in the DoDI and relatively prescribed and -

DR. PHILLIPS: Right.

MS. DAILEY: And they have was of checking it and tabulating it from the DoD level to quality control it at the DoD level, to quality control it at the higher levels. Pull packages, basically.

And the CTP is a vast document. It has technical difficulties. I have to tell you guys we're making a recommendation on

1 fixing technical difficulties that are
2 ubiquitous and everyone has to deal with them
3 every day.
4 CO-CHAIR GREEN: Well, that's why I
5 think the answer we'll get back even on the
6 feedback loop, should be establish to ensure
7 reviews.
8 I think you're going to hear DoD
9 say, hey, we look at these all the time, okay.
10 And the problem is that they're not looking at
11 any patient input and not looking at how the
12 RCC is reacting to the patient input, they're
13 looking for is this box filled, is that, you
14 know. That's the problem.
15 CO-CHAIR CROCKETT-JONES: So, maybe
16 I'm tired. So, what is it exactly we're
17 talking about recommending?
18 CO-CHAIR GREEN: Let me see if I
19 can help. So, basically on Number 4 we'll say
20 that the CRP/CTP has been clearly delineated
21 as the responsibility of the RCC and the
22 communication plan to the - and that the RCC

1 is responsible for communicating the plan to
2 the recovering warrior, okay.
3 Our visits indicate this tool is
4 not yet a meaningful tool for recovering
5 warriors to track progress, the CRP/CTP should
6 be accessible to the recovering warrior, the
7 family and caregivers, and that
8 servicemember/family/caregiver should be
9 encouraged to contribute to the CRP whether
10 electronic or paper.
11 Feedback loops should be
12 established to ensure review of utilization of
13 this tool, and that the RCC is responsive to
14 the recovering warrior/caregiver inputs.
15 Now, if you want - I didn't
16 include anything specific because I'm assuming
17 they will give us all those kinds of things
18 that basically back this up.
19 But, I mean, from the standpoint
20 of dissatisfaction with the electronic tool or
21 satisfaction with the electronic tool if we're
22 going to say that the CTP is a best practice

because of the effort to make it electronic, I mean, that's okay.

But, I mean, whatever the backup to this is and then the question is, do you want to be more specific on what the feedback should be, or do you want to be more specific about how often caregivers should be putting - or the, you know, family member, the recovering warrior should be putting things in that?

From my perspective, somebody who's basically stable and waiting on IDES if they don't have an entry for several months while they're, you know, that's okay. If that's okay with both parties, then that's okay. It's really about communication.

CO-CHAIR CROCKETT-JONES: No, I think what you've written is actually fine. I just needed to hear it in a cohesive sentence beginning to end rather than -

LTCOL KEANE: Next one - or go ahead.

MS. DAILEY: A couple more things I just - in the units and programs. I am concerned we took command climate issues off. We considered it a met piece.

Sir, ma'am, I do have concerns when you talk to Congress, what they hear mostly are the command climate issues. Frankly, that's what comes to them almost all the time. That's what breaks their threshold of awareness.

It is having to chase down chains of command and unit climate issues that servicemembers have brought to them.

I'm not sure you should leave the command climate without a recommendation that you still recognize it as something that needs work and needs continuous emphasis.

DR. PHILLIPS: I might add or suggest I add to that comment is that the command climate depends on the location.

I mean, if we were at Walter Reed, it's a lot different than Twentynine Palms.

So, I don't know if we have to consider that. And that, to me, fits in somewhat in Number 2. And even with 16.

LTCOL KEANE: For some of these, do we actually need to make a recommendation, or we as a Task Force need to put it on our back burner?

And if it continues to not improve or get worse, then at a following recommendation, I mean, we would have two years of data and say, here, you know, we recommend it in Year 1. Now, it's Year 3.

CO-CHAIR CROCKETT-JONES: And I - to go along with that, I think that as it was worded, we asked them to define the command climate and to disseminate standards. And I believe that they had - they did that.

Whether their standards are being met, whether that is actually fixing the issue, is sort of a different - I think that we - that that recommendation was not about outcomes. It was about taking action.

1 And if we want to recommend in the
2 future, we need to be talking about the
3 outcome that we want to see rather than an
4 action without an outcome.
5 MS. DAILEY: Yes, the best model
6 for trying to address these types of topics,
7 I think, come from the equal opportunity
8 environment in which commanders publish an
9 equal opportunity statement saying no one will
10 be discriminated against. Everyone is equal,
11 race, color and creed, religious and other
12 factors. And, you know, a product that
13 commanders might want to think about producing
14 would be a equal statement.
15 You're a soldier, sailor, airman,
16 marine. You will not be diminished because of
17 your illness or injury. You will not be
18 accused of malingering in my organization.
19 I'll treat you with the respect and the care
20 that you require.
21 And if you find anyone who accuses
22 you of malingering, you're to bring them to my

1 attention so that we can address this.
2 Something along those lines.
3 That's the model, so to speak.
4 DR. PHILLIPS: Maybe I could take a
5 crack at Number 2 and Number 5 in a broad
6 area. Because Number 2, we said, was not met
7 and has to do with standards and criteria.
8 And maybe I'm off track, but I was
9 looking at this last night. And if we go to
10 Tab J, Page 2, it's the second bullet down,
11 purpose of a WTU.
12 And if you look at the purposes
13 that are described under the hollow bullets,
14 to me it backs into a definition of a WTU
15 which in some respects, broadly covers issues
16 of command climate and so forth; provide
17 holistic care and leadership to soldiers,
18 singular mission is to provide comprehensive
19 care management, et cetera, et cetera.
20 And I'm just trying to find
21 perhaps the right words to somehow redo 2 and
22 5 and combine it with 16, because I think

they're all connected to make it meaningful.

That if we define a WTU as it already is defined in the handbook or purposed in the handbook, then I think the other things fall into place.

Now, I just throw that out for discussion, but that's the way I was picturing it.

And I might add that perhaps we may have to think about the WTUs at different levels like we do trauma centers. Level 1 trauma center is comprehensive 24/7 with all services. Level 2 is a little different, and Level 3.

And going back to Mac's point, I agree with you that Twentynine Palms is not going to get rid of and none of the remote bases are, but maybe you can define - and I don't want to complicate it anymore than it is, but define the WTUs at different levels.

And then maybe early on people with Level 3 or even some Level 2s can go

1 directly there to the holistic environment
2 than staying in the remote environment.
3 I don't know. I'm just throwing
4 that out and I haven't really defined it.
5 CO-CHAIR GREEN: They didn't
6 understand what we said the last time. And
7 so, I think that maybe we should be very
8 specific. And the way to do that may be to
9 talk about as we see diminishing flows of
10 casualties, the Department will need to make
11 decisions on where to maintain WTUs and WWRs.
12 And should be developing guidelines for which
13 facilities would be sustained longer term and
14 whether or not there should be some
15 capability, some transition units that are
16 aligned with VA institutions that have a
17 longer term rehabilitation capability.
18 I think we, I mean, we ought to
19 push them a little bit. Because if we do
20 that, and then kind of the follow-on piece is
21 decisions on services to be available at base
22 level will play into the need for WTUs.

1 So, we bring that SFAC one, which
2 I think was 16, and we bring that one into
3 this. Services that will be available on base
4 will have an impact on this.
5 But if all services closed down
6 all their transition unites, then, you know,
7 basically DoD is going to lose it's expertise.
8 And so, how do you cover that?
9 That's what I tink we need to capture in this.
10 DR. PHILLIPS: I think you defined
11 it for me. I mean, I buy into that and I -
12 really spot on. You were spot on yesterday
13 with the integration of the VA rehab and I
14 think we should add that.
15 CO-CHAIR GREEN: I just think it's
16 an opportunity we should kind of for them to
17 think about because it is something that's
18 real.
19 I mean, they may come back and say
20 we're going to maintain, you know, as this
21 happens, we're going to maintain Walter Reed,
22 okay, the Walter Reed, Bethesda campus and the

1 San Diego campus, okay, and they may say one
2 other. So, SAMMC would be the other likely
3 one that DoD would retain.
4 And so, if that's what they're
5 going to do, then that's okay. But they ought
6 to be thinking about this from a DoD
7 standpoint, because it's going to be
8 significant.
9 DR. PHILLIPS: I would love to
10 recommend even a pilot where you integrate a
11 VA and a DoD rehab as a test, you know. Find
12 some cool located facility and say, listen,
13 let's see how this works.
14 Because as we draw down and move
15 from DoD to VA, personnel who have been moved
16 as well. I mean, I think it's what you said
17 yesterday. It was very logical.
18 CO-CHAIR GREEN: Yes, to put in
19 there and say that consideration should be
20 given to leveraging the VA's long-term
21 rehabilitation hospitals in this plan, I mean,
22 so we could basically see that kind of

1 interaction.
2 MS. DAILEY: They do have two
3 combined facilities that I can count, right?
4 North Chicago and Nellis and Vegas.
5 CO-CHAIR GREEN: Nellis, Travis,
6 North Chicago. I mean, there's a lot of
7 combined facilities. But when you're talking
8 about the VA's rehab capability, it's really
9 soon to be San Antonio, down by Tampa, I mean
10 -
11 MS. DAILEY: What is a rehab
12 facility, yes.
13 MS. MALEBRANCHE: Well, our
14 polytrauma center, I was thinking we should
15 maybe have the rehab person come talk to us,
16 but there's five. Well, San Antonio is the
17 fifth one. But Minneapolis, Palo Alto, Tamp
18 and Richmond.
19 MS. DAILEY: Those are the
20 polytrauma centers.
21 MS. MALEBRANCHE: Right, but those
22 are - polytrauma centers are really major

1 rehab facilities.
2 MS. DAILEY: Okay.
3 MS. MALEBRANCHE: And the general
4 was absolutely right. That is our business.
5 And so, that might be something that would
6 come out of her as well. It makes sense.
7 CAPT EVANS: Right, but they're not
8 integrated facilities.
9 MS. MALEBRANCHE: No, they're not.
10 And North Chicago is the total federal
11 facility. And that's probably the -
12 CO-CHAIR GREEN: But remember what
13 we're suggesting is that DoD maintains some
14 expertise in this field by putting their
15 people in those VA facilities.
16 It doesn't necessarily have to be
17 an integrated facility that we do this at.
18 It's just that we need to think about how are
19 we going to maintain skills. And the VA
20 really does have a lot greater chance of
21 taking care of chronic rehab long into the
22 future than DoD does.

1 CAPT EVANS: Are we able to make
2 that recommendation from the Task Force?
3 MS. DAILEY: Yes.
4 CO-CHAIR GREEN: I think so. San
5 Antonio is fairly easy based on a large
6 presence down there. Richmond is a little
7 harder, but there are some existing
8 relationships with the national capital area.
9 And so it's -
10 MS. MALEBRANCHE: And the Navy - or
11 I mean in the medical - the civilian sector
12 too, but San Antonio would be ideal for that.
13 And it seems like this task force ought to be
14 addressing some of the obvious things with
15 drawn-down, and that would be certainly one of
16 them.
17 MS. DAILEY: Yes, unlike some of
18 the other recommendations, I mean, it is a
19 prospective. It's a leaning forward. I don't
20 have a lot of data behind it other than
21 collective expertise of my members here to say
22 we think this is a good idea.

1 CO-CHAIR GREEN: I think we use the
2 data showing the decreasing size of the
3 numbers, but like we can use the marines
4 especially where the decreasing numbers will
5 lead to decreasing personnel. And therefore,
6 decreasing expertise.
7 MS. DAILEY: Okay. I mean, if
8 you're talking the WWR, the WWR has increased
9 in size over the last year. And the Army has
10 maintained its WTU population from last year
11 to this year.
12 Now, it doesn't mean that we're
13 not drawing down. I just don't want to use
14 those figures.
15 CO-CHAIR GREEN: If you use the
16 casualty flow, the casualty flow is definitely
17 diminished when you look at the numbers coming
18 in on airvac. I can get those numbers for
19 you.
20 MS. DAILEY: Okay. I mean, yes, we
21 can peg it to that. But the unit sizes as of
22 right now are the same as they were last year,

1 and the Wounded Warrior Regiment has increased
2 in size.
3 CO-CHAIR GREEN: I think that just
4 the IDES is going down? Is that what -
5 because, I mean, they've cleared out hundreds
6 out of their IDES program. It was fairly
7 impressive at Lejeune.
8 LTCOL KEANE: I think Ms. Dailey is
9 talking about not just the wounded, ill and
10 injured, but also the cadre. For that, we
11 have a more -
12 CO-CHAIR GREEN: Are you talking
13 cadre size, or are you talking about the
14 number of patients?
15 MS. DAILEY: They are in proportion
16 one to ten. So, as the cadre size and the
17 wounded warrior size goes up, they're in
18 proportion.
19 Now, the IDES, the backlogs in the
20 IDES, that's a correct perception, sir. The
21 backlogs in the IDES are being cleared out.
22 Your overall IDES population is

1 22,000 and it's on one of these. Not saying
2 it's not going to be dropping off, but WTU,
3 Wounded Warrior Regiment sizes are - for the
4 Army, it's comparable to last year. And the
5 Wounded Warrior Regiment is a little larger.
6 The other item we might want to
7 peg in here, ladies and gentlemen, considering
8 you're still going to need an oversight
9 organization to bring these organizations to
10 look into the future, the change in trend, the
11 change in the upcoming - not necessarily the
12 change, but the upcoming elections change
13 policies.
14 The Wounded Warrior Care and
15 Transition Policy Office is not in
16 legislation. It could easily go away with new
17 personalities, with new leadership. It might
18 be something you want to embed in the DoD as
19 an agency to drive policy change in this area
20 in the future.
21 There's nothing that anchors
22 Wounded Warrior Care and Transition Policy to

1 DoD. It's a new office. It's less than three
2 years old.
3 MS. MALEBRANCHE: Ms. Dailey, isn't
4 the Wounded Warrior Transition Policy, aren't
5 they currently moving under Health Affairs?
6 I know there's -
7 MS. DAILEY: Correct. Mr.
8 Campbell's office, Mr. Burdette's office moved
9 under Health Affairs.
10 MS. MALEBRANCHE: Okay. They're
11 not permanent though is what are you saying,
12 or are you talking about the -
13 MS. DAILEY: That's correct.
14 They're not a permanent - they're not
15 permanent. They're not established in
16 legislation.
17 Ad hoc from the beginning to deal
18 with many of these issues sort of like the
19 SOC, stood up. Potential for it to stand
20 down.
21 If you were thinking about long-
22 term transition policy development, you have

1 the potential to lose that office and for it
2 to go back to the services, which is not a bad
3 idea, but I need you to philosophize about how
4 much DoD oversight and long-term DoD oversight
5 of non-medical care management do you want
6 institutionalized in the Department of
7 Defense?
8 And the only way you're going to
9 be able to do it is probably with legislation.
10 MS. MALEBRANCHE: I guess I don't
11 know. We deal a lot with that office, I mean
12 those offices from VA. And I'm thinking
13 Health Affairs has the ability to create or
14 not, I guess, certain agencies within the
15 services.
16 But I don't know - I'm not exactly
17 sure about this one. I'm thinking that they
18 have now a work group under the JEC. And so,
19 even though there is not the WWCTP office, is
20 what we call it, the WWCTP under Health
21 Affairs, you do have it in the JEC. And that
22 is a legislative body that can create or not.

1 So, you know, I don't know how
2 much you think it's important to have it in
3 there.
4 CO-CHAIR GREEN: Yes, I hate to
5 dictate what the org structure should be. I
6 thought that when we put this into the JEC,
7 that that basically had it covered. Am I
8 missing something?
9 MS. DAILEY: You put the - you
10 requested that the SOC functions -
11 CO-CHAIR GREEN: Right.
12 MS. DAILEY: - which is a working
13 group, be integrated with the JEC. The Policy
14 Office for Non-Medical Case Management, the
15 Policy Office that wrote the RCP, the Policy
16 Office that runs the Warrior - the Policy
17 Office that runs the Operation Warfighter, the
18 Policy Office that's supposed to be writing
19 the internship program's DoDI, the Policy
20 Office that writes the IDES is -
21 CO-CHAIR GREEN: So, rather than us
22 saying what the Policy Office should be, I

1 think that when we talk to that one that we
2 say that we've - the SOC has been incorporated
3 into the JEC and that we still require
4 legislation to get the, you know, to solve the
5 leadership issue. But we can put another line
6 in there saying that policy, you know, now
7 that it's a line, DoD must ensure that they
8 maintain a policy function within without
9 necessarily telling them how to establish
10 that.
11 MS. MALEBRANCHE: Yes, I think
12 that's - the function stays regardless of the
13 organization.
14 CO-CHAIR GREEN: The org structure,
15 right.
16 MS. MALEBRANCHE: That makes a lot
17 more sense.
18 CO-CHAIR GREEN: Because, I mean,
19 essentially we say thank you for doing this.
20 And then we say DoD must maintain a policy
21 function. And then we talk about the
22 congressional language that's required for

1 this. I think that would solve it.
2 MS. DAILEY: Okay, ladies and
3 gentlemen, it is - we can work a little
4 longer. We are an hour behind. We have not
5 have a chance to get to medical case
6 management.
7 Dr. Phillips and Lieutenant
8 Colonel Keane, what else do you have on your
9 list?
10 DR. PHILLIPS: 12 and 16. 16 we
11 agreed, I think, to move into Number 2. So,
12 basically it's Number 12 which we really
13 discussed and has been partially met.
14 The only suggestion or thought I
15 had was to add language to develop a core
16 competency curriculum.
17 We recommend training, ongoing
18 training, skill identifiers and so forth, but
19 I don't know if there's a basic core
20 competency curriculum --
21 MS. DAILEY: Yes.
22 DR. PHILLIPS: - that everybody

uses.

MS. DAILEY: Well, the services briefed us on their training requirements in December. And then the Marine Corps briefed us as part of their briefing in February. This is partially met again.

Right now, ladies and gentlemen, I know you all said to be revisited and identified with the training gaps and with examples. I don't have any right now.

CO-CHAIR CROCKETT-JONES: Do we have the response for Number - what was the implementation response for Number 12?

MS. DAILEY: That they are trained. That they've got skill identifiers. They laid it out when we asked for them in the February and December briefings.

Hard to evaluate - hard to evaluate when new programs are so new. I mean, the apps, the Marine Corps talked about the apps that they were using for training and access to apps.

1 Wasn't that one that he was very
2 excited about?
3 CO-CHAIR CROCKETT-JONES: This
4 might be one that we need more data.
5 MSGT MacKENZIE: Well, the fact of
6 the matter is that everybody has addressed
7 this and they're ramping these things up. But
8 like Denise said, I mean, it's fledging. It's
9 new.
10 I think the only thing we saw that
11 was potentially recommendable was that
12 jointness of training where there was
13 resources available in the Marine Corps, there
14 was resources available with the Army
15 training, there was resources where we could
16 combine some of this training and come out
17 with very skilled individuals. But the
18 reality is the training that we ask for, I
19 believe they are standing up and it needs to
20 have further follow-up in another year to say
21 is this actually meeting a need. Do we see a
22 change in the quality and so forth of the

1 individuals?

2 CO-CHAIR CROCKETT-JONES: Yes, this

3 may be one that we need to be careful about

4 collecting data at our upcoming installation

5 visits in order to revisit next time around.

6 CSM DeJONG: Looking at the votes

7 that are there, I even yesterday looking at

8 it, it's hard to say partially met because the

9 votes that are there, I believe, are met based

10 off of the responses that we got from each

11 service.

12 CO-CHAIR GREEN: You can say all

13 services have addressed training and

14 established standards. Future site visits

15 will evaluate quality of this training and

16 implementation, okay, because, I mean, it

17 really has to be implemented.

18 And then you can go on and talk

19 about your issue with continuity, okay. We

20 are very interested in continuity of services

21 and continuity of expertise.

22 And so, I mean, however you want

to say that.

MS. DAILEY: Yes, and we don't have to recapture last year's recommendations as met or not met. We - yes, yes. So, if we are looking at continuity, if you're still concerned about continuity in these organizations, yes.

If we're looking at training and are the adequately trained, you know, there's been a recent revamping of the POIs and tough then to subsequently evaluate that with so little time.

And the jointness, you know, some of this training could be integrated to create joint or purple or more purple cadre and expertises out of the box. A good idea.

MR. REHBEIN: The second bullet, though, the recruitment and retention, have we really heard anything about what they're doing to make those positions prestigious and career-enhancing?

CSM DeJONG: Well, we can give

1 examples. I mean, there's nothing wrong with
2 giving examples of positive things where we've
3 seen those kinds of activities. And then just
4 kind of ending our comments with we remain
5 vigilant to see continuity of operations and
6 experience.
7 And so, that's what they hired us
8 to do for five years.
9 CO-CHAIR CROCKETT-JONES: Yes, and
10 since that's more of the commentary, that's
11 probably part of the executive summary and not
12 a recommendation we need to revisit.
13 CO-CHAIR GREEN: We don't have to
14 go back and say met or not met. We don't have
15 to address last year's findings at all. I
16 mean, I think that, yes, you're right. It may
17 well just go on the exec summary and then we
18 go on to what we really want to talk about
19 this year.
20 CSM DeJONG: I thought the main
21 reason that we were looking at last year's is
22 just to see if there's something - like some

of that they clearly didn't understand, sir.

It was important enough to put on last year's. If they clearly didn't understand her wording, possibly want to revisit it this year with some wordsmithing.

LTCOL KEANE: Sir, you brought up a good point which made me think of the ones that we tabled last year. Not to add more homework to us, but is there any way the team in the back can let us know which ones we tabled last year to see if we need to revisit them this year?

CO-CHAIR GREEN: IDES was the big one, but there are some others. You're right.

MS. DAILEY: And if you all take a look at your discussion points, they are captured in there.

LTCOL KEANE: Denise, these are the ones from last year, right? The ones that we tabled that we decided not to recommend?

MS. DAILEY: Yes. We went back through those and some of them are in here.

1 They're kind of rejiggered with updated
2 information and updated information that you
3 all have talked about over the year.
4 For example, last year we tabled
5 whether we wanted to make recommendation on
6 for medical case management. We tabled
7 whether we should tell them to publish the
8 policy because we were going to bring them in
9 and have them talk to us about the policy.
10 So, I've had them in twice talking
11 about medical case management and the status
12 of the policy. And so now here you see we are
13 ready to tell them to publish it. Stop doing
14 whatever you think you need to do, and
15 publish.
16 And so, you see a lot of this in
17 here that we put off because let's see how
18 it's going, you know, let's get a little more
19 data and, you know, time to execute.
20 Same thing with TAP. Last year we
21 didn't say, TAP, you need to put a DoDI out in
22 here. We didn't get to it yesterday, but I'll

roll it into the next one. I mean, that's kind of recycled from last year. Publish a DoDI.

So, yes, your discussion points are a comprehensive opportunity to discuss these issues, both last year's and this year's, and your observations.

LTCOL KEANE: Thank you.

MS. DAILEY: Lunch.

CO-CHAIR GREEN: And, Denise, what time do you want us back?

MS. DAILEY: One o'clock.

CO-CHAIR GREEN: Okay. Thanks.

(Whereupon, at 11:59 p.m., the above-entitled matter went off the record and resumed at 1:07 p.m.)

1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N
2 1:07 p.m.
3 CO-CHAIR CROCKETT-JONES: Once
4 again we're going to review the topic of
5 medical case management. Last year we created
6 recommendations 2, 3, 7 and 11 related to this
7 topic. Although, I'm not really sure that 11
8 is - I'm not sure I put that in there.
9 Effectiveness documents for this
10 topic can be found in Tab K. It falls under
11 Restoring Wellness and Function.
12 So, once again Dr. Phillips,
13 Lieutenant Colonel Keane. Medical case
14 management, I think we should also - we might
15 want to tap out the - what is this called?
16 CO-CHAIR GREEN: Discussion items.
17 CO-CHAIR CROCKETT-JONES:
18 Discussion points.
19 LTCOL KEANE: Of those numbers you
20 read, ma'am, I believe that leaves us with 11
21 that we haven't actually discussed today; is
22 that right?

1 MR. REHBEIN: Well, we spent a lot
2 of time on the last sentence of 11, but I
3 don't know that we've touched any of the rest
4 of it.
5 CO-CHAIR CROCKETT-JONES: Isn't 11
6 mostly non-medical case management?
7 MSGT MacKENZIE: It's a combination
8 of both of them and I think we're trying to -
9 the disparity between that connection and the
10 - between, you know, DoD, VA medical case
11 management for the individual, for the
12 recovering warrior and their family. I think
13 that's what we were looking at, but -
14 DR. PHILLIPS: We were sidebarring
15 here and as Dave said, we spent a lot of time
16 talking about the last sentence. And I'm not
17 sure what the issue related to the rest of it
18 would be.
19 MSGT MacKENZIE: One of the things
20 was the number of people responsible for the
21 care, I think was the gist behind that. Was
22 everybody, you know, you end up with an FRC,

1 and RCC, a medical case manager, a non-medical
2 case manager.
3 And I think we were trying to
4 define the individual roles and how they play
5 in to the care to reduce the number of people
6 that are, quote/unquote, the one go-to person
7 for all care.
8 DR. PHILLIPS: So, I certainly
9 understand that. It's just that I didn't know
10 if there was ambiguity in the way we phrased
11 it last year or - it seems pretty clear. Just
12 define the roles.
13 CO-CHAIR GREEN: Didn't the DoDI
14 just do this?
15 CSM DeJONG: Discussion Point 1
16 talks about publishing the medical case
17 management DoDI and clinical case management.
18 CO-CHAIR GREEN: So, it's not
19 published yet, but it's - we've got the draft.
20 Because we've been looking at that regularly.
21 MS. DAILEY: Correct. There have
22 been significant commitments that it's going

to be in coordination, or it's in coordination, or that we're revising it.

And we had them and they briefed us. They seemed to have a plan. But the best way to hold them accountable to it is, you know, put the put or put the published language in a recommendation. Publish it. Get it on the street. Provide that guidance.

CO-CHAIR GREEN: The line should read something like gray draft, publish the damn plan. So, got it.

(Laughter.)

MS. DAILEY: Yes, that's it, sir. They've briefed us twice and the DTM is two years old now. They've gotten extended. I think it gives them motivation for us to have this in the report, get it down to them, see that we're paying attention.

CO-CHAIR GREEN: So, the other thing kind of related to 11 is this issue that we were working on regarding who is it that the people are really using, right?

1 There was a lot of confusion at
2 least earlier in the year talking about are
3 there too many case managers? Is there too
4 much redundancy? Do we have too many people
5 involved with this to where our casualties or
6 recovering warriors are actually confused by
7 who they should go to?
8 And so, thoughts on that. I mean,
9 we spend a lot of time kind of trying to
10 discern that. Do we think that there are too
11 many? Is there anything we want to say in
12 that light?
13 MSGT MacKENZIE: I want to look at
14 it from a VA perspective, okay. The VA,
15 you're dealing with two separate things;
16 benefits and healthcare.
17 Okay. When you're talking about
18 the care management of the warriors, it's the
19 same thing. You've got your non-medical
20 benefits coordination way ahead, so on and so
21 forth. And you've got your medical. This is
22 your medical treatment plan.

1 I mean, we're not going to reduce
2 this to one point of contact for the warriors.
3 I think what we need to do is clarify that
4 there is your medical treatment plan, medical
5 recovery plan with your medical case manager.
6 And there is your benefits and,
7 for lack of better terms, personnel actions by
8 your non-medical care manager who then is
9 determined as either - like in my case, you
10 know, I have an AFW2 advocate. That's my
11 lead. My non-medical care person who's
12 looking after the non-medical stuff. And I
13 have a nurse case manager who's looking after
14 my medical stuff.
15 You know, those two are still
16 talking, but it's - those are two distinct
17 lanes that I think when you look at the VA,
18 they have that right where you can't get to
19 one person. You have to look at benefits and
20 - benefits and non-medical actions in your
21 medical treatment recovery plan.
22 CO-CHAIR CROCKETT-JONES: And my

1 impression from our comparing installation
2 visits this year to last year, is that
3 recovering warriors have a better idea of what
4 is their medical case management. Medical
5 care is what that job really is.
6 I mean, they can sometimes
7 oversimplify and they can, you know, if you
8 try to ask them to differentiate between these
9 two, they're like do you mean the person who
10 makes my appointments, or do you mean the
11 person who sends me to TAP?
12 So, I mean, we've heard that kind
13 of conversation, you know, that kind of
14 response and discernment. I think that
15 they're getting more clear on this. I don't
16 think we have to revisit that.
17 MSGT MacKENZIE: I just think we
18 need to re-look at our recommendation because
19 we were trying to get it to one person. And
20 I think that we really need to emphasize that
21 there are two and that it's clearly defined
22 not only from the professional side, but from

1 the recovering warrior side.
2 Because I think if they're led
3 that way, they really do understand that
4 there's two entities. Although they work in
5 conjunction, there are two professionals that
6 look at this.
7 LTCOL KEANE: Without rewriting the
8 DoDI, the RCC is that person. I don't agree
9 that there's two. I believe there's one. The
10 RCC.
11 CAPT EVANS: Well, the RCC is non-
12 medical. You also have to rely on your case
13 manager for the medical. So, that's why he
14 was saying you have a non-medical and a
15 medical.
16 MR. REHBEIN: Yes, but I remember
17 some of that conversation correctly. And I
18 think a lot of the conversation revolved
19 around some of the more seriously injured.
20 And they were being besieged by three or four
21 or five people all wanting to help. And they
22 really were having trouble understanding -

they and their family were really having trouble understanding from their point of view, what each of these roles was, who these people were, what sort of reservices and resources that they each brought to bear.

And so, I think that standardize and clearly define the roles and responsibilities is as much for the benefit of the recovering warrior so that they know who these people are, as it is for each of these people to understand their own role.

So, I think I'm looking at it from a little different perspective from that person who's trying to recover and figure out who all these people are.

MS. MALEBRANCHE: And I know exactly what you're talking about. The FRCs were created because of that for the very catastrophically injured. And they had - they were the ones that came and first said they had so many. They needed a case manager for their case managers.

1 And the FRC was supposed to bridge
2 that gap, which is why the FRCs though
3 clinical, social work or nurses, they also
4 touch to the nonclinical side and they have
5 that whole FRC - the FRP, the federal recovery
6 plan.
7 I thought like Colonel Keane
8 mentioned, the RCC was supposed to be that
9 complement for all the others that weren't
10 quite so catastrophically ill, but to kind of
11 bring those pieces together. And I don't
12 think that is clear.
13 I do know the RCCs are non-
14 medical, but I did think that they were
15 supposed to have a single touch point and that
16 was supposed to be that touch point.
17 But fully knowing that they're
18 non-medical and that people do have two
19 separate issues, medical and non-medical,
20 hopefully he two are talking to each other.
21 And if not, I would think that the RCC is the
22 person to bring that together. I don't know.

1 But just like Sergeant MacKenzie
2 said, that has to happen because they have to
3 connect, but there are different points in
4 time that you need different people.
5 Like when you're seriously ill,
6 you need an acute case manager. You might
7 need a spinal cord injury case manager or TBI
8 case manger. Then the handoff as you get
9 better medically gets different.
10 The non-medical is also different
11 points at different time that you need
12 benefits or information about it. So, I think
13 we are not clear in here. I'm not quite sure
14 how we want to get that.
15 DR. PHILLIPS: I think part of the
16 problem was in the staffing so people were
17 crossing over their roles. I don't know what
18 he staffing is right now.
19 CO-CHAIR CROCKETT-JONES: And I
20 think that the tool by which they're supposed
21 to be keeping track of what each other is
22 doing is that CRP. So, until that's really a

1 functional tool, we're going to keep seeing
2 this gap.
3 MS. DAILEY: Keep in mind the
4 services run the allocation of the FRC and the
5 RCC. They are aligning them at the points in
6 time when they are - they want them in the
7 picture.
8 And I think, Colonel Keane, you
9 can describe the Marine's process for when the
10 FRC comes in and when the RCC comes in.
11 Is that at the same time, or are
12 you -
13 LTCOL KEANE: RCC first.
14 MS. DAILEY: First, okay.
15 LTCOL KEANE: To remind everybody,
16 the FRC is a - you need to be nominated. The
17 FRC program is in receipt. They have a secure
18 fax and that's how they - the primary means of
19 getting their datasheet in and that's how they
20 review cases.
21 They don't review every single CAT
22 3 catastrophic case. Only those that are

1 presented to them.

2 MS. DAILEY: Okay. And DoD is

3 controlling that. It is the service that is

4 saying we're - and in conjunction with the

5 servicemember that we're going to turn this

6 case over to an FRC.

7 LTCOL KEANE: Again, the FRC is for

8 the life of the servicemember. RCC is during

9 his time on active duty. So, it's initially

10 an overlap in conjunction.

11 MS. DAILEY: If the Marine Corps or

12 the Army or the Air Force has initiated the

13 process with the FRC.

14 LTCOL KEANE: And the come back and

15 evaluate the case and add that caseload to the

16 FRC program, that's correct.

17 MS. DAILEY: Correct. So, a

18 service may elect to not move a seriously

19 wounded servicemember into the care or under

20 the care into the program of the FRC until

21 farther down the road, a month, two months.

22 I mean, it is a service call.

LTCOL KEANE: It is anyone's call. A DISC, a nurse case manager. Anyone in the healthcare can present that one page to the FRC program.

The FRC program is a DoD/VA program. Not much DoD in there.

CAPT EVANS: We refer every Category 3 and some, again, some Category 2s. We, the medical side, refer those patients to the FRC program.

So, that's a referral from the social worker to the FRC.

MS. DAILEY: Good.

CAPT EVANS: So, we rarely wait for the services to make that call. Medical makes that call.

MS. DAILEY: Okay. I'm telling you that there are other people who think that the service is running that piece, too. That they're holding - there is a piece of philosophy that the service will want to utilize their RCC and wait until further down

1 the process before an FRC is assigned.
2 CAPT EVANS: Right, and we - what
3 we have done, we've asked the FRC not to come
4 into play until later in the picture. So,
5 they are not involved with the patient until
6 a closer time to outpatient or even when
7 they're getting ready for the disability
8 process.
9 MS. DAILEY: Okay. So, that's kind
10 of where I was going to you're not seeing the
11 FRC early in the process. The services, the
12 RCCs are medical, are providing those
13 services, and it is an active handoff to the
14 RCC.
15 CAPT EVANS: And I'm looking at
16 Karen. That is a change, because initially
17 they were involved in the inpatient side. And
18 we had to go back because the patients were
19 complaining of so many - of the hand - of who
20 has the lead role. Who's my one point of
21 contact?
22 And so that change we tried to

make - we did make that change in a lot of feedback from the Marine Cops as to too many people going into the room.

MS. DAILEY: So, there has been some separation of these roles for the RCC and the FRC in consonance with the services and when - and I use the word "services," but medical, yes, when the service wants to bring in the FRC.

I put that on you plate because is that how far down the line you think the FRC should be? I mean, they've struggled to kind of separate these roles?

Have they gone in the right direction?

LTCOL KEANE: Just to reiterate, since the second week of March the Marine Corps and the FRC program have been identifying FRCs earlier in the process.

MS. DAILEY: Okay.

LTCOL KEANE: It's a hard thing trying to get - there's 31 of them or 33 of

1 them, FRCs, because they are so proactive, to
2 stay in their lane, remind them that the RCC
3 is the lead.
4 But the idea between the FRC and
5 the Marine Corps is bring the FRC in earlier,
6 and there's really not a handoff because
7 they've been there at the get-go.
8 At the tactical 25,000 foot level,
9 the squad leader is there day to day, the RCC
10 is there week to week, the FRC may be month to
11 month or every few months.
12 But as the time gets closer and
13 closer to DD214, RCC is backing off, FRC is
14 getting more involved and then if the marine
15 needs a DISC also.
16 MS. MALEBRANCHE: I understand that
17 process. I'm just thinking the FRC was when
18 they first came up, but they are highly
19 skilled and, I mean, a lot of training goes
20 into those very few. And so, they have a very
21 broad brush.
22 It makes sense what you're doing.

1 It makes sense to me now because they have
2 that ability for that oversight and to oversee
3 and know who to bring in when. And it's
4 better earlier than later.
5 So, this is one of the things this
6 other group that's been charged to come
7 forward is to recognize who does what, because
8 this question is still not answered.
9 And it wasn't answered in the SOC.
10 And now the SOC's morphed into the JEC, and
11 it's still not answered.
12 CAPT EVANS: And it would be nice
13 to have those lanes clearly defined. Again,
14 we try to make it a referral process, you
15 know, why the VA came back to Walter Reed and
16 said we'd like to have referrals put into the
17 system when you ask for a FRC. So, that's the
18 way we - the route we went.
19 But when they come into the
20 picture, still it's very - we still have that
21 problem. FRC, RCC, case manager all walking
22 into the room to tell the patient I'm here to

1 help.
2 So, who's truly on first base is
3 the question.
4 MSGT MacKENZIE: See, the - I ran
5 into this several times being at the bedside.
6 And it - the problem was not with the
7 servicemembers. It's with these individual
8 agencies, okay.
9 When you've got a skilled nurse
10 case manager and you've got a skilled liaison
11 or non-medical person there at the bedside,
12 these things are being handled and that
13 communication needs to run between those other
14 professional agencies and the other, you know,
15 between professional agencies.
16 And that was where really the
17 disconnect lie is these people come into the
18 room and they were confusing the recovering
19 warrior and their families. Where it's just
20 as easy as I would pick up the phone, you
21 know, I've got a critically wounded guy, long-
22 term recovery plan. I'm talking to his FRC,

1 you know. I'm talking to his nurse case
2 manager. They're talking to, you know, we get
3 those lines of communication over. The FRC is
4 still managing what this individual needs
5 through the person who's got hands on.
6 I mean, when you've got that nurse
7 and that doc providing direct medical care
8 during a time where direct medical care is
9 required, you know, that's who should be
10 communicating with the FRC.
11 The FRC should not be
12 communicating at the bedside. And I think
13 that's what the services and some other people
14 are trying to establish, because there was -
15 a lot of my job was doing just that. It was
16 gatekeeper going, you know, when is the right
17 time to release the information with - during
18 the current phase of recovery when you've got
19 your non-medical person and your medical
20 people talking to one another, those other
21 agencies that are there in an overwatch
22 position waiting to move in are your go-to

1 people to make sure everything is going
2 correctly professionally as a professional
3 guy.
4 And then as that time happens,
5 they come into play. But it's, you know,
6 keeping the minimum number of people at the
7 bedside while still following the needs of the
8 overarching agencies.
9 And I don't know if I've just
10 totally confused everybody, but that's kind of
11 where the marines went with that. The FRC is
12 still there involved, involved through and
13 with the team, not inundating the
14 servicemember and their family at the bedside.
15 MS. MALEBRANCHE: Well, now - and
16 I'm harping on this one more time, but how the
17 Air Force presented what they're doing made so
18 much sense. And actually the pulling together
19 of the personnel and health people together,
20 I mean, in that area, just made so much sense.
21 And I'm wondering if part of, I
22 mean, I don't know if that's a pilot to look

1 at as something for future use or, you know,
2 jump right in, but that just seemed to me like
3 that was such - it's like why didn't we see or
4 do this before.
5 I don't know how that would work
6 with all this, but this obviously is that -
7 CO-CHAIR GREEN: We've had the DAWG
8 for about three years. Actually, it was
9 something we were putting into play about the
10 time that all this happened back in `07. So,
11 it's been in existence for a while. It's very
12 successful.
13 We didn't have as much luck with
14 the DAWG making the decision to enter into
15 IDES. That's where that 20 percent comes
16 from. And I really chalk it up to having
17 relatively junior physicians.
18 And so, that's why we centralize
19 to have a senior occupational physician make
20 decisions in terms of when it entered the
21 IDES.
22 That's brand new. That's just

1 really just started just here in the last
2 couple of months.
3 But the idea that everybody comes
4 together and discusses somebody, it's almost
5 like a family advocacy case. I mean, I know
6 that's the negative side of something very
7 positive, but it really brings all the
8 different places and people together so that
9 you kind of know when you stand it up, that
10 you've got all the parts and pieces to make a
11 decision.
12 MS. MALEBRANCHE: It's like that
13 CRP that we were talking about. I mean, it's
14 like a patient care conference is what I think
15 we used to call them. Similar.
16 CAPT EVANS: I believe in the Air
17 Force, the case manager, the medical case
18 manager drives a lot of as to overarching
19 bringing everyone together. And the Army is
20 the same way as the medical case manager.
21 And so, that's the - I think we
22 need to take that in consideration of the

1 models if we want to make a recommendation.
2 Because it seemed to me when I
3 looked at the different services, the ones
4 that have the medical side to take the lead in
5 organizing and bringing everyone together,
6 that's just again the small time I've been
7 involved, seem to have the most success in
8 taking care of that warrior.
9 So, again, I think we need to just
10 look at a model and maybe make a
11 recommendation from a model.
12 CO-CHAIR GREEN: So, in terms of
13 what we're trying to say here, it sounds like
14 to me that we're saying the evolution of roles
15 between the RCC and the FRC is progressing and
16 making significant progress with deconflicting
17 roles.
18 Still might be a role for FRC
19 earlier which is now being explored by the
20 marines. And then they altogether - I think
21 we just kind of put it into we're going to
22 continue to monitor this to make sure that

1 there's no confusion as to watch what DoD and
2 VA are doing. Because there is a work group
3 right now talking specifically to this to try
4 and see whether they should put them all into
5 one category, which would be interesting as
6 well.
7 The one that's meeting today that
8 you're both not there and delinquent, yes.
9 That's not good.
10 MS. DAILEY: Yes, making them one
11 group is a legislative change also because it
12 is a - the two roles are legislatively
13 mandated.
14 CO-CHAIR GREEN: We might want to,
15 I mean, we haven't talked very much about it,
16 but there could be an advocacy role for us
17 because this could be a way to get the VA and
18 that, you know, some of the things we talked
19 about yesterday in terms of getting
20 alternative futures in front of people
21 earlier, that might be a way of doing that.
22 MS. DAILEY: So, for medical case

1 management, we are going to put on the table
2 the new DoDI, publishing the case management
3 requirements, codifying them, so to speak, in
4 Department of Defense terms. We want to
5 revisit the roles and clarification of the
6 roles particularly between the FRC and the
7 RCC.
8 Medical case management is
9 something of a success, which is why we aren't
10 having a lot of material here.
11 I think that where we might have
12 some gaps would be in the Reserve component.
13 Iowa is a very good example of no case
14 managers on ground not - and those who are
15 calling themselves case management which are
16 heroic efforts, are - they're not in
17 compliance with the DoDI which has certain
18 training requirements to be called a case
19 manager.
20 So, I think the gap in case
21 management is probably in the Reserve
22 component.

1 CO-CHAIR GREEN: Do any of the
2 other services have centralized case
3 management or what we are calling our MEDCON
4 cell, medical continuity for the reservists?
5 Does anybody else have something like that?
6 MS. DAILEY: The Guard, sir, has a
7 fledging program which they briefed us on in
8 October at a pilot in seven states. And we've
9 captured their numbers in the effectiveness
10 document.
11 So, there is a pilot out there for
12 the National Guard to do it state by state.
13 It takes funding. It's going to take
14 resources. There's the gap.
15 CO-CHAIR GREEN: So, the other
16 thing we might want to highlight here is that
17 a consideration should be given to the
18 possibility of centralized case management for
19 reservists, if you see what I'm saying.
20 Not that any one role - model is
21 right, but just say we are noticing several
22 efforts to centrally case manage reservists

brought back on Title 10 orders. And I think that we will, again, we can comment that we're going to kind of evaluate that further.

I don't know we can say we have enough yet to talk about the success. But between the Guard program and the Air Force program, it might be worth pursuing because I do think there should be some type of case management for the Reserves. Otherwise, they'll get lost.

MS. DAILEY: Yes.

MSGT MacKENZIE: One of the sidebar discussions we had last night which I'd like to throw out to the task force for consideration was, in the role of activating a National Guad under Title 10 orders, there's several months of train-up, you know, train, equip and prepare this National Guard.

However, there are no time frames for the same level of resources during demobilization.

If the active component is

1 investing the time and the money in preparing
2 these warriors to join us on the battlefield,
3 what about that same level of input or
4 involvement to return them home?
5 It's just a concept to think
6 about.
7 CO-CHAIR GREEN: Yes,
8 demobilization efforts are interesting. A lot
9 of different things going on.
10 So, you've got the Army which
11 obviously, you know, we've seen one state that
12 had some problems before McCoy. But in large
13 part the Army's program of bringing them back
14 to one site for about seven days is working
15 fairly well.
16 The Air Force started bringing
17 their higher risk deployers, those people who
18 were working outside the wire, through about
19 a two-say program back in Landstuhl where they
20 get a lot of briefings on things that they
21 need to be considering.
22 And that's total force. So, it

1 really is about where you did your mission
2 versus whether you're active duty guard or
3 reserve.
4 And then I'm not as familiar with
5 the Navy's program for demobilization whether
6 you bring them back to a single site or not.
7 CAPT EVANS: No, I think it's east
8 coast, west coast as the site for demob.
9 Great Lakes is one site that they demob. And
10 they have another site on the west coast.
11 CO-CHAIR GREEN: I mean, is it a
12 standard length of time? Is there something
13 you're doing in terms of a two-day program, a
14 seven-day program?
15 CAPT EVANS: I'm not sure for the
16 Reserve. I'm not sure.
17 CO-CHAIR GREEN: But if we're going
18 to talk to demobilization, we really haven't
19 looked at that. So, there are some efforts to
20 basically do just what you're saying for all
21 service-related efforts in terms of where
22 they're taking people.

1 And so because we haven't looked
2 at it, we may want to see what they're doing
3 before we - so, that could be something we
4 table and look at next year to try and look at
5 a demob site especially based on McCoy.
6 So, we could even put in a report
7 that we want to look at a demob site to see
8 what are the standard processes.
9 MSGT MacKENZIE: And that's why I
10 wanted to just throw it out there, you know.
11 You bring in case management, you bring in
12 some of these other resources for four months
13 to make sure everything is broken down, you
14 know, versus, you know hey, we'll do seven
15 days and we're good, peace out, have fun.
16 Is that, you know, the level of
17 investment in time and resources to prepare,
18 we don't -- I don't think the active -- the
19 same level of commitment is given on the
20 backside.
21 And so, I just throw that out
22 there as something --

1 MS. MALEBRANCHE: I was going to
2 say one thing. I'd like to make a little
3 marketing thing here.
4 If you would invite the VA to
5 these demob exercises -- and we've been trying
6 to and we've been actually almost inviting
7 ourselves to many of them. To come in and
8 register these folks, because understanding
9 that they don't all stay where they demob, but
10 we have case managers, care coordination at
11 several facilities and in areas where the
12 services don't. And we also can let the folks
13 know what's out there and we can help with
14 some, I mean, this is our job. This is what
15 we are there for.
16 So, I think maybe more effort on
17 the demobilization piece of letting the VA
18 know when that's going to occur, you know.
19 We're invited guests. We can't go forcing our
20 way into these, but we do have to make some
21 plans and have like some electronic setups.
22 But I would say that maybe we

1 should do something in the way of
2 recommendation that the local VA or the VBA to
3 get us in there at this point, because they
4 get healthcare for five years, you know, when
5 they're demob'd back.
6 And they become veterans, and then
7 they're active duty, and then they're
8 veterans. So, we have a big part to play in
9 here and I think this is a good opportunity.
10 LTCOL KEANE: Ma'am, are you not
11 seeing that at the VA?
12 MS. MALEBRANCHE: We are in some
13 places, but not everywhere. Some places we're
14 like, you know, really trying hard.
15 And then the other thing, I think
16 it's dependent on what we know ahead of time.
17 I mean, it has to be planned. And most of the
18 time it's on the weekends, which is fine, as
19 long as we know in advance.
20 Because our same people that are
21 working during the week are the ones that are
22 coming out on the weekends. So, we've got

1 plans to make.

2 CO-CHAIR GREEN: I suggest for the

3 report because we haven't looked at a demob

4 site or what their standard processes are,

5 that we table some of it talking about based

6 on what we saw at Iowa, that we'd like to look

7 to see whether the VA is being routinely

8 incorporated.

9 I mean, drop the hint and so see

10 what -- if that doesn't change it without us

11 actually doing a finding, if you will.

12 If I can go back to the case

13 management, there's one other clinical case

14 management thing. We've talked about MEDCON

15 cells and centralized case management possibly

16 for the reservists based on a couple of pilots

17 that are out there.

18 But the other thing that came up

19 based on McCoy was once the state had a

20 problem, there was no outreach effort to help

21 them solve the problem.

22 And so, the other question would

be, do we need to comment at all on the need for recovery teams when a problem like this sets up?

I say "recovery teams," but I'm really talking about an outreach team, somebody who understands and knows how to work a lot of the issues, because I'd ask whether state to state was whether partners would help each other and whether you go back to big Army, you know, in this particular case.

I mean, And there seems like there should be somebody that could go out there and help Iowa with this and I just don't know who that should be. And so, what is the outreach team?

CSM DeJONG: I'd like to see something similar to mobilization -- and that's following up with the demobilization.

This was a conversation Mac and I had for quite a while last night, but I'd like to almost see a medical team come in for demobilization similar to how 1st Army does

1 mobilization.
2 That way they can start
3 coordinating a few things. They can have the
4 resources available. They can have -- as you
5 mobilize, it takes four months. They've got
6 all the equipment, ideas, trainers, all the
7 rest. But when you demobilize, you leave
8 theater, you fly back into your state and it's
9 just kind of you're on your own.
10 And now that we're getting more
11 complex into how we're doing this, our
12 warriors are getting smarter. And we're
13 coming up with more and more after two, three,
14 four mobilizations for some of them, they're
15 getting smarter and they're starting to want
16 to utilize what's out there. It's just that
17 states aren't ready for the sheer numbers that
18 are trying to get the help.
19 MS. DAILEY: And I definitely think
20 we have a gap here. What we need to probably
21 say is, is that the state surgeon is at, and
22 his team is at, all the demobs.

1 They do a white cell. This was
2 described to us at all three states. They
3 have a white cell and which at the end of the
4 medical demob line, they get to weigh in on
5 the referrals. And they get to weigh in on
6 the evaluations done on every member.
7 And then they get to butt heads
8 with the docs, with QTC who's doing those
9 evaluations, and attempt to turn around the
10 cases they feel have been misjudged, not
11 evaluated correctly, underevaluated.
12 That process is in place. Is that
13 what we're talking about? It's called The
14 White Team for each demob.
15 CSM DeJONG: Similar. Something
16 close to that, but that White Team needs to be
17 able to reach out to someone for federal
18 resources or more resources when they start to
19 get overwhelmed.
20 MS. DAILEY: Okay. So, when all
21 those cases are coming back to the states and
22 they've been unsuccessful in getting them to

1 a WTU, in getting them into a -- okay. All
2 right.
3 CSM DeJONG: And you're dealing
4 with sheer numbers in an area where you have
5 no medical treatment facility.
6 MS. DAILEY: Correct. Okay. Okay.
7 MR. REHBEIN: That was one of the
8 recommendations --
9 MS. DAILEY: Correct.
10 MR. REHBEIN: -- that Colonel
11 Osborne made when Iowa was out here to brief
12 us.
13 MS. DAILEY: Okay. Good.
14 MR. REHBEIN: If there had been a
15 group that could have come in --
16 MS. DAILEY: Right. Right.
17 MR. REHBEIN: -- maybe even in
18 that first 30 days to just help them get their
19 feet on the ground. Because so many of the
20 people that were handling the demobilization
21 were also demobilizing.
22 And so, they were conflicted.

1 CSM DeJONG: It goes along with
2 Number 2 in the discussion points under non-
3 medical case management, but we can throw this
4 into medical case management also to where it
5 says 54 states and territories of Guard
6 members who -- Guard and Reserve members who
7 meet the criteria for Category 2 designation,
8 but are not eligible for an RCC or to enter a
9 transition unit, will have access to alternate
10 resources.
11 That's where those alternate
12 resources would come from.
13 CO-CHAIR GREEN: You know, for the
14 case management, for instance, our expertise
15 rests in that MEDCON cell. And so if we had
16 a state that had troubles with a demob, we'd
17 send people forward from that site to
18 basically work directly with the state to get
19 some of this resolved.
20 It would be augmented by the Guard
21 or the Reserve headquarters if, you know, to
22 try and find where they're going to get help,

1 but none of that is very -- is specified right
2 now.
3 And so, each service may or may
4 not have a plan for how to help the ARC
5 forces, which is what I'm -- that's what we
6 found out with McCoy. Where do they turn?
7 And actually, it's not clear.
8 So, I do think that the gap is not
9 the white cell. But when things escape past
10 the white cell and there's a problem at state
11 level, where do they turn?
12 MS. DAILEY: Okay. Good. The
13 other resource you all might want to think
14 about, which is a little out of the box, is
15 who -- what's TRICARE's role in case
16 management?
17 We talk about hiring case
18 managers. Why can't DoD get case managers
19 hired in TRICARE and try and move some of this
20 case management role into TRICARE?
21 CSM DeJONG: They can. Kind of
22 where I was going down the line with that

1 yesterday with once you meet the medical
2 decision point, turning it over to VA, those
3 TRICARE case managers are working hand in hand
4 to get the VA care, which is covered under
5 TRICARE.
6 I know it's way out there, but I'm
7 not letting that one go.
8 CO-CHAIR GREEN: I mean, there's a
9 program for children with disabilities that
10 they call the ECHO program that basically
11 mandates that TRICARE will provide the case
12 managers, case management, et cetera. And so,
13 there are programs that could be done that
14 way.
15 The harder part is whether or not
16 how -- what regions are going to be most
17 effected. I just, you know, I'm a little
18 hesitant because if they're really in the kind
19 of shape that they need case management, I'm
20 a little surprised they're not on Title 10
21 orders. I mean, that -- if you know what I'm
22 saying.

1 So, if they're on Title 10 orders,
2 then they should be able to get a TRICARE case
3 manager. It's just how it's allotted, but it
4 should be overseen by DoD.
5 Now, there was one suggestion that
6 was made yesterday -- and I think, Steve, you
7 made it -- that I honestly think we should
8 consider putting in as a recommendation.
9 And that was that the TAMP, which
10 currently starts the day they get back and
11 demob, to have them consider and look at the
12 logistics and possibilities of having TAMP be
13 the six months starting from the time of the
14 first appointment and any time within the
15 first two years. Because that would be a big
16 boon for the PTS and some of the other things
17 that come up at six months.
18 So, if they would actually
19 consider having to start on the day of the
20 first appointment so if you really don't have
21 anything you need to follow up on, but then
22 six months later you're having some

1 difficulties, you get your first mental health
2 appointment and you have six months of
3 benefits, that might get you through it.
4 And so, I thought that was kind of
5 a brilliant concept that I'd love to capture
6 as a recommendation for them to consider and
7 look at the possibility.
8 I mean, it's really a no-cost
9 option, but it extends the benefit. Because
10 I think it's just policy on TAMP. I'm not
11 sure that that's legislative.
12 MS. DAILEY: We'll check, sir. We
13 need to check on --
14 CO-CHAIR GREEN: Okay. But even if
15 it's legislative, it's worth checking into
16 because it would be something simple. I mean,
17 if we're authorizing six months worth of
18 benefits, why not have it when the patient
19 needs it rather than some artificial time
20 frame?
21 MS. DAILEY: Good. Yes, we'll look
22 into it, sir. And, yes, that was mentioned

yesterday and that's developable.

CAPT EVANS: Going back to Number 11. So, we're going to stay with partially met and still would like to have define roles; is that correct? Or are we --

MS. DAILEY: Yes, do we want -- just up or down, do we want to reiterate DoD needs to create a better definition or clarify the roles of the RCC and the FRC? It would be that clear.

CO-CHAIR GREEN: Yes, I think we basically recognize that they have done what we asked in the draft DoDI and need to publish it.

So, we don't want to give them a met. We give them a go do, okay, get this thing published so everybody will understand. And then we go to the next step to say the ongoing discussions regarding the roles of FRC and RCC and deconflicting will, you know, take us even further towards finding solutions to best serve recovering warriors.

1 So, it's, you know, it's kind of a
2 two hit, you know. The first one is we know
3 you've done the work. Get it on the street.
4 And then the second one is, we
5 know you're doing the work, okay, we look
6 forward to seeing, you know, where you go with
7 this as -- and we could even give some
8 suggestions in there, some of the things we've
9 been talking about.
10 So, I think that we don't give
11 them -- none of these are going to be met or
12 not met. Most of them are going to be we
13 admire their progress, or, damn, you got a lot
14 of work to do, or we really confused you last
15 year. Let us restate this type thing.
16 MS. DAILEY: And then, ladies and
17 gentlemen, you might want to direct your
18 attention to Page 7 of the discussion points.
19 These are more medical in nature.
20 We discovered them out in the field. 3 and 4
21 under the Interdepartmental Collaboration
22 talks about the pharmacy, the pharmacological

1 differences between transitioning from DoD to
2 VA. It's just those bottom two.
3 I just want to check if that
4 resonates with you. If not, don't have to go
5 down that road. Hold it until next year and
6 get some people in to brief us on it.
7 CO-CHAIR CROCKETT-JONES: Yes, I'm
8 not sure we've -- we've gotten hints at this.
9 I'm not sure we've gotten the data we need to
10 know what we'd want to recommend.
11 MS. DAILEY: Okay.
12 CO-CHAIR CROCKETT-JONES: I know it
13 is an area of concern. I mean, it concerns me
14 and I would like to see some data on, you
15 know, we've heard this from -- in focus groups
16 from recovering warriors saying they -- when
17 I have a problem, they just give me a new
18 medication.
19 And we heard from OIF and OEF
20 program managers at VA, that part of the
21 process they almost always, you know, part of
22 the process they do with bringing folks in and

1 helping them is getting them under -- less
2 medicated in order to make them more
3 functional.
4 So, we've seen the complaint from
5 two different sort of sources. What we
6 haven't seen is hard data.
7 MS. MALEBRANCHE: I think for
8 Number 3 you're right. Probably need to talk
9 to the mental health and also pharmacy.
10 The Number 4 piece that General
11 Green mentioned, I know that Jack is
12 addressing some issues with pharmacy right
13 now. And so, that's probably something we can
14 look at for the next year.
15 I don't know about 3 how to -- but
16 you're right. We need data on that.
17 CO-CHAIR GREEN: And it would be an
18 easy thing and completely justifiable to say
19 that differences in DoD and VA formulas are
20 causing patients to have to change medications
21 at a critical time in transition and that
22 we'll be evaluating this more thoroughly next

1 year. Because that way we give them a hand,
2 okay, in terms of what we're seeing.
3 And then the VA/DoD practices with
4 -- that one is tougher. The only people I
5 remembered talking to us was the people who --
6 the expert panel we had on PTSD. And they
7 came and talked fairly significantly about the
8 treatments and what was recommended, yes.
9 And so, but I don't remember them
10 highlighting any problems in terms of
11 prescription practices. So, we don't have
12 anything really solid that I think we could
13 base that on.
14 MS. DAILEY: Okay. We do have a
15 section in the report that says this is what
16 we're doing next year.
17 CO-CHAIR GREEN: Okay.
18 MS. DAILEY: Yes, this would be a
19 good one.
20 CO-CHAIR GREEN: But I think you
21 could comment on the change in medications at
22 a critical time in transition, which I think

1 will get everybody's attention without
2 necessarily making a recommendation, just
3 saying we'll look at it.
4 MS. DAILEY: Okay.
5 CO-CHAIR GREEN: If that helps.
6 MS. DAILEY: Yes, yes.
7 CO-CHAIR GREEN: Any objections?
8 MSGT MacKENZIE: I don't have any
9 objections, but I do, you know, along with
10 what Suzanne said, I do know that although we
11 haven't collected factual data, there is a
12 trend where these recovering warriors are
13 continuing on medication and the actual
14 recovery plan, not to use that term
15 inappropriately, hasn't quite been
16 established, you know.
17 It's anecdotally on my part when I
18 was in treatment last year watching some of
19 these folks that were on a significant number
20 of medications through an alternate treatment
21 plan where you're able to come off of these
22 medications. Yet, it took them weeks of

1 coordination with the VA to go quit sending
2 this guy these meds, he's not on them anymore.
3 We get somebody, you know,
4 reevaluate the treatment plan to go how can we
5 get these meds off?
6 I mean, there are some things that
7 will always require medication as the
8 treatment plan, but sometimes as I understand
9 it from a knuckledraggin' helicopter guy
10 perspective, sometimes medication is a way to
11 get you to that overall treatment which will
12 get you -- you won't be on the meds forever
13 once that treatment is -- completely gets you
14 there. You see a duration that just seems
15 like it goes on forever.
16 CO-CHAIR GREEN: This one is
17 probably not a CRP issue. this is probably a
18 question for a clinical practice guideline.
19 It's really ripe for a clinical
20 practice guideline, because DoD and VA would
21 then follow that. And even making a comment
22 as to whether or not this might be - have

1 potential for a clinical practice guideline
2 would be a good thing to put in the report as
3 we look at it next year and talk to experts.
4 MS. MALEBRANCHE: I was thinking
5 the CPTs are perfect for this. And also there
6 is that integrated mental health strategy.
7 I don't recall if there is a part
8 of this in there at all, but maybe there is a
9 place to put it in there.
10 (Discussion off the record.)
11 MS. MALEBRANCHE: But it does reek
12 for CPTs.
13 CO-CHAIR GREEN: If you don't know,
14 there's a working group that's looking at an
15 integrated approach to mental healthcare
16 between DoD and VA, but they started with 24
17 different facets.
18 And so, there's like 24 -- they
19 wanted originally 24 work groups. And I think
20 we combined them into three or four, but
21 there's a lot of work going on in this area.
22 It's just it's complex and it's

1 huge, but we might be able to get to a
2 clinical practice guideline that we could get
3 all the players.
4 So, just mentioning it might get
5 them thinking about where do we go with this.
6 (Discussion off the record.)
7 CO-CHAIR GREEN: I can be more
8 directive if that's what you want. I'm sorry.
9 I tend to default to the political, I guess.
10 You know, I just assume keep them on our side,
11 but I understand.
12 CO-CHAIR CROCKETT-JONES: Well, I
13 think if we don't have the data yet to know
14 what we're recommending, we can be nice. But
15 eventually we need the data and we've got to
16 stop being nice.
17 (Laughter.)
18 CO-CHAIR GREEN: I got Suzanne.
19 That's why we have co-chairs here, okay.
20 You'd think the roles would be reversed, but,
21 you know, what can I say?
22 (Laughter.)

1 MS. DAILEY: Speaking of putting
2 the hammer down, on Page 1 of your discussion
3 points under the medical case care management,
4 Number 3 talks about profiles being in violate
5 -- making them a document has to be adhered to
6 by the chain of command regardless of their
7 unit's chain of command or WTC or WWR and
8 that, you know, individuals are accountable,
9 leadership is accountable for violating
10 profiles.
11 CO-CHAIR GREEN: That's a problem.
12 A profile is a recommendation from a medical
13 officer to a line commander. When a line
14 commander chooses not to follow a profile, he
15 takes the accountability for not following
16 that profile upon himself.
17 But, I mean, it's not an order
18 from a doctor to a commander. It's a
19 recommendation from a doctor to a commander.
20 So, you have to be careful saying that they'll
21 be in violate, okay.
22 What you really want to say is

1 there must be accountability when a commander
2 clearly does not -- if harm is done when a
3 profile is not followed. I mean, that's the
4 key, okay.
5 The commander is indeed
6 accountable if he doesn't follow a profile and
7 somebody has further injury. And that's the
8 part that's probably not as well understood,
9 but that's also why most commanders pretty
10 much adhere to what we put in a profile, if
11 it's a well-written profile.
12 CO-CHAIR CROCKETT-JONES: Well, I
13 think it's not necessarily just for their
14 injury. If they delay recovery significantly,
15 I mean, that --
16 CO-CHAIR GREEN: I understand.
17 CO-CHAIR CROCKETT-JONES: You know,
18 because we basically put tons of pressure on
19 recovering warriors who take too long in the
20 process of recovery.
21 They get -- they feel it. We hear
22 it everywhere we go. They know that they've

1 got a set amount of time and they feel very
2 pushed aside if they go over that time.
3 But if they started out that
4 recovery process with a line unit commander
5 who made them reschedule appointments, had
6 them doing more than they could really handle,
7 you know, that accountability, it's very
8 subtle if they just did that a little. But
9 that the person who's going to really be
10 accountable for that is after another -- a
11 year has passed, is the recovering warrior.
12 That's, I think, what we were
13 talking about with why this is important.
14 CO-CHAIR GREEN: But I think it
15 goes back to the commander's intent. You
16 could actually make it a service intent if you
17 wanted to put a recommendation in along these
18 lines, you know. We could ask the services to
19 reiterate, you know, that decisions not to
20 follow medical profiles do have -- they're
21 accountable both for any further injury or for
22 any further delay in recovery. And so, I

1 mean, it might be possible to do something
2 along those lines.
3 I think that it's you don't want
4 to say that a profile is in violate. You
5 don't want a medical officer giving a line,
6 you know, unfortunately we have a lot of very
7 junior medical officers and it can be misused.
8 And I think it should always be a
9 recommendation. And then, frankly, if the
10 commander doesn't follow it and there's -- and
11 no one is harmed and there's no delay to their
12 recovery, et cetera, then I think that, you
13 know, that's the commander's prerogative. And
14 the reason for this is the commander is
15 responsible for achieving the mission.
16 And so, you don't want to in any
17 way interfere with the commander's ability to
18 complete the mission. And sometimes that
19 means that you have to do something that may
20 delay, I mean, so delay a medical appointment
21 or delay a -- I mean, that happens. So,
22 that's why it's a recommendation.

DR. PHILLIPS: Question. Not passing the buck, but just this is obviously a very important issue. Have the Surgeon Generals addressed this?

I mean, I'm sure you have at some point.

CO-CHAIR GREEN: I would be startled if you didn't hear the exact same words that I just said. Army, Navy, Air Force, Marine, I mean, all the surgeons I think would say the same thing.

DR. PHILLIPS: That's why I asked.

CO-CHAIR GREEN: Yes. I mean, you guys, Navy, Marines, I mean, Army, I mean, am I stating it wrong?

CAPT EVANS: No, as far as Navy, it's correct.

MSGT MacKENZIE: I think it's just -- I think it's just that final follow-on step --

CO-CHAIR GREEN: Correct.

MSGT MacKENZIE: -- that I think

1 people don't believe is there.
2 CO-CHAIR GREEN: Correct.
3 MSGT MacKENZIE: Which is, you
4 know, the doctor says, hey, this is what's
5 going on, this is my recommendation. The
6 commander makes the decision as commanders do.
7 If something goes wrong, there doesn't seem to
8 be any recourse, you know.
9 What is that recourse? Where does
10 it exist, because it just doesn't seem to be
11 out there. I mean, it's stated, but the
12 action doesn't seem to be happening.
13 What is that recourse?
14 CO-CHAIR CROCKETT-JONES: What does
15 that accountability look like?
16 CSM DeJONG: Correct. And it's not
17 so much causing further harm as it is in the
18 Twentynine Palms examples of constantly
19 delaying appointments, which then puts them
20 into their second LIMDU. Which then they're
21 under the gun or they're looking at other
22 actions being taken against them because

they're in their second LIMDU. But at no fault of theirs, because they weren't allowed to make three of their six appointments.

CO-CHAIR GREEN: The more common profile violation is for a commander to decide that somebody can deploy despite something that's been put on a profile.

And so, if you deploy somebody and then essentially they get returned home, that gets a huge amount of visibility, okay.

Now, in terms of how it happened in terms of the accountability you're talking about, if there's an issue where the doctor raises it to his commander's level and it can't be resolved at the wing level, that's why each of the services have from MEDCOM to BUMED to -- basically it's elevated to a level above, in our world, the wing commander and a MAJCOM will look at it and decide whether they want to intervene or not.

A lot of it has to do with whether it's one time and it's a lesson to be learned,

1 or if it's a repetitive thing.
2 And so, you know, I wasn't at
3 Twentynine Palms. So, I don't know how
4 egregious this was. But if it was egregious,
5 then the answer should be that the medics
6 would raise that up within the Navy channels
7 and you see activity at the marine surgeon
8 level.
9 But probably it's going to go from
10 Navy back to the marine surgeon and back in
11 terms of what's going on, but there is an
12 accountability chain here and that docs do pay
13 attention, believe it or not.
14 It's just that the question on a
15 delay is harder to judge than harm, okay. I
16 mean, just frankly. So, if you delay the
17 recovery, I mean, that's almost perception.
18 So, you're delaying my recovery because, you
19 know, I haven't had to go out with -- do PT,
20 and so you're delaying my recovery.
21 And so the line -- if I was the
22 line commander, the following question is, I'm

1 maybe delaying your recovery slightly for your
2 ankle, but I'm making sure that you're still
3 attached to the unit and still the military
4 professional I need you to be. And so, it's
5 a two-edge sword.
6 DR. PHILLIPS: I think what we
7 heard at least, or what I heard, it was more
8 in terms of a priority for the commander
9 related to a visiting dignitary and they
10 needed bodies standing out front as opposed to
11 what, you know, is appropriate.
12 I don't know if this is a good
13 analogy, but the judicial system, I mean,
14 you'd rather free a hundred guilty people than
15 convict one innocent.
16 And I don't know where we should
17 stand related to one servicemember being
18 harmed because of this issue versus the other
19 side of the coin.
20 But it was more related to
21 positioning the commander that they needed
22 bodies available for ribbon cuttings that we

1 heard, or for visiting dignitaries.
2 CO-CHAIR CROCKETT-JONES: Yes, and
3 my concern about this is that the amount of
4 pressure for -- and relevance to the timeline,
5 the weight of that right now is pretty heavy
6 on the recovering warrior.
7 They have limited amounts of time.
8 Nobody lets them go on forever and they know,
9 they feel it. I mean, we hear this everywhere
10 we go. They know that they've got to, you
11 know, that there's a timeline.
12 And they already feel that the
13 timeline is about dollars and that their
14 value, the service that they've given is being
15 basically balanced against budgetary concerns.
16 We hear this wherever we go.
17 And there's a component to that
18 timeline that if they've got a line commander
19 who made it very difficult for them to even
20 get to a WTU and they, you know, they feel
21 this. And I'm not sure that -- I just want to
22 -- I would love to be able to create a

recommendation that lets that sense of weight of the timeline and what it means, because this is, you know, that timeline can really guide a person's whole life. Their life might change dramatically based on how long their timeline extends. And their treatment within the units that are supposed to be having them healed changes if they go past a certain timeline.

This is pretty big in the -- a looming issue in the life of a recovering warrior. And I'd like to get a sense that line unit commanders have some sense of that.

I mean, I don't think they're being asked at all. Even though they can affect it, they're not being asked to feel any of that.

CO-CHAIR GREEN: The only thing that's somewhat problematic with what you're saying is that I'm trying to understand what's causing the pressure. What is it?

So, in other words, you're making

1 it sound like they have a limited amount of
2 time to recover. And the question is, is that
3 because they think that they might progress
4 and, therefore, lose their position? Is it
5 because they feel that pressure because if
6 they're not completely well, they won't get
7 promoted or they might not be able to deploy?
8 Do you see what I'm saying? Some
9 of that is internally driven.
10 CO-CHAIR CROCKETT-JONES: This is
11 especially I think for those who know they're
12 going to go to IDES. They know that there's
13 a clock ticking that's going to start that
14 board.
15 And those -- and if they aren't --
16 haven't gotten most of their things, you know,
17 their healthcare, the big items that they are
18 concerned about when that board thing starts,
19 they believe they are going to not get healed
20 and that they're going to be pushed out
21 because they haven't met their timelines and
22 they're going to be out of the service and

1 they're going to be still broken and they're
2 not going to have great options.
3 This is the time pressure they
4 feel and it's pretty -- it's not an imaginary
5 pressure. And if they start out this whole
6 process with someone who says, you know, I
7 don't care about you getting your -- this is
8 more important, and especially when what's
9 more important is attending routine classes
10 or, you know, skip this because I want to send
11 you to this formation and that line unit
12 commander doesn't feel any of the pressure of
13 his decisions.
14 CO-CHAIR GREEN: So, once you're
15 determined that you're no longer going to be
16 retained, okay, so, i.e., you're going into
17 the IDES system, which is kind of what that
18 means, really your focus should be in large
19 part, on getting well and getting --
20 maximizing what you need to get done to be
21 prepared for the next -- whatever is next in
22 your life.

1 And so, that one is not a bad --
2 we've captured a little bit in the kind of
3 equal opportunity letter in terms of the
4 commander's intent, but I think it might be
5 worthwhile to find a way to write up a
6 recommendation that for those once they enter
7 the IDES, that really the focus should be on
8 their recovery and transition, and not as much
9 on, you know, routine unit functions because,
10 I mean, it's a little different.
11 There are still mission things
12 that happen at home. Some of the things
13 you're talking about with DB visits and that
14 kind of stuff, I mean, it depends. You don't
15 want the folks to idle, but you don't want it
16 to interfere with vital appointments and
17 things.
18 So, how exactly to capture that in
19 wording is something we'll probably struggle
20 with when we sit down for this last little bit
21 of this piece of --
22 DR. PHILLIPS: But let me add I'm

1 troubled at a little different level. And I
2 understand that there are junior physicians
3 that are influenced by servicemembers and so
4 forth, but I'm coming from the direction where
5 a subject matter expert makes a
6 recommendation, and a non-subject matter
7 expert, granted there are gray areas,
8 supercedes that recommendation. That's what
9 I'm thinking about.
10 I know all the things you
11 mentioned are probably good starts, but --
12 CO-CHAIR GREEN: Spoken as a true
13 doc.
14 (Laughter.)
15 MR. REHBEIN: I think we've got
16 actually a couple subjects in play here. One
17 being the physical profile recommendation.
18 But what I just heard Suzanne say seems to me
19 to be -- go back to Recommendation 5, the
20 command climate.
21 CO-CHAIR GREEN: No.
22 MR. REHBEIN: We're putting that

1 down as met.

2 CSM DeJONG: No, not so much the

3 climate. It's the accountability. The

4 climate can be there. It's the

5 accountability.

6 And I agree with you, sir. We did

7 speak to that several times this year about

8 focusing. And again it goes back to that

9 medical decision point when you know that

10 you're going to be within the next, you're

11 reaching IDES, that your focus needs to be

12 learning how to be a civilian, a husband,

13 father, what have you, wife, mother.

14 What we're talking about is prior

15 to the IDES. Prior to meeting IDES. I agree

16 with the recommendation for once you meet IDES

17 that medical decision point has been made.

18 What we're looking at is delay in

19 care or somehow influence, you know, not

20 allowing care to happen by delaying it, missed

21 appointments, what have you, prior to reaching

22 IDES. Because they don't -- a lot of them

1 don't want to make it to that medical decision
2 point of IDES.
3 They know that they've got 12
4 months to recover or they're going to be in
5 the group that's going to IDES, and they don't
6 want that. So, how do we hold them
7 accountable prior to IDES?
8 CO-CHAIR GREEN: Just remember that
9 the other side of this is that these folks are
10 drawing an active duty paycheck and the line
11 commander expects them to do an active duty
12 job.
13 And so, the reason I focus a
14 little bit on the IDES is clearly the balance
15 shifts a little bit when somebody is headed
16 out.
17 On that time frame before the one
18 year while you're on a profile trying to avoid
19 the IDES, you know, you really have to work
20 with the immediate supervisor. I mean, the
21 commanders are not necessarily getting
22 involved. It's really the immediate

supervisor who's making decisions.

And so, the hard piece of what you're asking is how do you get the supervisor's attention? And one of the things that's going to happen is as the money gets tighter and the services get somewhat smaller, there will be people that are, you know, they will be anxious for them to kind of get on either full up or full out.

And so, I think you're going to see some differences in the approach. Think about it. We've had ten years of war where you're really trying to retain absolutely everybody, and now we're coming into a time when the wars will stop and there will be a draw-down, because there always has in American history.

And so, whatever that draw-down ends up being will force some of this to where people feel even more hurried, okay. It's going to make that worse.

So, there's just a delicate

1 balance. I don't know, you know, I don't know
2 how to solve it.
3 MSGT MacKENZIE: Here's something
4 to think about because unfortunately we're
5 focusing on the positive here. But with every
6 positive, there's a negative, okay, where for
7 everybody who's trying to get through in a
8 timely fashion to reach that execution point,
9 there are people who are kicking and screaming
10 not trying to get there.
11 In every place where we tighten up
12 or loosen a regulation, we're going to create
13 an environment for people to do what they want
14 to do. We are still in the military.
15 I think what, and maybe I'm
16 totally off base here, but it's that
17 involvement with leadership, you know. If I'm
18 on a profile and you've got me for an
19 appointment and, you know, my first sergeant,
20 my section leader or whatever says, hey, we
21 got to go do this event, you need to cancel
22 that appointment, it shouldn't be up to the

1 individual to burden that role. That
2 leadership level then gets -- that's where
3 that communication happens where they say,
4 hey, I need to get him rescheduled as soon as
5 possible, but I need him for this event where
6 leadership has an active role in adjusting
7 your medical recovery timeline.
8 Right now the way it stands it's
9 up to the recovery servicemember to adjust his
10 timeline. What that does is that provides
11 that involvement. But yet at the same time,
12 doesn't open the door for those who don't want
13 to move fast, to find a way to not move fast,
14 okay.
15 I mean, it's a hard thing to say
16 because we all look at these guys and want to
17 make sure we're doing the right deal, but I
18 think the line unit leadership does have a --
19 at the level at which it belongs, does have
20 responsibility to the medical professionals
21 when they need to alter this individual's
22 timeline, that there is that communication.

1 And that, I think, would change
2 things significantly and we don't allow those
3 who are trying to slow down, that opportunity.
4 But at the same time those that are trying to
5 get things done, have that buy-in by their
6 leadership to do such.
7 DR. PHILLIPS: I think it's
8 location-dependent as well. I mean, if I miss
9 an appointment at Walter Reed, I could
10 probably re-book within the week.
11 If I'm at Twentynine Palms and I
12 miss my ride and I miss my appointment and I
13 miss yah-dah-yah-dah-yah-dah, so I think --
14 MSGT MacKENZIE: That's not what
15 we're talking about. We're talking about the
16 leadership requesting it.
17 DR. PHILLIPS: Yes, I --
18 MSGT MacKENZIE: Then it no longer
19 becomes me missing my appointment or me
20 changing my appointment. It becomes my
21 supervisor or my platoon sergeant or whatever
22 saying, hey, I need this guy, please

1 reschedule him.
2 DR. PHILLIPS: No, I agree with
3 you. But rescheduling from Twentynine Palms
4 to Balboa is a lot different than rescheduling
5 at Walter Reed.
6 MR. REHBEIN: I don't understand
7 because I've been out of the uniform too long,
8 exactly what the two words "command climate"
9 mean to you, but what he said is what I was
10 trying to get at.
11 CO-CHAIR GREEN: The doctors and
12 stuff would, I mean, we've reviewed no-show
13 rates and late cancellations and do that kind
14 of stuff with our line counterparts. And to
15 have somebody who misses an appointment that
16 they can't get another appointment for another
17 month, should be something that there is, you
18 know, clear accountability for because some of
19 these subspecialties, they're hard to get to.
20 And so, I think there's a way to
21 word this so that it would actually get across
22 what you're saying and try to get it to where

1 it's when the supervisors make decisions that
2 affect specialty appointments and recovery
3 times, that they need to take -- they need to
4 take the next steps and work within the
5 medical units to try and make certain that
6 they're minimizing the consequences. And so,
7 I think we can find a way to basically
8 wordsmith this.
9 Now, I have to tell you that I
10 need a bio break, okay? And so, the good news
11 is that we've missed two of my lines now
12 because I was supposed to tell you to go to
13 lunch. I missed that one. And I was supposed
14 to tell you to go to break and, you know, I'm
15 going to take liberty and come back on the
16 green boxes here.
17 DR. PHILLIPS: As we're going out,
18 can I just add I think we should also
19 compliment the line commanders who make every
20 effort to get the folks to appointments and
21 make sure they get their rides and so forth.
22 So, I don't want to come down too

1 hard on that, because it works both ways.
2 CO-CHAIR GREEN: Right. I just
3 think that as they -- when they make a
4 decision not to have them keep their
5 appointment, then they need to be the active
6 component, the active part of this, just like
7 you're saying, Mac, to try and get
8 collaboration with the hospital to essentially
9 help these folks.
10 And so, that would go a long way.
11 CO-CHAIR CROCKETT-JONES: Yes, that
12 would be a way to show them being accountable
13 and routine continuity value.
14 CO-CHAIR GREEN: I think you need
15 to realize that some of these decisions are
16 not made at a command level. They're made at
17 a supervisory level.
18 And so when we focus this, we
19 don't simply want to say commanders must. We
20 need to say supervisors must understand that
21 when they force a cancellation of a hard-to-
22 get subspecialty appointment, that it's their

1 responsibility to assist in the re-booking so
2 that they take accountability for it.
3 Okay. All right. We are on
4 break. Let's see. We'll come back at 2:30.
5 Thanks, everybody.
6 (Whereupon, at 2:19 p.m., the
7 above-entitled matter went off the record and
8 resumed at 2:36 p.m.)
9 CO-CHAIR CROCKETT-JONES: I think
10 we have to move on to the topics on PTSD AND
11 TBI.
12 MS. DAILEY: Real quick, maybe, one
13 point we need to clarify and it's going to
14 rejigger your thought process a little bit,
15 ladies and gentlemen, is I had a clarification
16 come up about TAMP eligibility.
17 A servicemember is eligible for
18 TAMP benefits after the six-month period. If
19 they have done a line of duty or there's a
20 line of duty that was done in theater or when
21 they got back in that six months, let's say
22 they blew out a knee, so to speak, they've

1 been through rehab, they've been through
2 physical therapy, it looked like it got better
3 and they're moving around, six months passes
4 and they get farther down the road and it's
5 not healing, they can't move anymore, it's
6 swelling up, they've incapacitated themselves,
7 they are now incapacitated, they go back to
8 that line of duty and the TAMP will provide
9 the care.
10 So, I think we need to keep that
11 in mind as we make a medical case management
12 recommendation. There are --
13 CO-CHAIR GREEN: Title 10 orders?
14 MS. DAILEY: Correct, it is not.
15 It's past the six-month time period and it is
16 still tied to that TAMP benefit and the line
17 of duty that was more than likely generated in
18 that time period, or identified after that
19 time period as having been caused in that six-
20 month period.
21 So, that TAMP benefit is available
22 after the six months.

1 CO-CHAIR CROCKETT-JONES: Does the
2 TAMP benefit have a limited duration?
3 MS. DAILEY: If you interpret it
4 the say that I just described its
5 accessibility after six months, the answer
6 would be no. It does not have a termination
7 date as long as your care is tied to the line
8 of duty in deployment and in the six months
9 after the deployment.
10 MSGT MacKENZIE: But that's
11 interpretation. It's not clearly written, is
12 it?
13 MS. DAILEY: Yes, it is.
14 MSGT MacKENZIE: Okay.
15 MS. DAILEY: That your TRICARE case
16 managers, that your individuals at state level
17 know to take this line of duty and take this
18 case back to TRICARE and say, this is a TAMP
19 benefit, that might be the problem.
20 But if you make recommendation
21 that they need a longer one or they can't
22 access benefits after the six months, we have

1 a factual inaccuracy there.
2 DR. PHILLIPS: If there was no
3 attempt to say that I have something wrong,
4 it's eight months or a year later, a piece of
5 shrapnel may have perhaps migrated somewhere
6 or it's a posttraumatic stress issue, does
7 that still hold true? Can they still get that
8 care if they hadn't made an appointment at
9 all?
10 MS. DAILEY: That benefit is still
11 - they are still eligible for that TAMP
12 benefit. They are eligible for it. The
13 ability to link the servicemember up with it
14 based on the knowledge of the people working
15 these issues is - appears to be the shortfall.
16 CO-CHAIR CROCKETT-JONES: Okay.
17 So, the language really needs to be that
18 servicemembers who are eligible for TAMP
19 benefits need - okay. I have to think about
20 that.
21 CO-CHAIR GREEN: I think it's
22 easier than what you're thinking because the

1 reality is it's still a benefit for the TAMP
2 to start the six months of automatic
3 eligibility, to start with the first
4 appointment because the line of duty can delay
5 therapy by three to six months.
6 And so if you said that the TAMP
7 benefit started with the first appointment, in
8 essence that would give them six months that
9 they could do this.
10 And so, the question is going to
11 be the line of duty. And what I'm trying to
12 do is avoid the line of duty for those six
13 months.
14 After that when you have a line of
15 duty, it wouldn't hurt for us to even
16 reemphasize that TAMP benefits can be extended
17 if the individual has a line of duty. But
18 even that's problematic because most of our
19 system gears off of an ID card.
20 And so, I assume you're going to
21 go to a physician's office for your TRICARE
22 benefit and you're going to show them your

1 line of duty order.
2 MS. DAILEY: But this comes back to
3 the case management piece where you are left
4 out in the system on your own. Someone needs
5 to know TRICARE well enough, a nurse case
6 manager or a - I mentioned a TRICARE case
7 manager needs to know the benefit well enough
8 that they've got the line of duty, they've
9 entered your requirement in the correct
10 places, which engages the TRICARE system for
11 a referral that is transparent to the
12 servicemember and the doctor. All those
13 pieces are in place.
14 CSM DeJONG: But this also moves us
15 into the PTSD portion to where 90 percent of -
16 and I'll go with reservists are coming out of
17 theater without an LOD for any PTSD. The
18 symptoms don't show up for another six to 12
19 months. And that's where they would kick off
20 that first appointment of trying to go for
21 help.
22 CO-CHAIR GREEN: That's why I think

1 - see, you still having to start with the
2 first appointment means that you don't have to
3 wait for a line of duty to get the initial
4 therapy you need. And it buys you six months
5 for you to get the line of duty done, which is
6 why it's written the way it is now.
7 But of course if the problem
8 doesn't develop in those first six months the
9 way it's written today, then, as far as you
10 know, you don't have any benefit until you get
11 the line of duty, which is true.
12 MS. DAILEY: Sir, I think that for
13 the reserve component, no one gets services
14 without a line of duty. So, whether they've
15 started it in theater, whether they - that
16 TAMP benefit is not -
17 CSM DeJONG: No, you get six
18 months. Six months of full coverage.
19 MS. DAILEY: Correct. But you
20 still have to have a line of duty for your
21 injury or your disability.
22 CSM DeJONG: No, no.

1 CO-CHAIR GREEN: Not for the first
2 six months. That's why they did it to try and
3 avoid having to give a line of duty and
4 basically having delays in care.
5 So, the TAMP benefit actually is
6 automatically returned from anything greater
7 than -
8 MS. DAILEY: All right.
9 CO-CHAIR GREEN: It's a certain
10 number of days you have to be deployed. I
11 think it's -
12 MS. DAILEY: Okay.
13 CSM DeJONG: Because as you leave,
14 as you demobilize for reservists, you get a
15 card. You get a separate ID card for your
16 medical benefits that expires in six months.
17 MS. DAILEY: Okay. All right. I
18 got it.
19 Okay. I see the six-month piece
20 where the TAMP benefit starts. I understand
21 it much better with that little card, yes.
22 Yes, we're good. I'm sorry to drag you

1 through that. But, yes, I see now where -
2 CSM DeJONG: It led us right into
3 PTSD.
4 MS. DAILEY: What's that?
5 CSM DeJONG: It led us right into
6 PTSD.
7 MS. DAILEY: Led you right into
8 PTSD. All right.
9 Do you all want us to summarize
10 medical case management and what we pulled out
11 of it, what would be crafting a recommendation
12 on for you, or are you going to leave that up
13 to us?
14 CO-CHAIR CROCKETT-JONES: I'm
15 comfortable with leaving it up to you all.
16 MS. DAILEY: Okay.
17 CO-CHAIR CROCKETT-JONES: I don't
18 think we need to rehash how we arrived at what
19 we, you know.
20 MS. DAILEY: Okay. We're on -
21 we're doing okay on time, ladies and
22 gentlemen. It's a quarter to 3:00. We have

1 PTSD and the IPO.
2 CAPT EVANS: I think a couple of us
3 would like to recommend and I know we need
4 more information from the Air Force, but we
5 really like the recovery coordination process.
6 And so, I'm not sure how we can
7 later get - I think this has been into play
8 for how long?
9 CO-CHAIR GREEN: The DAWG, the
10 first portion of that, has been in play for
11 several years.
12 CAPT EVANS: Okay.
13 CO-CHAIR GREEN: The issues now
14 with centralization of our MEDCON cell along
15 with the personnel is new and won't be fully
16 up until July, but all the players are now in
17 the process of moving.
18 So, there's kind of two parts to
19 it.
20 CAPT EVANS: So, I think we would
21 like to see -
22 MS. MALEBRANCHE: We've talked a

1 little bit about a model or a pilot. That
2 just - because - but we also have this other
3 work group that I think somehow -
4 CAPT EVANS: We may take this -
5 maybe we'll take this to the other work group
6 to see -
7 CO-CHAIR GREEN: Sure. And Colonel
8 Zeh is available to you any time you need her.
9 CAPT EVANS: Okay.
10 MS. MALEBRANCHE: And I think this
11 group with what we have or what we're putting
12 forth is going to keep that door open or kind
13 of enhance that road, if you will.
14 CAPT EVANS: Right. Because we are
15 looking for a model to try to get as much as
16 possible standardized across the -
17 MS. MALEBRANCHE: Yeah, I think the
18 way this is going to be worded or the way we
19 talked about it sure seems like this is the
20 entre to support that.
21 CO-CHAIR CROCKETT-JONES: All
22 right. We're going to review the topic of

1 services for PTSD and TBI.
2 Last year we created
3 Recommendation 10 which related to this topic.
4 Effectiveness documents for this topic can be
5 found in Tab L. And again this topic falls
6 under Restoring Wellness and Function.
7 So, would Dr. Phillips and
8 Lieutenant Colonel Keane like to start off our
9 discussion in the review of Recommendation 10?
10 CO-CHAIR GREEN: If I could help, I
11 agree that we have not met this one in terms
12 of what we realized here.
13 I mean, we made a fairly simple
14 statement, and yet it's a very hard thing to
15 basically make available the same services
16 across the total force.
17 And so, there's been a lot of work
18 done on - I'll use my service, Directors of
19 Wing Psychological Health, with different
20 referral areas, regional efforts to try and
21 get the Yellow Ribbon program more formalized.
22 A lot of things trying to make

1 services available, including the Joining
2 Forces Initiative from the White House, to try
3 and get a lot of people better educated on how
4 to treat these folks in anticipation of what's
5 coming.
6 So, I think we again need to start
7 off with a very positive statement with
8 regards to efforts that are being made. But
9 the fact is, you know, that we are not getting
10 the same services out to folks.
11 And at least in a recent briefing
12 to me as we talked through this, I'm actually
13 expanding the number of regional types of
14 mental health and active duty outreach trying
15 to standardize some of the agreements between
16 our bases and our reserve units.
17 And it's usually the Guard,
18 because reserve bases are typically co-located
19 or close to an active base, but the Guard in
20 my service has 40 bases that are completely
21 separate and don't have any routine medical
22 care. And so, this PTS/TBI issue is really

1 problematic.

2 One of the things that, you know,

3 I've been toying with and I ask my folks to

4 tell me what the total cost of programs are

5 and support to the Guard and reserve, because

6 at a certain point it will become less

7 expensive for the - simply to create a benefit

8 that authorizes just like our family members

9 get today, the ability for any active duty

10 servicemember to go get eight mental health

11 visits.

12 And I honestly think that we might

13 be better off rather than trying to create a

14 direct care system, to essentially let them go

15 and seek out those eight mental health visits,

16 not worry about it too much, I mean, they need

17 to come back and let us know.

18 But even if they don't let us

19 know, we'll see it in the billing. And so,

20 we'll know then to follow up.

21 But I guess from my perspective,

22 at some point it may be less expensive to give

1 them those same eight mental health visits
2 that we give to our family members kind of no
3 questions asked, get the help you need, than
4 to continue to try and build this in terms of
5 whether a direct care system or a grievance
6 with the direct care system or the Yellow
7 Ribbon or the Directors of Psychological
8 Health.
9 So, just - that's kind of my two
10 cents. I can't tell you yet whether it's cost
11 effective to change the benefit, but I
12 wouldn't be surprised. I wouldn't be
13 surprised.
14 CO-CHAIR CROCKETT-JONES: Well, I
15 think also we have - we've seen Army and
16 Marines both also working very hard to bring
17 services to units and to create easier access
18 and sort of change the culture of thought
19 about PTSD. But these are all really young
20 programs with, you know, units having their
21 own individual behavioral health sort of
22 support.

1 So, I think that the only thing
2 that I am - my only concern about these new
3 programs, I want to know if they're effective.
4 I hope they're tracking metrics to figure out
5 if this is a good way to get better care.
6 DR. PHILLIPS: Yeah, just a couple
7 comments to follow up just briefly on what you
8 mentioned.
9 There's a fairly high dropout
10 rate, according to our notes. And I don't,
11 you know, it's the nature of the beast, but is
12 there anything in depth that we could do to
13 evaluate why they're dropping out?
14 People drop out because of failure
15 of treatment, or because of the basic disease
16 process.
17 We say this in a number of places
18 that training is very important for the health
19 providers, and I wonder if we could be a
20 little more specific or should be a little
21 more specific if they even exist, provide the
22 health providers whether they're civilian or

1 military, with definitive clinical practice
2 guidelines and update those as they are
3 published.
4 I've had a number of calls from
5 neurologists and people in the civilian sector
6 that volunteer at the VA, do things like that,
7 saying we don't even have a definition of
8 posttraumatic stress disorder. My colleague
9 down the hall is saying, yea, and I'm saying,
10 nay, or vice-versa.
11 And so, I don't know if it's
12 something that we should do, but should we
13 suggest that there should be a separation of
14 PTS and PTSD? I mean, there should be some
15 definitions if it's possible at this point.
16 CO-CHAIR CROCKETT-JONES: I'm not
17 sure that the research has been done yet, but
18 we've just been presented with the idea not
19 too long ago that there are literally
20 thousands of presentations.
21 As things stand now in the
22 definition of PTSD, there are thousands of

1 ways it can be presented.
2 And so, are those - we haven't - I
3 don't think anyone's even looked yet at to
4 whether there are differences, significant
5 differences between what kind of presentation
6 and do different presentations respond to
7 different treatments.
8 I'm not sure that that work has
9 been done. And we're pretty late in the game
10 on this, it seems. I'm sort of amazed that
11 that work hasn't been done.
12 I don't know if that is where we
13 want to place our recommendation since they -
14 even though people are still having wait times
15 and there is some concerns about getting PTSD
16 treatment, I also see efforts being made.
17 So, I don't - I understand if
18 research is not where we want to go with the
19 recommendation in gathering that information,
20 but I think that it's going to hamstring any
21 recommendations we make since we don't really
22 have the information.

1 DR. PHILLIPS: I'm just saying
2 scientifically and it's not published and
3 proven, but people are beginning to say you
4 have to have had a TBI in order to associate
5 it with posttraumatic stress disorder.
6 I mean, that's one connection
7 people - Bruce, perhaps you have more
8 information than I do. I'm talking about NIH
9 and things like that.
10 CO-CHAIR GREEN: Huge controversy
11 right now with this being discussed at the
12 American Psychiatric Association and the
13 American Psychological Association trying to
14 decide whether they're going to change
15 actually the name of PTSD, because there is a
16 very vocal group right now that's saying you
17 have to have some type of an injury to
18 actually have the disorder.
19 And an emotional injury is no
20 different than a physical injury. It
21 basically creates an imprint, is what they're
22 saying.

1 And so, extensive literature from
2 the VA based on the Vietnam War. And so, a
3 lot of things that have come out, all the
4 clinical practice guidelines for PTSD actually
5 have stemmed from VA work. A lot of different
6 therapies, but it seems to always come back.
7 The most prominent in the literature is
8 prolonged exposure and cognitive processing
9 therapies.
10 And so, that's what pretty much
11 everyone is trained on. And that's how they
12 intervene.
13 And the problem with those
14 therapies are that they tend to be six-week
15 and longer courses, but they're very similar.
16 And so, it - they're just very similar. And
17 so, they don't know of a better way to do it.
18 The most effective thing I see is
19 when you have non-clinicians. Because one of
20 the things that makes these therapies not as
21 effective is having someone who hasn't been
22 there and done that.

1 So, when you have somebody who's
2 been, you know, kind of a part of a unit like
3 that and can relate, there's a different level
4 of attachment, a different level of
5 interaction. And it doesn't have to be a
6 professional. It just has to be someone who
7 has got some understanding of this and can
8 help people get through it.
9 That's not as scientific as the
10 stuff that's going on with the APA and the
11 stuff coming out from the VA. But my
12 experience has been the people who have had
13 similar experiences when they have the right
14 training to help people deal with this stuff,
15 get them through it faster than any of these
16 therapies.
17 DR. PHILLIPS: And I don't know
18 that we even need to make a recommendation.
19 We had this done last year where perhaps all
20 we say is we understand the global
21 difficulties and we realize that every
22 effort's being made to address these issues,

1 and leave it at that.
2 I'm not sure anything that we
3 could say could change anything that's going
4 on.
5 LTCOL KEANE: That was my thought
6 too, sir, was to have it in the Executive
7 Summary to make a comment about it that we
8 continue to watch this and hope to get
9 metrics, but not necessarily make
10 recommendation.
11 CO-CHAIR GREEN: I think we take
12 the recommendation and we talk about all the -
13 I mean, there's - if you look through the
14 things that are in this under L, there's a
15 huge number of positive things in here in
16 terms of actions that have been taken;
17 standardized training, updates of clinical
18 practice guidelines, psychological health
19 towards the end there that some of the things
20 the Marines have done, the embedded units - I
21 mean the embedded teams.
22 There's a ton of things that are

1 going on to try and intervene in this. And
2 so, I think we can give credit for the
3 yeoman's work that's going on, but still
4 identify that there are people that are
5 clearly not getting the same services and
6 there are still delays in people getting
7 services.
8 And so, I'm a little more hesitant
9 to say that we don't think what they're doing
10 is working. But, I mean, we can. It's just
11 that your frustration, I think, is you folks
12 have been through several of the courses and
13 you've found that it doesn't - there's no
14 magic pill here. I mean, that's the problem.
15 MSGT MacKENZIE: Some of the things
16 that I think can be highlighted -
17 CO-CHAIR GREEN: I mean, that's the
18 problem.
19 MSGT MacKENZIE: I mean, some of
20 the things I think that can be highlighted is
21 there is a difference between PTS and PTSD,
22 okay.

1 And some of the efforts that's
2 going on in the Marine Corps, in the Army
3 within Special Operations to move these
4 resources to a level that's common amongst the
5 warriors is very effective at meeting those
6 needs of PTS.
7 However, one of the things that we
8 did find that we deal with within Special Ops
9 that I saw within the Air Force especially,
10 some of the new roles that the Air National
11 Guard is taking on, is people at the
12 appropriate classification level and some of
13 those areas that require it where the efforts
14 that were put forth were not effective because
15 it wasn't at the level that that resource was
16 needed, where you deal with, you know,
17 security issues and stuff.
18 And we face that a lot within the
19 Air Force. Some of our co-locations, people
20 don't talk to each other because of security
21 clearance.
22 Well, you give somebody a security

clearance and a read-in, and all of a sudden now you've got that player there.

So, with a little more attention to detail in that aspect, I certainly think that that's one of those things that's really going to change the dynamic to these, you know, PTSD cases because we're putting that resource at point of need.

And then of course I think it also ties back to addressing those needs with the Guard either with the six-month from visit and as well as the non-medical, the RCC component when these folks are retained or brought back on Title 10.

That's going to leave me a lot, but there's a lot of great progress. And I think we need to highlight that progress with a little more attention to detail in looking at that.

LTCOL KEANE: I have faith in the VA. Ms. Malebranche, do you know out of the number, the 1900 number PTSD, how that breaks

1 down? There's like X amount of nurses, X
2 amount of doctors and other technician-type
3 people.
4 MS. MALEBRANCHE: Yeah, I think -
5 we just had a hearing on this last week on
6 mental health. And, you know, we had the
7 5,000 hires last year. We're still having
8 trouble in some areas. But I think also like
9 the general mentioned where you have trouble,
10 you have trouble.
11 I mean, the providers were
12 increased. Now, 1900. We got the PTSD app
13 out that started to be a pilot and now it's
14 full blown.
15 So, I am all about, I think,
16 making this more, like you say, on a positive
17 note what we've got to. There's still work to
18 be done.
19 There is this stigma reduction.
20 That's cultural change over society. I think
21 that has been phenomenal. And you can see
22 that in the VA numbers. And that our mental

1 health people tell me that they have more
2 people coming in now for PTSD from Vietnam
3 since this anti-stigma campaign. Folks who
4 didn't come before. So, there's those pieces.
5 The 1900, I don't know exactly how
6 it breaks down, but they're breaking it down
7 to workable levels. And we have to report
8 back in a fairly short time. And I believe
9 our undersecretary was given a pretty short
10 timeline to get those people on board.
11 We're doing some more with
12 telehealth and telepsychiatry, tele-mental
13 health. And I think, you know, we should keep
14 striving on that one. That's a fairly -
15 somewhat new, but we've done a lot of work on
16 that.
17 So, I think tremendous progress
18 has been done since last year, but there's
19 still more to be done for all the reasons that
20 I think you all have mentioned.
21 And I rather like that idea that
22 you talked about, the eight visits. Because

1 if people are near home and they can get it,
2 that to me would seem - and if there's other
3 folks in the family, you know, again, where
4 one goes for healthcare, maybe the other will
5 go too.
6 That's an interesting idea. And
7 like you said, we could find out by billing.
8 I know there's other issues tied up with that.
9 We've been dealing with Health Information.
10 But I think that that opens
11 another venue that maybe we haven't thought
12 about.
13 CO-CHAIR CROCKETT-JONES: Yeah, I
14 don't want anyone to have the impression and
15 I don't think that these programs are - or
16 efforts aren't having a positive effect. I
17 think they really are.
18 I think for the bulk of folks who
19 need these services, I think things are
20 improving. I think the culture is improving.
21 And I think moving assets into line units
22 actually improves the culture, because it

means people get treatment and it's not - it's viewed differently because they just get treatment and then are better as opposed to it being this death sentence or something.

But I don't mean to say that I don't think that they're working. I think that we can't say that they're working until they've been in the - we have some evidence.

I'm not saying that they're not working. I'm saying we might need to - this might be sort of - we might have something to recommend in this area. But as far as the programs go, we need to wait and see what evidence they produce for us.

MR. DRACH: I'm hearing a lot of different things about PTSD lately - or not only lately, but the last ten years or so, but there's a couple things - just fairly recently I was doing some research unrelated to the Task Force on military culture.

If you Google military culture, at least the first ten pop-ups are military

1 culture as it relates to treatment of PTSD.
2 So, whoever is doing this is not separating
3 military culture from PTSD. It's part of
4 military culture right now.
5 There's online training that you
6 can get continuing education units for on PTSD
7 for clinicians. There's a ton of stuff out
8 there.
9 We're seeing a preponderance of
10 diagnoses of TBI also are being diagnosed with
11 PTSD, but one is not necessarily complementary
12 or connected with the other. But there is a
13 preponderance of TBIs who also are getting a
14 dual diagnosis of PTSD, but not necessarily
15 vice-versa.
16 The discussion about dropping the
17 D and calling it an I, and dropping the D or
18 the I, I mean, I heard on the news this
19 morning - weren't talking about PTSD, but they
20 were talking about the changes to the DS&M.
21 They've had 25,000 comments on
22 proposed changes to the DS&M. And that's not

1 all on PTSD, obviously. I don't know what the
2 breakdown was, but 25,000 comments.
3 So, when are we going to see the
4 new DS&M? I don't know. When are they going
5 to solve it? I don't know.
6 We collectively, the government,
7 everybody is encouraging servicemembers,
8 veterans to go seek treatment. Well, guess
9 what. You go seek treatment and you got to
10 wait six months to see a doctor.
11 Now, they're experimenting with
12 all kind of different therapies. I just saw
13 yesterday where I can't remember - I can't
14 pronounce the name exactly right, but they've
15 been doing it with TBI for a couple of years
16 now. It's the hyperbaric oxygen therapy
17 treatment. It's shown considerable successes,
18 as I understand it, with TBI.
19 Now, they're experimenting it with
20 some PTSD patients somewhere. I forget what
21 hospital, but they're finding that not one
22 size fits all. You know, there's no cookie-

1 cutter approach to treatment. What might work
2 for me may not work for you.
3 And the other thing is that in
4 some of the group therapy sessions, some of
5 the veterans that are in group therapy or the
6 servicemembers that are in group therapy said,
7 group therapy is not for me because all I hear
8 is that everybody wants to talk about their
9 own problem. They don't want to talk about
10 the collective problem. They just want to
11 talk about their experiences and their
12 problem. So, I'm not getting my problem
13 addressed or my problem issued.
14 So, what I'm reading from that is
15 that individual one on one, but there's a lack
16 of psychological health professionals to
17 provide that treatment that's needed one on
18 one.
19 So, what's the answer? I don't
20 know.
21 MSGT MacKENZIE: Some of that goes
22 back to what the services are doing, which is

1 bringing that stuff closer while it's still
2 just posttraumatic stress.
3 You know, you haven't reached that
4 disorder part. Everybody deals with this
5 stuff. You're bringing it into the line unit.
6 It's becoming commonplace. I mean, I don't
7 think we can fix the overarching problem as
8 much as we've got to start somewhere and we're
9 building that future and catching what we can
10 and what we can get a hold of, you know, and
11 you're right. There's different philosophies
12 out there.
13 I know it's interesting to see
14 some of the folks that I work with absolutely
15 despise that group session. Yet you go to a
16 civilian facility where they say group session
17 is about dealing with group problems, you
18 know. Personal problems you deal with
19 personally, you know.
20 And, you know, it's kind of
21 interesting the different - the different
22 looks at these things, but that's kind of it.

1 We didn't do anything in group session that
2 was based on a personal problem. It was based
3 on group interaction, social interaction, all
4 these group things. The personal stuff was
5 handled one on one.
6 So, I'm just a helicopter guy, but
7 I certainly think we have a way ahead with
8 this. And I think that maybe that's the focus
9 is the way ahead and not necessarily trying to
10 find a solution to something that's no matter
11 how many times you come at it, it fights back
12 12 different ways.
13 CO-CHAIR GREEN: I need to clarify
14 a couple of quick things.
15 The hyperbaric research has mostly
16 been on TBI and most of it coming out of
17 Louisiana from one particular site that's a
18 very active lobbyist.
19 The initial study done by the Air
20 Force trying to duplicate that showed no
21 difference between controls and the people in
22 our treatment folks.

1 And there's a fairly definitive
2 study going on by DoD now to see if we can't
3 once and for all make the decision whether
4 hyperbarics makes a difference.
5 And so that one, the initial
6 results are very close, but I don't think we
7 have anything solid saying that hyperbarics
8 makes a difference.
9 The - well, I'll defer that.
10 There's one other thing I want to say before
11 we go on.
12 MR. REHBEIN: If I may, sir, I'd
13 like to argue towards keeping a recommendation
14 on PTSD. Because of the size and the
15 magnitude and the priority of the problem, I
16 think we need to keep a recommendation, but I
17 think we can word it such to recognize the
18 steps that DoD and VA have taken.
19 And we look forward to the results
20 from those steps, but we also encourage them
21 to continue to look for new ways - new steps
22 to take. But I think it needs to stay a

recommendation so that it carries more weight than it would if we put it in the Executive Summary.

MS. MALEBRANCHE: I think Ms. Crockett-Jones said, too, I mean, keep it in there, but let's get maybe some metrics now or some measurements to show continuous improvement.

I think that's maybe the addition to it or -

CAPT EVANS: Or even look at some best practices that we -

CO-CHAIR GREEN: Right. I think we can make it a recommendation and basically talk to the things that have been done and the work that still needs to be done. I don't think that's an issue and that's kind of where we started.

The one final piece that I wanted to bring up and I don't know that we have enough information to say anything to this, but there is one side of this which is a

1 little odd. And that is that there is - if
2 you're watching what's going on at Madigan and
3 the things that have become so sensitive with
4 Congress right now based on the recent
5 testimony, there is another problem which has
6 to deal with how we pay for people who have
7 PTS.
8 And the problem is that
9 essentially getting better loses benefits,
10 which is a problem.
11 And so, I don't know how to deal
12 with that one, but there really is a problem
13 when if you get better, you lose a benefit.
14 And so, it creates kind of a perverse
15 incentive.
16 And that's not saying that I don't
17 think these people shouldn't have benefits.
18 Please don't misinterpret what I'm saying.
19 It's just that we want the incentive to be to
20 get better.
21 And so, how do we get there? And
22 I don't know the answer.

1 CO-CHAIR CROCKETT-JONES: Okay.
2 I'd like to point out that as we've embedded
3 stuff in line units, the incentive will be to
4 get better, not to go into the system.
5 So, it's sort of - do you see what
6 I'm saying? And when it comes to benefits
7 right now, we have these temporary benefits
8 that then people are afraid to lose.
9 And I think that a slightly lower,
10 but, you know, a lower but permanent benefit
11 makes more sense, because then there isn't an
12 incentive to stop getting treatment.
13 And since we cannot definitively
14 say that someone getting better is going to
15 stay better, that this might - that people
16 might have lifelong issues with this, they
17 might recur, other things might compound, and
18 the service-related issues that started them
19 down this track of posttraumatic stress, they
20 don't disappear with getting better.
21 So, a recurrence caused by late in
22 life that still has - that benefit is still

tied to it. And so, I think that we ought to encourage a permanent, smaller - a smaller rating, but permanent. And that we -

CO-CHAIR GREEN: For me, it's not about rating, just so we understand.

CO-CHAIR CROCKETT-JONES: I mean not rating. Benefit.

CO-CHAIR GREEN: But I'm not trying to raise it, lower or raise it. I just - I'm wondering if some of the - I don't know if it's Canada, but there are some of the other countries that have looked at giving a lump sum payment.

So, the diagnosis is real just like servicemen's traumatic life -- the SGLI or the traumatic insurance, TSGLI. And so, giving a lump sum payment which then allows the individual to basically take the next steps.

There are pros and cons to that because it is something that really does not ever, I'll say, resolve, but people get to a

1 place where they're able to go on and do other
2 things.
3 And so, I'm not advocating for any
4 one venue right now. I just think that there
5 are some issues in terms of what happens with
6 PTSD. And it's very obvious when you listen
7 to some of the Congressmen talk in terms of
8 expectations for someone who has this in terms
9 of long-term payment, et cetera.
10 And so, I just don't know how to
11 deal with it right now, but it's a real issue.
12 CO-CHAIR CROCKETT-JONES: Well, I'd
13 say my only concern about a lump sum payment
14 is that we are in a healthcare system that the
15 costs are rising annually faster than anybody
16 could get even if they invested.
17 That lump sum to put aside for
18 some future incidents and treatment, I mean,
19 I think -
20 CO-CHAIR GREEN: Again, assuming
21 that you get your healthcare, I mean, you
22 actually get healthcare benefits. So, it's

1 not an issue of whether you're going to get
2 the healthcare benefit. It has to do with
3 other compensation and that type of thing.
4 So, let me make one positive
5 comment.
6 CO-CHAIR CROCKETT-JONES: But
7 getting the healthcare benefit is tied to your
8 rating.
9 CO-CHAIR GREEN: Yeah, but I'm not
10 talking about the rating. I'm just talking
11 about longer term payments.
12 I understand. I understand. It's
13 a very complex issue. And so, I'm not trying
14 to solve it here. I just think that it is
15 something that's an issue.
16 The other thing I was going to say
17 that's very positive that no one has talked
18 about is I was just over in the theater and
19 there are several things that are going on
20 right now that are bringing back combat
21 psychiatry and essentially taking people out
22 of the fight for a short time to basically

1 apply the BICEPS principles of combat
2 psychiatry to get people back into the fight
3 to try and prevent longer term issues with PTS
4 and PTSD.
5 And so, I think that some of the
6 things happening in the theater right now are
7 extremely positive. Both with the Navy, the
8 Marines and the Army, it's very - it's not
9 quite standard, but very similar in terms of
10 what they're doing with removing people for
11 short periods of time close to the
12 battlefront, and then getting back to the
13 battlefront.
14 So, I was very impressed with some
15 of the things we're doing over in the theater.
16 CAPT EVANS: That's the new -
17 that's that recent - maybe a couple years now,
18 the clinical guideline for removal and then -
19 right.
20 MS. DAILEY: Can I get everyone's
21 attention?
22 We do have some solid treatments

1 going on in the services. We had a very good
2 panel talk to us about the three empirically-
3 based treatment modalities and their
4 effectiveness and the amount of training
5 that's been delivered to Department of
6 Defense.
7 So, there are things you can
8 reinforce and affect and place emphasis on for
9 the Department of Defense to help them kind of
10 focus their resources.
11 If I can direct you to Page 3 of
12 the discussion points starting at the top,
13 there's been a huge push on training providers
14 on the three empirically-based treatment
15 modalities.
16 And there is - again, I use those
17 words, "empirically-based." So, we have data
18 that says these treatments are effective.
19 Telling DoD that we recognize the
20 effectiveness of these programs and to
21 continue to train service providers on these
22 treatments. And to continue treatment

1 fidelity, i.e., individualized treatment
2 followed through a course, changing those
3 courses when it's not working for that
4 individual. So, there's some flexibility in
5 there. And then bringing it to as successful
6 a conclusion as they can.
7 And in the absence, in a dropout
8 of the individual and the inability for them
9 to complete the program, feedback mechanisms
10 to get them back into a program under a
11 treatment modality that works.
12 In guiding the Department of
13 Defense making a recommendation that they are
14 -- and they exhibit fidelity to these
15 treatments and fidelity to following up on
16 patients who are not able to complete them is
17 a good direction for a recommendation
18 acknowledging all the training, all the
19 providers they've brought on.
20 CAPT EVANS: I believe Portsmouth,
21 Naval Hospital Portsmouth, provided that exact
22 example of how they are using that training

1 and recapturing some of the PTSD. Am I
2 correct? Did we have a brief from Naval
3 Hospital Portsmouth on their - from the
4 behavioral health providers?
5 MS. DAILEY: This is - these three
6 items on Page 3 come out of the departments we
7 talked to providing PTSD care. And it came
8 from a very effective panel by our three
9 service PTSD experts.
10 So, the direction was let's
11 reinforce for the Department of Defense that
12 these empirically-based treatments need to be
13 - continue to train the behavioral health
14 professionals, as completely trained a force
15 as you can achieve. That the treatments once
16 they are trained on them have fidelity. We
17 can go back and check, as we noted earlier,
18 with clinical review of records for the
19 fidelity of these treatments. And then follow
20 up with servicemembers who have been unable to
21 complete the program for brining them back
22 into a program that they need, that they have

1 faith in.
2 This is not just the guys at the
3 hospital. These people are being trained in
4 the OSCAR units, these empirically-based
5 delivery methods. We talked about OSCAR.
6 These types of empirically-based methods need
7 to be used in the unit levels with marines,
8 with the Army embeds that we talked about at
9 Fort Stewart and Fort Carson.
10 This type of training needs to get
11 all the way down to those types of providers.
12 And then the fidelity of the treatment needs
13 to be monitored. And then the individual
14 participating needs to be brought back in the
15 loop if they can't complete it.
16 That is the long-term fix. Very
17 effective treatments, evidence-based
18 treatments, delivered in service to the best
19 of the service's ability.
20 CO-CHAIR GREEN: Yes, I agree,
21 Denise. The only other concern I have is we
22 tend to throw PTSD and TBI and we throw them

1 all in the same bucket, and there are very
2 clearly differences.
3 And so, you know, I mean, if you
4 have TBI whether or not some of these
5 therapies that we're talking about are going
6 to be effective for PTSD, it's unknown. And
7 that's what's leading all these discussions
8 from APA, et cetera, on how to do that.
9 And obviously more science coming
10 as some of the markers come through in some of
11 the work that's being done.
12 I mean, it's just an interesting
13 time because the medical science cannot yet
14 give us answers on this. But there's a -
15 people are getting confused with regards to
16 what happens with a true diagnoses of PTSD
17 meeting all criteria at least in the Air Force
18 today, somewhere between 70 and 90 percent.
19 I saw 75. Last time I saw it, it was as high
20 as 90 are returning to duty.
21 Which means that they're actually
22 being given skills to continue to do military

1 duties, not just other duties. I mean,
2 they're coming back in full up for military
3 duties.
4 And so - and that is not the
5 perception of the public, okay. Their
6 perception is quite different in terms of if
7 you have PTSD, that that means that you're no
8 longer going to be a productive member of
9 society, which is frankly just not true. And
10 that's part of our problem.
11 CO-CHAIR CROCKETT-JONES: I do like
12 the language on this Page 3 for these 3 lines
13 of thinking. And I like that they are
14 specifically for PTSD.
15 I think that, in fact, the only
16 thing that I would say is that the first one,
17 we want 100 percent of the behavioral health
18 providers to receive training - well, actually
19 I think it goes without saying. I think that
20 it's fine, because it is very specific to
21 posttraumatic stress disorder.
22 The only question I have is we

1 don't indicate who we think should monitor -
2 who's responsible for monitoring the dropout
3 rates and the provider efforts to re-engage
4 patients.
5 I mean, I don't know if we have to
6 be more specific in order to make that an
7 effective recommendation.
8 MS. DAILEY: Probably best directed
9 at both the health provider and the
10 commanders.
11 A lot of the feedback we got from
12 servicemembers and providers in the field was,
13 I've got a six-week treatment plan here, but
14 not only does the young servicemember want to
15 go into training with its unit getting ready
16 to deploy, but, you know, commanders also want
17 them to stay in the unit for training. And
18 that means that that six-week treatment might
19 either get truncated or it might get turned
20 off. I'm fine, I'm not going to go through
21 treatment.
22 So, it is both a medical provider,

1 the servicemember and the commander trying to
2 come together to emphasize six weeks this
3 treatment is required, you're not required in
4 the train-up for the deployment, because I
5 can't take you on the deployment if you don't
6 go through those six weeks.
7 So, it's got to be a provider and
8 a commander to collaborate on a full
9 treatment.
10 CO-CHAIR GREEN: I think that the
11 other obvious thing we should be - that we
12 should include in the positive steps is the
13 VA/DoD/White House initiative to improve
14 training for civilian providers in
15 anticipation of a larger problem.
16 And so, it's not captured here
17 that I saw.
18 MS. DAILEY: It's Number 3 right
19 below Two, sir, on Page 3.
20 CO-CHAIR GREEN: I don't see it in
21 there.
22 (Discussion off the record.)

1 CO-CHAIR GREEN: Yes, but I'm
2 talking way beyond contract, okay. What the
3 Joining Forces effort is about is training
4 every provider and every physician in the
5 nation to deal with this.
6 And so, this isn't about contract.
7 This is -
8 MS. DAILEY: It's not about the
9 network. Not about TRICARE network.
10 CO-CHAIR GREEN: No, it's not about
11 the network.
12 MS. DAILEY: Okay. All right. We
13 can -
14 CO-CHAIR GREEN: It's about
15 changing --
16 MS. DAILEY: -- extend it.
17 CO-CHAIR GREEN: -- medical school
18 and nursing school training to identify it
19 earlier and to be able to intervene earlier.
20 MS. MALEBRANCHE: And that's
21 something we might want to also make a segue
22 in here for, because VA is working with this

1 Joining Forces and that's exactly what we
2 discussed that it needs to be in the academic
3 affiliations where we have schools for
4 physician curricula. And I think that
5 actually works pretty nicely if we can grab
6 some language for that.
7 CO-CHAIR GREEN: The big advantage
8 being that if you're able to - if 75 to 90
9 percent are being returned to duty and able to
10 function, but we know that they may have
11 relapses, then regardless of where they are,
12 they would be recognized and be able to get to
13 therapies, which is what we're interested in.
14 Do we need to talk at all about
15 TBI as a separate entity, or are we ready to
16 go on?
17 MS. DAILEY: Number 5 on Page 3
18 might warrant your review.
19 CO-CHAIR GREEN: Actually, it's a
20 good - I agree with the language there.
21 That's fine. And we'll get to some of that
22 when we talk on the next one. So, why don't

1 I go ahead and do my part here.
2 We'll now review the Centers of
3 Excellence. Last year we created
4 Recommendation 9 related to this topic.
5 Effectiveness documents for this topic can be
6 found in Tab M, okay.
7 This topic falls under Restoring
8 Wellness and Functions. So, I'll turn this
9 over to Dr. Phillips and Colonel Keane.
10 LTCOL KEANE: Nine was met. They
11 identified Nine as being met.
12 CO-CHAIR GREEN: So, I guess
13 although we think that it's being met as
14 basically these things are aligned to the
15 services and moving forward, there's still
16 some issues with regard to common services and
17 whether they're going to be provided at, I
18 think, ultimately MRMC is what is supposed to
19 happen starting as of October of this year.
20 So, the decisions have been made,
21 but they're not fully implemented yet. So,
22 when you say "met," I just would caution that

1 some things are still in progress.
2 MSGT MacKENZIE: Plus, there's the
3 hiring issue versus the funding issue. As we
4 saw with several of them, they had all the
5 funding. But because of the restrictions,
6 they weren't allowed to hire the people they
7 needed to continue forward.
8 CO-CHAIR GREEN: I think after that
9 meeting I talked with the joint staff and we
10 got them clearance to hire. So, I think that
11 was released.
12 So, I went and talked with
13 director of staff, the joint staff, and we got
14 authority for them to go hire. So, they've
15 been hiring now. That's no longer a delay,
16 but it did take some - they just weren't aware
17 at the highest levels.
18 MSGT MacKENZIE: Because, I mean, I
19 thought that was a pretty powerful move at
20 least with a vision center of excellence where
21 they took our Year 1 recommendation and
22 challenges to the way they were doing

1 business, and revamped that and came to brief
2 us on the really, really good stuff.
3 So, it's good to see that they're
4 getting the manpower as well now. So, that's
5 good.
6 CO-CHAIR GREEN: Anything more?
7 LTCOL KEANE: No.
8 CO-CHAIR GREEN: Okay. The only
9 other frustration I had in this as actually
10 making progress now, is on the registry
11 business. The vision center of excellence had
12 actually been identified as the one to take
13 this far forward and the hearing will follow
14 using a lot of the same thing.
15 And of course the JTTR, the Joint
16 Theater Trauma, is actually serving for the
17 Amputation Center of Excellence.
18 And then I'm not sure that the
19 NICO has a true - any type of listing right
20 now in terms of how they're doing registry
21 work other than patients who are being
22 referred to them.

1 And so, just something to work
2 through. And they may have another registry.
3 I don't know, but that's identification and
4 tracking of people that they're seeing to
5 basically learn what's working and what's not
6 working as important as we try to advance the
7 science through these Centers of Excellence.
8 Okay. I think I'm still on here.
9 My goodness. Let's see. And we're not even
10 at the break yet. Damn, okay.
11 (Laughter.)
12 CO-CHAIR GREEN: So, that was
13 pretty straightforward. So, we'll review the
14 topic of interagency program office.
15 Last year we created
16 Recommendation 20 relating to this topic. And
17 the effectiveness documents for this topic can
18 be found in Tab N.
19 This topic falls under the
20 Enabling Better Future. So, this goes over to
21 Ms. Malebranche and Mr. Rehbein.
22 MR. REHBEIN: Let me kick this off

a little bit. Obviously Recommendation 20 has not been met since there is not yet a common electronic health record.

When we first discussed this last year, my feeling then was it's a good recommendation. It shouldn't take more than about 15 years.

Listening to - and I don't know if his title was acting director or interim director brief us earlier this year, my expectation of that timeline has shortened considerably. And I think it's reflected here in the effectiveness measures.

As far as that electronic - common electronic health record, in my opinion, they have taken two major steps. One where they resolved which way the platform was going to go whether it be AHLTA, VistA or something else. And they decided on something else.

Secondly, when they made the decision to do open source and modular programming.

1 The speaker we heard yesterday,
2 that book Dangerous Enthusiasms, those huge
3 projects that fail are mostly because it's a
4 single contractor trying to do the entire
5 project.
6 And when you do modular
7 programming, modular assembly like this, you
8 get a chance to draw expertise from a lot of
9 people and a single company doesn't have
10 expertise all across the board.
11 Somebody does better with
12 pharmacy. Somebody does better with x-ray.
13 Somebody does better with MRI imaging. You
14 get a chance to draw on that.
15 So, even though this
16 recommendation is not met, I'd like to somehow
17 put some positive words into it.
18 I don't know, you know, I'll leave
19 that to the people that are a lot better with
20 the English language than I am. And they're
21 all sitting back there shaking their head, we
22 don't know.

1 CO-CHAIR CROCKETT-JONES: I'd also
2 like to say not only did the speaker we heard
3 talk about multiple contractors less likely to
4 fail, he also said that using it is the way
5 you determine if it works. And with open
6 source apps, the folks who are the users can
7 test apps before they're selected. So, it's
8 a secondary way in which it's a really smart
9 move forward.
10 You know, it still has all the
11 potential problems that all --
12 MR. REHBEIN: Oh, absolutely.
13 CO-CHAIR CROCKETT-JONES: -- IT
14 projects do, but I think that they've made
15 some really bold decisions that are new ways
16 of thinking.
17 So, I'm a little heartened about
18 the timeline as well, but I still think we
19 need to re-voice our - that this still needs
20 to be a priority.
21 MR. REHBEIN: We need to applaud
22 the decisions that they made, but we also are

very much looking forward to continued progress as rapidly as possible because we believe that the common electronic health record is really going to help the people once we - in the transition not only within DoD and VA, but in that transition, because we know that transition right now is not as smooth as it could be.

CO-CHAIR CROCKETT-JONES: And that interim solutions are still viable to help recovering warriors. I mean, an interim solution for the smaller population of just recovering warriors is still something that would be helpful.

I mean, I don't think we need interim solutions for everybody. That would be nice, too. I still think that we've got this smaller population who could - the folks going through IDES might - that's a smaller population than everybody in the VA and the DoD.

MS. MALEBRANCHE: And we have that

1 tomorrow, too, to talk about IDES, but I think
2 that - and relating this record to the
3 disability I'm not sure because I don't think
4 we've heard that, but you know they are doing
5 those disability benefit questionnaires and
6 they're automating those. And they've
7 increased those numbers that they're using for
8 disability for the physicians to.
9 Are you aware of those, the group?
10 I think General Green is. And I think those
11 are automated and that should be a significant
12 improvement for the disability, the IDES, but
13 also relating here to the electronic health
14 record because that will be in the system.
15 I guess this recommendation when
16 we look at this focused on the electronic
17 health record, but also I wonder just about
18 the electronic record in general. Was that
19 discussed?
20 Because I wasn't part of this last
21 year, the VLER part.
22 MSGT MacKENZIE: It was discussed

1 pretty extensively, but actually what the
2 recommendation was about was an interim
3 solution, not about the total process.
4 We understood the mountain of
5 challenges and the duration it's going to take
6 to get this completely converted over, but the
7 recommendation was based on the need for an
8 interim solution to more effectively transfer
9 medical data between the DoD and the VA, and
10 that we weren't burning up resources creating
11 truckloads of paper that had to transfer and
12 finding a more effective way to transfer that
13 data between the two services as these guys
14 transfer through.
15 That was the recommendation and
16 which I don't see as being virtually not even
17 attempted.
18 CO-CHAIR CROCKETT-JONES: Can I
19 make the risk of incurring wrath from all
20 sides and say that there is now security
21 available for having data on thumb drives and
22 to increase the portability of the health

1 records of the recovering warrior in the IDES
2 population by using thumb drives that are
3 secure?
4 CO-CHAIR GREEN: Okay. Let me come
5 back to that. Okay. So, on this one we
6 really do need to incorporate VLER because
7 significant progress has been made in terms of
8 the identity management, which will help
9 significantly as we move forward.
10 And the most visible part of that
11 is identity management and how it's been
12 combined with e-benefits.
13 And so, e-benefits that the VA has
14 put out has enabled our veterans to basically
15 go online and get all kinds of information
16 from VA loan information to disability
17 information, et cetera, et cetera.
18 A lot of this is VBA, not
19 necessarily medical information. But because
20 the benefits ultimately define what happens
21 with health, it actually is extremely useful.
22 Same thing in the blue button

1 arena where both VA and DoD make personal
2 health records now available through a blue
3 button.
4 It's not wonderful, but it does
5 give the patient significant information and
6 access to their own data.
7 On the EHR, I need to point out
8 that there were a couple of things that we
9 heard from our NIH representative yesterday
10 that are worrisome with regard to the strategy
11 on IHR.
12 So, yes, they have made a very
13 clear commitment to stack data. That's fine.
14 They have gone to a regional data store,
15 although exactly how they're going to be
16 broken up regionally is not fully defined yet,
17 but they're looking at not having a single -
18 the big bang theory. And so, that part is all
19 good.
20 The single GUI interface, the
21 graphical user interface is very close and so
22 is that linkage now to the data.

1 The thing that he said yesterday
2 that was the good news is most of this is
3 being done with messaging and HL7, the
4 language, and most of it is being done so that
5 it's compatible with the common languages that
6 are out there. So, LOINC and - I won't go
7 through all of them, but there's multiple
8 languages.
9 And the common use between VA and
10 DoD of the Health Data Dictionary ensures that
11 we'll have relatively common datasets
12 eventually. I mean, there's a lot of work to
13 get there, but - so that part is all very
14 reassuring.
15 The PC he talked about that he was
16 not as optimistic about was the use of the
17 Electronic Security Bus, which is basically
18 leveraging a programming tool that ties into
19 APIs.
20 If you heard him, what he said was
21 it can get very confusing as you end up with
22 an API that doesn't have the same information.

1 And so, you end up with - it's like having a
2 definition.
3 And so, if I define something as
4 this and then I add to it this and that, I can
5 have an API for this and an API for this and
6 that, and it's duplicative and it becomes just
7 as confusing as current data systems.
8 So, there were some things that he
9 talked about that were a little worrisome in
10 terms of the strategy, but for the most part
11 we're breaking it up into apps, we're doing
12 all the things that he talked about, which is
13 very reassuring.
14 Coming to the DISC, the thumb
15 drive or what's becoming more common now with
16 the high-speed scanners is once you identify
17 and take the paper, they will scan it. They
18 typically don't give you - because you can't
19 put a - at least for the active duty members,
20 you can't use most thumb drives. Even though
21 you can get them secured, most people don't
22 maintain the - do the things often enough that

1 they need to, to get them scanned.
2 They're giving them a DVD. And
3 the DVD actually has their record available so
4 that the patient can have the full record
5 instead of a copy, if that's what they want,
6 which is actually fairly useful.
7 And when you look at what's
8 happened with the progression on the BHIE,
9 BHIE progress has been huge because now you
10 can literally - I saw out at Madigan where you
11 can actually in a personal health record, they
12 were bringing up all the notes that were in
13 AHLTA. The complete notes. Not the bits and
14 pieces, but the compiled note so that you
15 could actually get the physician's note and
16 pass it to the patient, if you wanted to, on
17 their home computer.
18 Now, I say "pass it to them." In
19 reality, it's a web-based personal health
20 record which is better, because then the
21 information is centrally stored.
22 And so, there's been huge progress

1 in terms of getting us closer to something
2 that's both focused on the patient and
3 omniavailable to the provider, but none of it
4 is in the provider's hands yet. And so, we
5 have to be cautious in how we endorse this.
6 I think that they are making very
7 good progress. There are some very big risks.
8 This integration of the data could take years,
9 okay, if they - depending on how they choose
10 to do it.
11 The co-location of the data is
12 happening as we speak. Integration of the
13 data depending on what methods they choose,
14 could take a very long time.
15 The nice thing there is that the
16 secretaries are very intolerant of delays.
17 And so, there will be two apps based on the
18 datasets that have to be ready to work in '14
19 for this to continue. That's a year and a
20 half away, okay.
21 Immunizations was one, and I
22 always block on the other, but those two apps

have to be ready to go in '14.

So, what I guess I'm trying to get you all to understand is, we need to be cautiously optimistic based on the briefings we've taken and what's going on and certainly when I talk with Congress about this.

I've actually offered not relating to this group, to talk with them about the insider information in terms of what's happening with that, but it is fairly positive.

I mean, that's actually too cautious. It's very positive.

MR. REHBEIN: Even cautiously optimistic is light-years farther than I was a year ago at this time.

And, yes, you're right. There are very large risks in a project like this, but I think this is one of those high-risk, very high reward projects.

And I think they can get there. I agree with you. We need to be optimistic, but

1 we don't want to put on our rose-colored
2 glasses and say it's a done deal.
3 CO-CHAIR GREEN: Yes, the open
4 source is interesting. I sit on the board and
5 there's some really good things happening, but
6 you don't yet have a lot of industry buy-in to
7 basically development of apps. And so,
8 there's some work to be done.
9 Right now it's working with VistA
10 and with AHLTA trying to see how we can take
11 what we have. And so, if we get industry
12 interested in developing apps, this will go
13 much faster.
14 So, it's actually - there's
15 reasons to be optimistic. There really are.
16 But with any big IT program, huge risks.
17 Probably the strongest thing I
18 would tell you that's going on right now is
19 Barkley having a single IPO chief who I do
20 believe has the authority to take this the
21 direction it needs to go.
22 MS. MALEBRANCHE: And I think the

1 other piece in addition to Dr. Barkley, is I
2 think having them report every other month on
3 progress.
4 So, there is consistent, steady
5 look and progress reports that are required.
6 And then also required if there's not
7 progress, why that is so.
8 So, it's a constant look. It's
9 got eyes on now.
10 MR. REHBEIN: With regard to the
11 concerns that Mac was expressing, and they're
12 valid, is there -- North Chicago is working
13 this kind of system.
14 Is there a possibility that we can
15 visit them, or is it necessary for us to visit
16 them? Is there some way we can measure the
17 effectiveness of how they're doing, how that's
18 working?
19 CO-CHAIR GREEN: North Chicago is a
20 one off. It's not necessarily the way ahead
21 for the iEHR. A lot of money has been spent
22 up there to get us, and there are certain

1 spinoffs that are going to actually help with
2 transition.
3 Probably the most useful is the
4 single sign-on context management which allows
5 you at North Chicago that when you put a name
6 in, it brings up both VistA and AHLTA records.
7 And so, you can look at both of them on the
8 same screen and it's matched.
9 So, not everybody up there is
10 using it. When I talk with people who go and
11 visit, particularly my VA friends, they were
12 a little disappointed that people aren't
13 bringing up both records all the time. But if
14 you think about it, the VA tends to see VA
15 patients and focuses on VistA and - but if
16 they are seeing the same patients or if you
17 want to know if there's any records, you
18 simply go into the single sign-on context
19 management and it brings up both records and
20 you can see all the visits from both sides.
21 So, that's a very strong thing.
22 There's some - it's techy - virtualization

1 concepts that will make virtual desktops and
2 upgrades to apps and things much simpler. And
3 those things are being rolled out within DoD,
4 which will actually - I'm not sure what VA is
5 taking away from that, but I think they're
6 also working with the ABHE, but I don't know
7 yet how they're doing on their virtualization.
8 But what happens is once you
9 virtualize your system and create the virtual
10 desktop which most networks are going to now,
11 it then allows you to use that single sign-on
12 context management wherever we take it.
13 And so, that then allows us with
14 the new record, to bring up the old AHLTA and
15 the new iEHR eventually.
16 And so, that's the kinds of things
17 that are being worked. So, they're working
18 transition plans, as well as development
19 plans. Which all of this is positive, but
20 North Chicago is truly a one off because of
21 the way it was developed.
22 It's become model in several

areas, but not what's going to be the final solution.

MS. MALEBRANCHE: I don't really have anything further there. I just saw it actually a couple weeks ago and went up there, and I know our secretaries are going up the 29th to see it.

So, I wouldn't say that we shouldn't like maybe later on if we need to, you know, wanted to see it. And there's also people here in D.C. that could even show us too from the IPO. So, we could have them come right here.

I'm not sure, though, as far as looking at this recommendation with the disability piece, what further - I know what you're saying about the thumb drive piece, but I know that we're able to get to an awful lot.

When you talk to Under Secretary Hickey, she's able to get to a lot of records right now that she wants fairly easily, but I think the issue we still have - and maybe

1 again this goes to the IDES - is when people
2 are seen on the outside and getting those
3 records in because, you know, neither TRICARE
4 provider network nor our fee-basis system
5 requires people to have anything electronic.
6 So, we're still having that piece
7 brought in by paper.
8 CO-CHAIR CROCKETT-JONES: Well, I
9 just, you know, we went and looked at these
10 large copiers that are creating four copies to
11 go out, which are then sent. I mean, the cost
12 of all that paper being sent around when
13 copiers could just as easily be taking the
14 paperwork from civilian providers and putting
15 it right onto a thumb drive, and that just the
16 cost of sending those thumb drives around is
17 so much lower than sending all that paper
18 around.
19 And the speed with which they
20 would get there would shorten our timelines,
21 it seems.
22 CO-CHAIR GREEN: Fully possible

1 today to make this entirely electronic in
2 terms of what the same copiers that do the
3 high-speed copying can do it right onto a
4 disk.
5 There are probably two problems
6 with it. One is that if you were to simply
7 take the electronic record without doing the
8 actual scanning, you might miss civilian
9 healthcare. And so, that's a problem because
10 sometimes you're going out for the more
11 complex issues especially if you're at smaller
12 bases.
13 And so, that's a problem. That's
14 why it really has to be printed once and
15 copied to make sure you have everything.
16 And then the secondary problem
17 with using an electronic, is that the C&P
18 physicians - and I shouldn't even say the C&P,
19 but the folks who are making the disability
20 determinations are still utilizing paper from
21 DoD because it's not a common format with
22 VistA.

1 And so, they're very good at using
2 VistA once it's in their record. And I can
3 use personal examples. They now can go into
4 BHIE and actually call up - I mean, they were
5 able to pull up studies that I haven't had in
6 six or eight years and they were immediately
7 available to them. They just ask for it, and
8 it was immediately available.
9 And so, some of that is going on
10 during the actual C&P exam, but again the
11 record is useful because it's organized
12 chronologically.
13 And so, whenever there was
14 something they couldn't find in the BHIE, they
15 basically then if you know the rough dates
16 when something happened, you can turn right to
17 it in a piece of paper.
18 And you'll be able to do that in
19 electronic health records, but it's not quite
20 there yet where you can sort it the way you
21 need to for the doctors to get rather instant
22 information.

1 You think the computer would be
2 faster, but I was able to find things faster
3 in a paper copy than he could, because he has
4 to go through and screen whether by date or by
5 a test and by, you know. And so, I could
6 actually show him on a paper copy faster.
7 So, it depends on - you may save
8 time with the people who are copying, but you
9 may extend the time with the people who are
10 doing the exam.
11 And so, the focus is still on the
12 people doing the exam to get the disability
13 determination made, if that makes sense.
14 Let's face it. Some of these
15 doctors are older doctors, okay.
16 (Laughter.)
17 MR. REHBEIN: Out of the discussion
18 points, and I don't know whether this falls
19 into what we're supposed to be discussing
20 right now or not, but the SOC
21 interdepartmental collaboration IPO set of
22 discussion points on Page 7, I think that

1 first one what you two just said about the
2 level of attention that the secretaries are
3 putting on this, on the electronic health
4 record, I think that only reinforces Number 1
5 to get the JEC revised so that we have the
6 deputies from both sides there just because
7 they bring that much bigger a club with them.
8 So, I'm hoping that somehow we can
9 work that into a recommendation.
10 CO-CHAIR GREEN: It is in the
11 recommendation. It's from last year.
12 MR. REHBEIN: It was in last
13 year's, but that was sort of a two or three-
14 pronged recommendation that the SOC and the
15 JEC be folded together. And I can see where
16 the impression could be made, well, we did
17 most of this, we don't have to do the rest.
18 And I think we need to make sure
19 we put attention on that last piece because we
20 think it's important.
21 CO-CHAIR GREEN: Yes, I can't speak
22 specifically, but I also think there's some

1 resistance in DoD to that latter piece.
2 So, it may be our interface with
3 Congress to get them just to work that.
4 MR. REHBEIN: That was going to be
5 my question was we turn this report into the
6 secretary, and the secretary writes an
7 implementation, and who champions something
8 like that? Is it up to us when our co-chairs
9 appear in front of the Congressional Committee
10 to - okay.
11 CO-CHAIR GREEN: My guess is now
12 that the report's been released to Congress
13 because they've got it now, right?
14 MS. DAILEY: Yes, sir. They had it
15 in September.
16 CO-CHAIR GREEN: Right.
17 MS. DAILEY: The implementation
18 plan - or evaluation was done in December.
19 Implementation plan in March.
20 Your visit up there will be about
21 focusing their attention on the two areas I
22 believe we said we need congressional

1 intervention in.
2 CO-CHAIR GREEN: Right.
3 MS. DAILEY: This was one of them.
4 CO-CHAIR GREEN: And in fairness,
5 Congress also does not like to tell any
6 department specifically how to do things.
7 MS. DAILEY: I think there are
8 other congressional parties that took an
9 interest in the report. I think that's one of
10 the reasons we saw a TAP go through. And
11 there was another one that showed up in the
12 congressional language also.
13 So, this one did not and I think
14 we just need to kind of, you know, the co-
15 chairs need to add their emphasis to it and a
16 personal touch.
17 CO-CHAIR CROCKETT-JONES: So,
18 Denise, have we - we have covered the topics
19 that we were assigned for the day.
20 MS. DAILEY: Yes, and I would
21 rather not go on. I would like you all to get
22 fresh.

CO-CHAIR CROCKETT-JONES: I think everyone is feeling the need to decompress.

MS. DAILEY: Okay. Good.

CO-CHAIR CROCKETT-JONES: So, I will say -

MS. DAILEY: I'd like everyone to be fresh tomorrow morning. It will be a full day.

CO-CHAIR CROCKETT-JONES: -- we will now close for the day and resume at 8:00 a.m. tomorrow morning; is that good?

MS. DAILEY: Yes, yes.

CO-CHAIR GREEN: Thanks for everybody's knowledge. I have a meeting at 7:00 with an international visitor. And so, I may be just a little late, please. I'll join you in progress.

(Whereupon, at 3:55 p.m. the meeting was adjourned.)

A

ABHE 368:6
ability 39:4 138:17 156:8 167:4 171:9 179:5 208:13 237:2 275:17 299:13 309:9 341:19
able 16:2 30:13 66:12 74:2 78:17 110:20 143:21 152:13 176:7 185:1 188:11 203:1 208:9 256:17 261:2 268:21 271:1 281:22 283:7 335:1 339:16 346:19 347:8,9,12 369:18,20 372:5 372:18 373:2
above-entitled 54:11 130:15 219:15 296:7
absence 339:7
absolutely 10:2 202:4 289:13 328:14 354:12
absorbed 96:3 101:9
absurd 181:13
academic 347:2
accelerated 76:18
access 8:13 18:15 61:8 74:6 89:5,22 131:3 134:10 169:9,12 170:2 179:2,5 212:22 258:9 298:22 310:17 359:6
accessibility 298:5
accessible 170:16 175:18 191:6
accident 87:9 107:3
accommodate 44:1
accommodates 98:4
account 35:15 113:7 152:20
accountability 65:16,21 100:5,19 119:3 121:17 138:20 148:8 176:17 177:2,9 178:18 183:9 272:15 273:1 274:7 277:15 278:12 279:12 287:3,5 293:18 296:2
accountable 96:10 125:11,16 148:8 172:20 223:5 272:8,9 273:6 274:10,21 288:7 295:12
accounts 123:6
accurate 31:20
accused 195:18
accuses 195:21
achieve 340:15
achieving 275:15
acknowledging 339:18
acronym 23:7
act 179:8
acted 181:13
acting 7:20 352:9
action 194:22 195:4 277:12
actions 225:7,20 277:22 317:16
activating 247:15
active 12:1 13:9 27:21 28:13 29:1 49:17 81:10 84:16 85:13 110:18 132:17 133:3 134:13 136:16 232:9 234:13 247:22 249:2 250:18 252:7 288:10,11 291:6 295:5,6 308:14,19 309:9 329:18 361:19
activities 216:3
activity 98:4 121:1 279:7
actual 75:18 174:8 174:20 176:3 268:13 371:8 372:10
acuity 152:15,21 153:2
acute 87:20 230:6
Ad 207:17
ADC 82:14
add 48:1 59:2 62:10 119:19 123:5 153:8,9,9 153:17 157:12 173:11 184:3 193:18,19 197:9 199:14 211:15 217:8 232:15 285:22 294:18 361:4 376:15
added 93:6
adding 151:11 157:8
addition 331:9 366:1
additional 23:18 28:1,8 40:22 69:2 143:2
additions 13:3
address 20:20 67:17 119:6 129:13 165:8 189:1 195:6 196:1 216:15 316:22
addressed 65:22 164:7,7 177:7 213:6 214:13 276:4 327:13
addressing 63:13 203:14 266:12 320:10
adequately 215:9
adhere 273:10
adhered 272:5
adjourned 3:23 377:19
adjudicated 33:18 34:2
adjust 291:9
adjusting 291:6
administered 89:4
administrative 7:5 97:13
Admiral 41:17
admire 264:13
admit 43:4
advance 252:19 351:6
advanced 103:10
advantage 347:7
advice 82:16 127:6
advised 125:20
advocacy 63:21 78:17 125:6 138:1 242:5 244:16
advocate 2:11 95:14 129:7 225:10
advocate's 95:16
advocating 335:3
Affairs 207:5,9 208:13,21
affect 282:16 294:2 338:8
affiliations 347:3
afraid 333:8
AFW2 55:12 95:14 95:19 98:12,16 115:18 142:8 162:9 225:10
agencies 208:14 238:8,14,15 239:21 240:8
agency 148:8 206:19
aggravated 6:2 10:10 11:11
aggressive 33:13
aggressively 186:7
aggressiveness 65:13
ago 88:21 154:14 312:19 364:16 369:5
agree 25:4,8 122:4 142:15 171:6 172:6 197:16 227:8 287:6,15 293:2 307:11 341:20 347:20 364:22
agreed 211:11
agreements 308:15
ahead 30:3,4 58:8 82:13 192:22 224:20 252:16 329:7,9 348:1 366:20
AHLTA 352:18 362:13 365:10 367:6 368:14
air 11:20,20 12:9 15:15,19 22:2 63:5,8 64:15 69:4 81:22 90:22 91:2 95:13 124:11 129:5 138:9 142:4 142:9 162:8 232:12 240:17 242:16 247:6 248:16 276:9 305:4 319:9,10,19 329:19 342:17
airman 93:9,22 124:14 127:11 195:15
airmen 127:14
airvac 204:18
AKO 164:12
alerting 13:5
Alexandria 1:15
Alexandria-Hist... 1:14
aligned 198:16 348:14
aligning 231:5
alley 112:15

allocation 231:4
allotted 261:3
allow 292:2
allowed 14:10 278:2 349:6
allowing 287:20
allows 68:4 75:12 334:17 367:4 368:11,13
alluded 111:19
alter 291:21
alternate 1:26 258:9,11 268:20
alternative 244:20
Alto 201:17
altogether 243:20
amazed 313:10
ambiguity 222:10
American 289:17 314:12,13
amount 13:16 32:10 96:22 101:10 134:18 139:1 143:2 274:1 278:10 281:3 283:1 321:1,2 338:4
amounts 281:7
Amputation 350:17
amputee 86:4,5
analogy 280:13
anchors 206:21
anecdotally 268:17
angle 44:18
ankle 280:2
ankylosing 4:19
Anne 1:26 154:13 180:7
annual 171:14
annually 335:15
answer 22:3 47:9 103:14 109:14,16 115:17 158:14 164:8 190:5 279:5 298:5 327:19 332:22
answered 141:15 165:19 237:8,9,11
answers 49:22 342:14
anticipated 134:5
anticipation 308:4 345:15
anti-stigma 322:3
Antonio 201:9,16 203:5,12
anxious 289:8
anybody 88:10 152:10 159:2 183:5 246:5 335:15
anymore 197:19 269:2 297:5
anyone's 233:1 313:3
AOR 107:18
APA 316:10 342:8
API 360:22 361:5,5
APIs 360:19
apnea 154:16
apneas 155:15
app 47:13 121:10 321:12
appear 375:9
appears 299:15
applaud 354:21
apply 337:1
applying 158:4
appointment 261:14,20 262:2 275:20 290:19,22 292:9,12,19,20 293:15,16 295:5 295:22 299:8 300:4,7 301:20 302:2
appointments 40:4 41:1 75:8 76:13 226:10 274:5 277:19 278:3 285:16 287:21 294:2,20
appreciate 15:11
apprised 5:15
approach 270:15 289:11 327:1
appropriate 72:7 280:11 319:12
apps 212:20,21,22 354:6,7 361:11 363:17,22 365:7 365:12 368:2
ARC 259:4
area 68:6 71:14 96:12 145:3 151:5 196:6 203:8 206:19 240:20 257:4 265:13 270:21 324:12
areas 40:14 251:11 286:7 307:20 319:13 321:8 369:1 375:21
arena 359:1
argue 330:13
ARMED 1:6
Army 24:8 56:1 58:16 69:22 81:21 93:11 106:3 122:15,15 123:5 123:14 126:11,14 130:5 136:20,21 142:4 144:22 159:1,19 162:8 164:11 173:20 175:9 184:15,16 185:1,20 186:10 187:6 204:9 206:4 213:14 232:12 242:19 248:10 254:10,22 276:9 276:14 310:15 319:2 337:8 341:8
Army's 123:7 124:5 164:6 168:2 182:1 248:13
ARNG 1:20
arrived 304:18
arrives 106:1
articulate 126:2
artificial 262:19
aside 274:2 335:17
asked 14:13 19:4 26:11 52:22 194:15 212:16 234:3 263:13 276:12 282:15,16 310:3
asking 34:4,22 38:12 48:8 91:9 125:9 130:8 154:9 169:10 289:3
aspect 28:6 320:4
aspects 113:19 163:20
assembly 353:7
asset 130:1
assets 139:3 158:19 323:21
assign 39:10 49:15 52:15 70:16 104:17 136:21 172:1
assigned 22:9 23:10 70:11,14 87:18 90:14 95:5 109:13 118:14 143:5 145:5 152:18 234:1 376:19
assignment 22:12 25:6
assist 144:2,5,7 155:14 296:1
assistance 18:9 40:22 74:9 135:3 135:6,14 144:9 183:8
assistance-type 121:11
assisted 183:6
associate 314:4
associated 59:14 60:13
Association 314:12 314:13
assume 13:4 271:10 300:20
assuming 31:17 191:16 335:20
assumption 28:2
assure 180:13
Asthma 154:18
asthmas 155:14
attached 6:10 280:3
attachment 316:4
attack 81:12
attempt 256:9 299:3
attempted 357:17
attempting 112:13
attended 66:14
attending 284:9
attention 28:12 45:21 196:1 223:18 264:18 268:1 279:13 289:4 320:3,18 337:21 374:2,19 375:21
augmented 258:20
authority 38:21 139:20 140:6 349:14 365:20
authorizes 309:8
authorizing 262:17
automated 356:11
automatic 300:2
automatically 303:6
automating 356:6
available 8:16,17 9:22 36:20 38:18 65:9 74:1 82:22 129:13 134:11,14 170:7,9 174:7,11 174:13,20 187:8 198:21 199:3 213:13,14 255:4 280:22 297:21 306:8 307:15 308:1 357:21 359:2 362:3 372:7

372:8
average 75:5
avoid 109:8 288:18 300:12 303:3
avoiding 7:11
avoids 7:4,10
aware 127:19 349:16 356:9
awareness 18:3 24:21 25:3,22 193:10
awful 369:18
AW2 55:13 58:16 126:15 129:7
AW2s 126:7
A-F-T-E-R-N-O-... 220:1
a.m 1:15 4:3 54:10 54:12 130:14,16 377:11
a/k/a 102:15

B

B 1:15,19
back 7:2 8:6 9:14 11:3 19:7 20:11 21:17 24:21 25:15 38:19 39:7,15,22 40:3 41:11,17 43:7 45:22 54:6,8 67:20 70:17 71:3 71:12 77:1 84:3 84:13 85:16 86:16 95:11 97:2 104:20 105:5 106:17 107:17 108:8,19 109:19 110:5,18 110:19 111:1,14 112:9 114:4,8 118:11 128:13 130:18 132:17 133:3,5,13 134:6 134:7 136:15 145:6 150:12 151:14 155:1,12 158:9 159:20,21 186:10 189:6,8 190:5 191:18 194:6 197:15 199:19 208:2 216:14 217:10,21 219:11 232:14 234:18 237:15 241:10 247:1 248:13,19 249:6 252:5 253:12 254:9 255:8 256:21 261:10 263:2 274:15 279:10,10 286:19 287:8 294:15 296:4,21 297:7 298:18 301:2 309:17 315:6 320:10,13 322:8 327:22 329:11 336:20 337:2,12 339:10 340:17,21 341:14 343:2 353:21 358:5
backdated 6:4
backing 236:13
backlogs 205:19,21
backs 196:14
backside 250:20
backup 192:3
bad 208:2 285:1
balance 19:2 33:11 288:14 290:1
balanced 281:15
Balboa 19:17 40:7 293:4
Ballroom 1:14
bandwidth 163:18 164:18 174:2
bang 359:18
Barkley 365:19 366:1
base 23:2 53:18 82:8 83:1 127:16 129:2,3,5 152:9 198:21 199:3 238:2 267:13 290:16 308:19
based 9:19 33:20 59:16 71:7,9 75:18 78:13 98:19 109:21 131:17 133:2 134:12 146:15 185:4 203:5 214:9 250:5 253:5,16,19 282:5 299:14 315:2 329:2,2 332:4 338:3 357:7 363:17 364:4
bases 39:3 93:21 197:18 308:16,18 308:20 371:12
basic 211:19 311:15
basically 19:16 60:8 71:22 73:6 83:19 84:9 93:21 98:15,20 103:2 104:19 107:5 110:5 115:16 119:7,18 124:6 158:17 161:5 166:18 179:13 183:20 184:1,3 188:11 189:19 190:19 191:18 192:12 199:7 200:22 209:7 211:12 249:20 258:18 260:10 263:12 273:18 278:17 281:15 294:7 303:4 307:15 314:21 331:14 334:18 336:22 348:14 351:5 358:14 360:17 365:7 372:15
battalion 25:19,20 26:8 35:12,22 51:9 65:7 182:17
battle 22:2
battlefield 248:2
battlefront 337:12 337:13
bear 127:20 228:5
beast 311:11
becoming 328:6 361:15
bedside 62:18 238:5,11 239:12 240:7,14
began 118:11,12,17
beginning 95:6 192:20 207:17 314:3
begins 87:1
behavioral 20:17 96:16 310:21 340:4,13 343:17
believe 4:11 14:7 39:21 63:3 65:19 70:7 91:17 112:8 117:8 120:4 125:14 131:19 137:16 144:13 150:6 151:6 165:4 173:19 176:19 179:9,11 194:17 213:19 214:9 220:20 227:9 242:16 277:1 279:13 283:19 322:8 339:20 355:3 365:20 375:22
belong 51:9
belongs 291:19
benefit 81:7,8,19 228:8 262:9 297:16,21 298:2 298:19 299:10,12 300:1,7,22 301:7 302:10,16 303:5 303:20 309:7 310:11 332:13 333:10,22 334:7 336:2,7 356:5
benefits 5:1,20 92:19 109:20 113:19 114:1,10 115:3,14 125:20 224:16,20 225:6 225:19,20 230:12 262:3,18 296:18 298:22 299:19 300:16 303:16 332:9,17 333:6,7 335:22 358:20
besieged 227:20
best 26:3 49:15 51:5 62:15 108:2 121:7 182:1 191:22 195:5 223:4 263:22 331:12 341:18 344:8
bet 106:10
Bethesda 199:22
better 20:18 23:17 29:16 31:6,8 32:1 32:7,15,21 35:14 61:17 63:19 66:9 101:17,18 107:14 117:17 146:4 149:21 165:5 225:7 226:3 230:9 237:4 263:8 297:2 303:21 308:3 309:13 311:5 315:17 324:3 332:9,13,20 333:4 333:14,15,20 351:20 353:11,12 353:13,19 362:20
beyond 11:1 60:1 69:14 116:1 181:1 346:2
BHIE 362:8,9 372:4,14
BICEPS 337:1
big 11:16 37:6 137:5 154:12 160:8,17 217:13 252:8 254:9 261:15 282:10 283:17 347:7

359:18 363:7 365:16
bigger 160:18 374:7
biggest 131:20
billing 309:19 323:7
bio 130:12,12 294:10
bit 11:18 17:21 24:7 32:9 38:2,3 42:10 48:3 50:16 56:8 62:10 120:22 132:1 137:10 157:14 162:1,3,16 170:14 175:12 180:11 198:19 285:2,20 288:14 288:15 296:14 306:1 352:1
bits 362:13
blew 296:22
blind 112:15
block 99:16 153:9 363:22
blocks 117:10,11
block's 146:20
blown 321:14
blue 358:22 359:2
board 5:22 6:16 8:16,17 9:1,6,16 14:9,11,14,18 15:2 18:20 28:14 36:9 44:4 45:7 51:20 52:4 53:11 59:10 63:4,10 66:4 81:5 89:18 91:10 125:6 147:1 147:12 283:14,18 322:10 353:10 365:4
boarded 86:8,10
boards 81:20
bodies 280:10,22
body 208:22
bold 354:15
book 353:2
boon 261:16
boosting 20:16
bottom 265:2
box 38:4 39:6 148:17 190:13 215:16 259:14
boxes 294:16
brain 107:3
branch 90:12
branches 113:2 138:17
brand 241:22
break 3:6,8,16 54:5 71:19 130:12,13 187:12 294:10,14 296:4 351:10
breakdown 42:10 326:2
breaking 322:6 361:11
breaks 193:9 320:22 322:6
breast 103:7
bridge 229:1
brief 26:15 257:11 265:6 340:2 350:1 352:10
briefed 6:20 168:3 212:3,4 223:3,14 246:7
briefing 146:9,13 146:16 147:6,8 153:2 212:5 308:11
briefings 212:17 248:20 364:4
briefly 311:7
brilliant 262:5
bring 18:12 28:11 28:22 29:13 34:16 44:11 59:13 108:3 108:18 151:13 195:22 199:1,2 206:9 218:8 229:11,22 235:8 236:5 237:3 249:6 250:11,11 310:16 331:20 368:14 374:7
bringing 8:22 25:18 28:13 44:11 45:15 171:2 242:19 243:5 248:13,16 265:22 328:1,5 336:20 339:5 362:12 367:13
brings 97:4 242:7 367:6,19
brining 340:21
broad 39:2 62:7 113:15 148:1 149:18 196:5 236:21
broaden 132:5
broadly 160:11 189:2 196:15
broke 155:9
broken 38:17 250:13 284:1 359:16
brought 35:12 111:14 112:9 127:20 132:16,17 154:13 158:2 182:15 193:13 217:6 228:5 247:1 320:13 339:19 341:14 370:7
Bruce 314:7
brush 148:1 236:21
bubble 129:12 168:6
buck 67:6 276:2
bucket 342:1
budgetary 281:15
build 51:4 310:4
building 328:9
bulk 323:18
bullet 196:10 215:17
bullets 196:13
BUMED 278:17
burden 110:18 291:1
Burdette's 207:8
burner 194:7
burning 357:10
burns 107:2
Bus 360:17
business 1:8 202:4 350:1,11
busy 62:20
butt 256:7
button 358:22 359:3
buy 49:10 199:11
buys 302:4
buy-in 292:5 365:6

C

C 85:6,7
cadre 38:21 205:10 205:13,16 215:15
call 32:15 69:12 82:16 122:16 130:6 153:10 184:17 187:12 208:20 232:22 233:1,15,16 242:15 260:10 372:4
called 22:10 93:11 129:5 139:7 220:15 245:18 256:13
calling 75:11 245:15 246:3 325:17
calls 123:6 145:1,2 312:4
camp 21:20 22:22 29:9 40:6 47:19 48:2 51:8 52:9 182:14
campaign 322:3
Campbell's 207:8
campus 199:22 200:1
Canada 334:11
cancel 290:21
cancellation 295:21
cancellations 293:13
cancer 99:6,8 103:7 155:5 160:17
cancers 81:10
candidate 83:18
canned 14:3
capability 198:15 198:17 201:8
capable 155:16
capital 203:8
CAPT 1:22 41:8 64:7 66:5 70:12 70:18 91:15 93:13 105:4,11,19 106:12,15,20 107:22 126:18 128:2,5,10 130:9 150:1 171:10 172:12 179:21 180:10 202:7 203:1 227:11 233:7,14 234:2,15 237:12 242:16 249:7,15 263:2 276:16 305:2,12 305:20 306:4,9,14 331:11 337:16 339:20
captain 55:1 138:21 139:8 142:14 143:4 167:2 182:15
capture 99:2 107:11 113:15 142:16 153:12 154:5,6,8,15 156:19 157:6,7 159:17,18 160:5 160:14 199:9 262:5 285:18
captured 56:22 111:22 118:8 132:9 142:20 161:1,20 176:14 217:17 246:9

285:2 345:16
capturing 138:19
car 107:2
card 300:19 303:15 303:15,21
care 1:4 3:15 20:15 23:18 24:13 26:20 27:12,15 30:14 32:11,11 33:3 34:12 38:11 39:7 39:14,18 40:6 51:3 56:16 57:6 63:20 64:3,9,10 67:15 71:8 76:21 82:4 91:18 92:3,5 95:18,22 96:7 100:15 108:7 114:9 125:1,2,9 125:11,18 131:5 137:22 138:7 139:16,20 153:11 162:9 195:19 196:17,19 202:21 206:14,22 208:5 221:21 222:5,7 224:18 225:8,11 226:5 232:19,20 239:7,8 242:14 243:8 251:10 260:4 272:3 284:7 287:19,20 297:9 298:7 299:8 303:4 308:22 309:14 310:5,6 311:5 340:7
career 15:6 18:9 50:19 127:10
careers 51:2,11,12
career-enhancing 215:21
careful 214:3 272:20
caregiver 169:20
caregivers 80:1 171:3 175:19 191:7 192:7
caregiver/family 170:21
carries 331:1
Carson 341:9
case 3:7,10,15 4:17 5:4,13,15,16 6:8 6:15,18,19 7:2,3 8:4 9:2,3,4 10:21 10:21 14:12 30:11 30:20 36:5 37:19 40:19 41:4,10,16 41:22 42:4,11 43:1,15 44:5,6,9 45:17,21 46:8,12 46:16 54:15 55:11 55:16,19,21 56:3 56:8,12,18,20 57:2,10,14 58:7 58:12,13,18,22 59:5,15 61:5,16 61:22 62:6,11 63:2,8 64:13 65:3 65:5 68:2 69:7,11 70:3 72:5,7 76:12 76:19 78:4 79:1,1 79:9,9 86:2,19 87:6,8,11,12,18 87:19 90:2 92:3 92:17 93:19 95:12 97:20 98:1 112:20 114:12 121:11 134:21 142:11 152:17 154:20 160:2 169:16 175:2 182:6 209:14 211:5 218:6,11 220:5,13 221:6,10 222:1,2 222:16,17 224:3 225:5,9,13 226:4 227:12 228:21,22 230:6,7,8 231:22 232:6,15 233:2 237:21 238:10 239:1 242:5,17,17 242:20 244:22 245:2,8,13,15,18 245:20 246:2,18 246:22 247:8 250:11 251:10 253:12,13,15 254:10 258:3,4,14 259:15,17,18,20 260:3,11,12,19 261:2 272:3 297:11 298:15,18 301:3,5,6 304:10
caseload 232:15
cases 6:11 7:17,20 8:15,21 9:8 44:6 105:15 147:3 149:17 152:7,8 231:20 256:10,21 320:7
cast 155:10
casualties 198:10 224:5
casualty 90:12 204:16,16
CAT 98:16,18 99:11,12,14,15 102:14,15,15 106:11,12,14 116:7 118:9 120:4 231:21
catastrophic 231:22
catastrophically 228:19 229:10
catch 107:15 110:9
catching 7:16,17 328:9
categories 76:7 105:7 148:22 149:2 151:18 152:11 154:3 158:10
category 59:4 61:20 62:3,5 63:12 67:13,14,22 68:1,4,14,20 71:14 72:1 73:4,5 73:11,16,21 74:13 74:14,19 75:2,4 75:11,12,18 76:11 76:20 77:7,9 88:22 90:5 94:15 94:20 105:10,13 117:5,7,8 119:8 121:1 142:21 145:14 148:18 150:5,15,19 151:7 153:11,11,15,20 157:12 233:8,8 244:5 258:7
caught 8:1
caused 297:19 333:21
causing 266:20 277:17 282:21
caution 348:22
cautious 363:5 364:13
cautiously 364:4,14
cell 246:4 256:1,3 258:15 259:9,10 305:14
cells 253:15
center 15:15,20 94:1 124:14 127:11 149:8 197:12 201:14 349:20 350:11,17
centers 3:20 93:10 197:11 201:20,22 348:2 351:7
centralization 305:14
centralize 39:6 241:18
centralized 188:13 246:2,18 253:15
centrally 246:22 362:21
cents 310:10
certain 46:20 71:8 71:8,9 83:1 98:4 113:18 114:10 115:13 125:22 129:22 130:4 137:3 139:1 149:10 152:9 176:2 184:1 208:14 245:17 282:8 294:5 303:9 309:6 366:22
certainly 38:2 108:18 111:20 118:8 203:15 222:8 320:4 329:7 364:5
cetera 80:9 103:11 125:6 163:14 165:11 196:19,19 260:12 275:12 335:9 342:8 358:17,17
CG 28:3
chain 122:16 189:6 272:6,7 279:12
chains 56:2 193:11
Chair 1:19
chairs 376:15
chalk 241:16
challenge 5:12 51:19
challenges 52:7 349:22 357:5
challenging 47:18 49:14
champions 375:7
chance 12:18 13:1 75:10 161:13 202:20 211:5 353:8,14
chances 133:4
change 15:1 42:20 63:14 95:2,9 116:8 133:16 137:5 148:18 150:9 153:8 154:9 206:10,11,12,12 206:19 213:22 234:16,22 235:1 244:11 253:10 266:20 267:21 282:5 292:1 310:11,18 314:14 317:3 320:6

321:20
changed 10:17
changes 185:17 282:8 325:20,22
changing 63:6 156:6 165:12 292:20 339:2 346:15
channels 78:22 279:6
characteristics 113:8
charge 166:12
charged 237:6
Charles 1:15,19
chase 193:11
check 117:9 262:12 262:13 265:3 340:17
checked 117:11 146:21 182:16
checking 189:16 262:15
checklist 142:13
checks 141:19
check-the-box 182:10
check-the-box-ty... 181:21
Chicago 201:4,6 202:10 366:12,19 367:5 368:20
chief 365:19
children 260:9
chime 132:22
choose 109:18 176:11,12 363:9 363:13
chooses 272:14
choosing 108:22 109:2
CHRISTIAN 1:23
chronic 155:17 202:21
chronologically 372:12
chunk 123:17
circumstances 38:8 50:15
civilian 17:10 51:18 133:6,11,14 133:18 203:11 287:12 311:22 312:5 328:16 345:14 370:14 371:8
civilians 52:9
clarification 30:6 91:14 173:17 174:6,17 245:5 296:15
clarify 67:19 111:13 154:10 165:10,13 225:3 263:8 296:13 329:13
clarity 72:10 170:3
clash 18:21
classes 284:9
classification 319:12
classified 67:13
clean 105:3 117:1
cleaner 107:5
clear 10:12 11:8,10 12:6,20 31:13 59:4 71:22 73:3 73:11 74:19 75:14 117:4 121:14 222:11 226:15 229:12 230:13 259:7 263:10 293:18 359:13
clearance 319:21 320:1 349:10
cleared 205:5,21
clearly 42:11 69:9 93:6 98:10 120:14 168:18,22 170:19 171:4 190:20 217:1,3 226:21 228:7 237:13 273:2 288:14 298:11 318:5 342:2
clear-cut 36:12
climate 30:10,18 42:21 193:3,7,12 193:15,20 194:16 196:16 286:20 287:3,4 293:8
clinical 222:17 229:3 253:13 269:18,19 270:1 271:2 312:1 315:4 317:17 337:18 340:18
clinicians 325:7
clock 283:13
close 39:11 128:15 256:16 308:19 330:6 337:11 359:21 377:10
closed 135:21 172:14,14 199:5
closer 75:6 234:6 236:12,13 328:1 363:1
club 374:7
CNS 1:23
Coalition 27:12,16 95:22 125:1,2 137:22 138:7
coast 249:8,8,10
Code 85:6,7
codify 60:2
codifying 245:3
coffee 54:8
cognitive 315:8
cohesive 192:19
coin 280:19
coincide 147:20
COL 2:12 16:10,13 16:18 21:12,16 25:4 28:17 31:21 35:1,8 39:9 47:15 50:18 52:6,20
collaborate 345:8
collaboration 264:21 295:8 373:21
colleague 312:8
collected 268:11
collecting 214:4
collective 203:21 327:10
collectively 326:6
colonel 16:8 88:20 94:13 162:6 186:18 187:3 211:8 220:13 229:7 231:8 257:10 306:7 307:8 348:9
color 195:11
combat 15:15,20 18:19 19:10 21:20 22:11 23:22 30:14 31:18 33:22 34:3 34:7 35:6 38:6,10 38:21 40:3 47:6 48:12,13,15,18 49:8 336:20 337:1
combating 23:15
combat-wounded 13:22
combination 221:7
combine 196:22 213:16
combined 201:3,7 270:20 358:12
combining 163:3
come 16:8 22:17 31:19 41:15 51:7 54:6,8 57:18 62:9 65:7 67:20 82:11 84:3 85:16 97:8 99:3 109:18 110:5 114:4 140:9 141:9 180:15 186:12 195:7 199:19 201:15 202:6 213:16 232:14 234:3 237:6,19 238:17 240:5 251:7 254:21 257:15 258:12 261:17 268:21 294:15,22 296:4 296:16 309:17 315:3,6 322:4 329:11 340:6 342:10 345:2 358:4 369:12
comes 90:12,12 105:6 106:16 121:16 134:19 145:6 189:8 193:8 231:10,10 241:15 242:3 301:2 333:6
comfortable 16:17 144:21,21 304:15
coming 13:11 29:1 49:19 70:17 78:21 97:1 98:3 104:8 126:4,6 133:3 158:5 181:17 204:17 252:22 255:13 256:21 286:4 289:14 301:16 308:5 316:11 322:2 329:16 342:9 343:2 361:14
command 12:5 15:22 18:4 30:10 30:18 38:20 42:21 54:22 56:2 90:3 122:16 155:3,5 193:3,7,12,15,20 194:15 196:16 272:6,7 286:20 293:8 295:16
commander 25:19 35:13 36:1 41:6 42:5,6 44:12 272:13,14,18,19 273:1,5 274:4 275:10,14 277:6 278:5,18 279:22 280:8,21 281:18 284:12 288:11 345:1,8
commanders 22:17 22:18 78:15 195:8

195:13 273:9 277:6 282:13 288:21 294:19 295:19 344:10,16
commander's 274:15 275:13,17 278:14 285:4
commands 43:12
comment 166:15 167:3 173:11 177:22 178:4 186:9 193:19 247:2 254:1 267:21 269:21 317:7 336:5
commentary 216:10
comments 47:16 130:10 177:13 179:18 180:5,22 181:2 187:17 216:4 311:7 325:21 326:2
commissioned 48:21
commitment 184:10 185:20 250:19 359:13
commitments 184:15 186:6 222:22
Committee 375:9
common 278:4 319:4 348:16 352:2,14 355:3 360:5,9,11 361:15 371:21
commonplace 328:6
Commonwealth 1:14
communicate 41:5
communicating 37:17 41:11 168:20 191:1 239:10,12
communication 27:7,9 28:8 29:18 29:22 35:14 37:12 40:19 42:2 43:11 159:15 178:9 188:4 190:22 192:16 238:13 239:3 291:3,22
communications 188:21 189:4
communities 78:19 108:9
community 39:17 64:14 78:16 112:22
Comp 133:12
companies 43:9
company 43:12 353:9
comparable 206:4
compare 122:22
comparing 226:1
compassion 19:3,6
compatible 360:5
compensation 336:3
competency 211:16 211:20
compiled 362:14
complaining 234:19
complaint 266:4
complaints 57:16
complement 229:9
complementary 325:11
complete 125:5 141:6 275:18 339:9,16 340:21 341:15 362:13
completed 53:5 139:21 140:7,16 158:21
completely 266:18 269:13 283:6 308:20 340:14 357:6
completes 139:15
completing 53:7 139:1
completion 178:20
complex 43:4,5 86:21 87:1 255:11 270:22 336:13 371:11
compliance 141:8 141:11 142:2,13 245:17
compliant 5:4
complicate 77:20 197:19
compliment 294:19
component 108:3 110:18 116:19,22 119:11 123:13 147:4 151:6,9,12 154:6 157:4 160:2 245:12,22 247:22 281:17 295:6 302:13 320:12
components 27:13 27:14 134:13 159:18,19
compound 333:17
comprehensive 121:18 125:5,10 127:18 132:12 143:13 153:21 157:2 159:10 161:15 170:10 176:8 184:21 196:18 197:12 219:5
computer 170:6 362:17 373:1
concept 248:5 262:5
concepts 368:1
concern 32:10 79:13 91:11 139:9 142:18 143:4 265:13 281:3 311:2 335:13 341:21
concerned 18:6 19:15 30:9 51:3 67:1 181:19 193:3 215:6 283:18
concerns 5:14 20:21 193:5 265:13 281:15 313:15 366:11
concluded 44:19
conclusion 339:6
concrete 40:17 42:18
concur 157:8
concurred 6:1
condition 5:18 6:1 10:7 76:17 84:17 95:2,9 107:18 112:19 113:6,11 113:16 115:6 116:18 119:13 133:3 143:11,15 144:15 161:3
conditions 4:20,23 4:24 5:7 7:6 9:20 9:21 12:2,8 31:14 33:18 113:1,14 119:9 143:8,9
conduit 105:1
conference 242:14
conflict 170:22
conflicted 257:22
confused 224:6 240:10 264:14 342:15
confusing 71:14 238:18 360:21 361:7
confusion 68:15 71:2 105:5 148:14 224:1 244:1
Congress 7:22 9:15 10:17 13:17 76:5 193:6 332:4 364:6 375:3,12 376:5
congressional 76:4 210:22 375:9,22 376:8,12
Congressmen 335:7
conjunction 227:5 232:4,10
connect 94:11 127:3 144:8 145:15 230:3
connected 4:22 10:9 12:2 64:17 67:8 72:7 101:13 197:1 325:12
connection 101:18 143:19 221:9 314:6
connectivity 36:11
cons 334:20
consequences 294:6
conserving 150:18
consider 143:21 194:1 261:8,11,19 262:6
considerable 326:17
considerably 352:12
consideration 200:19 242:22 246:17 247:15
considered 76:11 179:15 193:4
considering 206:7 248:21
considers 75:2
consistency 91:10
consistent 42:9 366:4
consistently 57:11
consonance 235:6
CONSTANCE 1:22
constant 366:8
constantly 22:19 277:18
constitutes 74:18
constraints 6:9 141:20
consultant 64:15

64:18
contact 7:21 225:2 234:21
CONTENTS 3:2
context 367:4,18 368:12
continuation 184:5
continue 28:13 36:3 109:3,17 171:12 177:15 243:22 310:4 317:8 330:21 338:21,22 340:13 342:22 349:7 363:19
continued 3:11 26:20 115:5 116:17 355:1
continued/return... 117:17
continues 6:12 194:8
continuing 268:13 325:6
continuity 28:8 57:13 110:1 111:5 114:1 115:14 118:13 119:16,20 119:22 120:11 214:19,20,21 215:5,6 216:5 246:4 295:13
continuous 113:20 193:17 331:7
continuum 131:5
contract 346:2,6
contractor 107:20 353:4
contractors 354:3
contrary 10:13
contribute 175:20 191:9
control 23:8 141:3 141:12,19 189:17 189:18
controlling 184:12 232:3
controls 329:21
controversy 314:10
conversation 112:13 118:18 226:13 227:17,18 254:19
converted 357:6
convict 280:15
convinced 102:11 140:13
convoluted 187:10
cookie 326:22
cool 200:12
coordinate 20:8
coordinated 55:3
coordinating 255:3
coordination 18:11 20:4 131:3 223:1 223:2 224:20 251:10 269:1 305:5
coordinator 124:13 125:10
coordinators 48:8 51:8
copied 371:15
copiers 370:10,13 371:2
copies 370:10
Cops 235:2
copy 362:5 373:3,6
copying 371:3 373:8
cord 230:7
core 211:15,19
Corps 2:12 15:14 15:19 24:2 39:10 56:1 65:4 137:13 137:17 138:1,10 140:21 141:15 142:4 167:12 184:10 212:4,20 213:13 232:11 235:18 236:5 319:2
correct 11:15 46:6 95:3 98:11 105:2 137:20,20 141:14 150:11,11 153:22 160:4 184:20 185:19 205:20 207:7,13 222:21 232:16,17 257:6,9 263:5 276:17,21 277:2,16 297:14 301:9 302:19 340:2
correctly 26:12 65:20 174:18 183:10 227:17 240:2 256:11
Cory 5:17 6:5 9:4
cost 309:4 310:10 370:11,16
costs 335:15
counsel 127:6
counselor 48:1
count 201:3
counterparts 293:14
countries 334:12
couple 25:16 119:1 121:13 193:1 242:2 253:16 286:16 305:2 311:6 324:18 326:15 329:14 337:17 359:8 369:5
course 22:12 23:12 49:17 52:14 302:7 320:9 339:2 350:15
courses 315:15 318:12 339:3
cover 90:6 199:8
coverage 302:18
covered 60:15 79:8 120:6 126:13 170:11,11 209:7 260:4 376:18
covers 162:7 196:15
co-chair 1:15,16,20 4:4 7:14 8:14,21 15:12 16:5,6,11 16:16,20 21:14 24:17 30:2,4,5,22 31:2,3,5,7,9,10,11 32:8 33:4 34:13 34:18 35:4 36:13 36:17 37:1,3,5 40:11 41:20 43:17 45:16 46:11,14,17 50:1 53:21 54:1,5 54:13 55:5 57:7 58:8,9 59:12 61:1 66:22 68:10 69:19 69:21 70:1,6,15 70:19 71:11,21 73:2 74:3,17 75:17 76:22 79:12 80:5 85:17 86:3 87:5 89:11 90:19 90:22 91:4,5,7 92:13 93:15,20 94:5 96:15 98:11 101:6 102:1,6,10 102:13 103:15,21 104:2,11 105:2,9 106:10,13,18,21 107:4 108:12,21 109:21 110:4,8,21 111:4,6,7,8,17 113:13 116:7,21 117:3,14 119:15 120:5,8,20 121:4 123:4,16 124:3 125:19 129:19 130:11 131:6,10 131:12 132:3 133:17 135:18,22 136:12,18 137:6 138:21 143:16 144:4,18,22 145:10 146:5 147:16 148:13 150:8 151:22 152:12 156:18 157:22 159:11 160:7 161:4,8,17 163:22 165:17 166:11,16 167:14 168:12,14 169:22 172:7,17,19,21 173:5,8,13,15 174:10 175:5 177:8 178:17,21 179:3,5,10 180:8 183:11 187:2,15 189:5 190:4,15,18 192:17 194:13 198:5 199:15 200:18 201:5 202:12 203:4 204:1,15 205:3,12 209:4,11,21 210:14,18 212:11 213:3 214:2,12 216:9,13 217:13 219:10,13 220:3 220:16,17 221:5 222:13,18 223:9 223:19 225:22 230:19 241:7 243:12 244:14 246:1,15 248:7 249:11,17 253:2 258:13 260:8 262:14 263:11 265:7,12 266:17 267:17,20 268:5,7 269:16 270:13 271:7,12,18 272:11 273:12,16 273:17 274:14 276:7,13,21 277:2 277:14 278:4 281:2 282:18 283:10 284:14 286:12,21 288:8 293:11 295:2,11 295:14 296:9 297:13 298:1 299:16,21 301:22 303:1,9 304:14,17 305:9,13 306:7,21 307:10 310:14

312:16 314:10 317:11 318:17 323:13 329:13 331:13 333:1 334:4,6,8 335:12 335:20 336:6,9 341:20 343:11 345:10,20 346:1 346:10,14,17 347:7,19 348:12 349:8 350:6,8 351:12 354:1,13 355:9 357:18 358:4 365:3 366:19 370:8,22 374:10,21 375:11 375:16 376:2,4,17 377:1,4,9,13
co-chairman 15:17
co-chairs 271:19 375:8
co-located 308:18
co-location 363:11
co-locations 319:19
CPT 174:4 175:11
CPTs 270:5,12
crack 165:22 196:5
craft 118:2
crafting 304:11
crazy 94:3
create 71:1 73:4 85:14 151:20 163:14 166:3 208:13,22 215:14 263:8 281:22 290:12 309:7,13 310:17 368:9
created 54:16 143:14 220:5 228:18 307:2 348:3 351:15
creates 72:1 314:21 332:14
creating 44:7 68:14 144:11 148:13 357:10 370:10
credit 318:2
creed 195:11
crisp 151:20
criteria 24:22 31:12,19,22 33:20 34:6 35:6,20 39:13 62:2 67:10 68:8 88:22 156:13 196:7 258:7 342:17
critical 62:12 63:2 130:7 266:21 267:22
critically 238:21
Crockett 15:17
Crockett-Jones 1:16,20 16:6,11 16:16,20 21:14 24:17 30:4,22 31:3,7,10 32:8 34:13 36:13,17 37:3 50:1 53:21 54:13 55:5 57:7 58:9 61:1 66:22 69:21 70:6 71:21 73:2 74:3,17 76:22 79:12 85:17 89:11 90:19 91:4 91:7 94:5 96:15 97:4 101:6 102:1 102:6,10 103:15 104:2 105:9 110:21 111:6,8,17 117:3 118:12 123:4,16 131:6,10 131:12 133:17 135:18 136:12,18 143:16 144:4,18 145:10 146:5 147:16 150:8 152:12 156:18 161:8 165:17 166:11,16 167:14 168:12 169:22 172:19 173:5,13 174:10 179:10 180:8 187:2,11 190:15 192:17 194:13 212:11 213:3 214:2 216:9 220:3,17 221:5 225:22 230:19 265:7,12 271:12 273:12,17 277:14 281:2 283:10 295:11 296:9 298:1 299:16 304:14,17 306:21 310:14 312:16 323:13 331:5 333:1 334:6 335:12 336:6 343:11 354:1,13 355:9 357:18 370:8 376:17 377:1,4,9
CROCKETT-PL... 144:22
crossing 230:17
cross-talk 36:2 43:15
CRP 60:4 65:15 89:3 119:3 131:2 131:16 138:4,13 144:12 147:6 149:17,17,19,20 158:21 159:14 162:14 166:7 168:17 171:20 173:1,4,6,21 175:7,20 178:1,1 180:14 189:5,10 191:9 230:22 242:13 269:17
CRPs 131:14 140:22 176:21 182:15 184:12
CRP/CTP 175:17 190:20 191:5
crutches 173:22
CSM 1:20 43:6 71:3 104:19 109:11 110:3 133:1 134:9 136:11,14 153:7 153:22 154:4,18 155:18 156:10 157:4,21 159:16 160:4 214:6 215:22 216:20 222:15 254:16 256:15 257:3 258:1 259:21 277:16 287:2 301:14 302:17,22 303:13 304:2,5
CTP 60:4 119:3 120:14,15 121:2 121:18 149:1,4 152:2,4 153:13,18 156:11 159:2 162:14 164:1 165:5 166:7 168:5 168:17 170:4,6 171:20 174:8,11 174:20 175:3 182:1,10 184:18 186:2,6 187:6,9 187:18 188:8 189:20 191:22
CTPs 176:21
cultural 321:20
culture 18:21 27:2 38:3 310:18 323:20,22 324:20 324:21 325:1,3,4
current 53:13 122:21 145:14 239:18 361:7
currently 32:1 53:7 82:4 207:5 261:10
curricula 347:4
curriculum 211:16 211:20
CURSEC 13:15,16 14:1
cut 35:19
cutter 327:1
cuttings 280:22
cycle 17:1
C&P 371:17,18 372:10

D

D 1:20 325:17,17
Dailey 1:25 15:9 34:15 46:5,12,15 52:17 55:4,7 64:11 67:11 71:18 75:21 76:3 78:12 93:17 100:14,17 101:22 102:3,8 106:22 107:12 108:1 116:4 117:2 117:18 120:17,21 121:19 122:8,10 122:13 123:2,8,12 123:18 126:1 130:17 131:8,11 131:14,22 137:20 140:19 150:2,11 153:18 154:1,11 154:20 156:20 159:5 160:1,5 161:2,10,22 163:12 164:6,15 167:10,16 170:3 173:18 184:9 185:19 189:11,15 193:1 195:5 201:2 201:11,19 202:2 203:3,17 204:7,20 205:8,15 207:3,7 207:13 209:9,12 211:2,21 212:2,14 215:2 217:15,21 219:9,12 222:21 223:13 231:3,14 232:2,11,17 233:13,17 234:9 235:4,20 244:10 244:22 246:6 247:11 255:19 256:20 257:6,9,13 257:16 259:12 262:12,21 263:6 264:16 265:11 267:14,18 268:4,6 272:1 296:12 297:14 298:3,13

298:15 299:10 301:2 302:12,19 303:8,12,17 304:4 304:7,16,20 337:20 340:5 344:8 345:18 346:8,12,16 347:17 375:14,17 376:3,7,20 377:3 377:6,12
daily 32:13
damn 223:11 264:13 351:10
Dangerous 353:2
Daniel 4:16 8:4
data 8:13 100:13 118:1 122:14 123:22 174:13 194:11 203:20 204:2 213:4 214:4 218:19 265:9,14 266:6,16 268:11 271:13,15 338:17 357:9,13,21 359:6 359:13,14,22 360:10 361:7 363:8,11,13
datasets 360:11 363:18
datasheet 231:19
date 61:11 298:7 373:4
dates 372:15
daughter 94:2
Dave 221:15
DAVID 1:24
DAWG 83:14 241:7,14 305:9
day 53:8 128:4 190:3 236:9,9 261:10,19 376:19 377:8,10
days 51:5 53:6 104:14,16 248:14 250:15 257:18 303:10
DB 285:13
DD214 236:13
deal 33:8 99:13 176:8 178:10 190:2 207:17 208:11 291:17 316:14 319:8,16 328:18 332:6,11 335:11 346:5 365:2
dealing 47:4 68:18 134:9 178:14 224:15 257:3 323:9 328:17
deals 328:4
dealt 33:19
death 324:4
debate 122:17
December 164:21 168:3 173:20 184:16 185:20 212:4,17 375:18
decent 170:2
decide 60:2 62:4 72:6 79:10,22 149:14 177:14 187:16 278:5,19 314:14
decided 34:6 162:19 217:20 352:19
decision 35:5,15 76:15 79:7 87:3 104:21 112:5 146:14 147:9 241:14 242:11 260:2 277:6 287:9 287:17 288:1 295:4 330:3 352:21
decisions 33:5 62:22 81:18 198:11,21 241:20 274:19 284:13 289:1 294:1 295:15 348:20 354:15,22
decision-making 111:21
deck 155:9
declined 135:20
decompress 377:2
deconflicting 243:16 263:20
decreasing 204:2,4 204:5,6
deemed 4:25 7:6 9:8 12:2
deeming 10:16
default 271:9
Defense 1:2 56:14 102:4 130:20 208:7 245:4 338:6 338:9 339:13 340:11
defer 330:9
deficiencies 165:2
define 69:6 71:6 72:20 79:15,22 90:5 98:18 117:6 121:17 124:19 138:22 180:11 188:18 194:15 197:2,18,20 222:4 222:12 228:7 263:4 358:20 361:3
defined 61:18 62:3 74:13,14 77:17 85:18 102:20 106:19 121:16 132:7 151:20 153:17 158:16 197:3 198:4 199:10 226:21 237:13 359:16
defining 71:4,5 121:1 138:18
definitely 44:10 74:19 204:16 255:19
definition 59:3 64:12 67:21 68:4 71:7 72:17 73:3,6 73:11 75:7 85:20 94:16 97:2 98:5 104:9 119:8 124:5 129:21 144:14 148:15 150:20 151:4 155:6 196:14 263:8 312:7,22 361:2
definitional 118:9
definitions 58:21 67:19 76:5 88:1 94:19 97:7 98:9 124:4 146:9 312:15
definitive 312:1 330:1
definitively 333:13
degrees 14:16 151:2
DeJong 1:20 15:22 43:6 55:1 71:3 104:19 109:11 110:3 133:1 134:9 136:11,14 153:7 153:22 154:4,18 155:18 156:10 157:4,21 159:16 160:4 214:6 215:22 216:20 222:15 254:16 256:15 257:3 258:1 259:21 277:16 287:2 301:14 302:17,22 303:13 304:2,5
delay 273:14 274:22 275:11,20 275:20,21 279:15 279:16 287:18 300:4 349:15
delaying 277:19 279:18,20 280:1 287:20
delays 303:4 318:6 363:16
delicate 50:7 289:22
delineated 168:18 190:20
delinquent 244:8
delivered 338:5 341:18
delivery 341:5
delta 122:20
demand 69:1
demob 249:8,9 250:5,7 251:5,9 253:3 256:4,14 258:16 261:11
demobilization 247:21 248:8 249:5,18 251:17 254:18,22 257:20
demobilize 255:7 303:14
demobilizing 257:21
demobs 255:22
demob'd 252:5
DeMunnik 6:20
DeMunnik's 9:4
denials 7:5
denied 9:19 88:3,10 118:22
Denise 1:25 109:12 186:9 213:8 217:18 219:10 341:21 376:18
department 1:2 6:12 56:13 102:4 130:19 198:10 208:6 245:4 338:5 338:9 339:12 340:11 376:6
departments 340:6
dependent 252:16
depending 77:18 103:9 363:9,13
depends 62:14 112:17 171:7 193:20 285:14 373:7
deploy 278:6,8 283:7 344:16
deployability 83:14

deployed 303:10
deployers 248:17
deploying 21:5
deployment 17:11 83:13 298:8,9 345:4,5
depth 311:12
deputies 374:6
DES 5:14,14 121:22
describe 108:2 231:9
described 7:2 196:13 256:2 298:4
designate 124:12
designation 258:7
designed 40:9,12
desktop 368:10
desktops 368:1
despise 328:15
despite 4:22 5:9 35:5 278:6
det 24:6 36:12
detachment 17:19 18:5 20:18 21:3,8 25:1 26:2,7,10,14 27:22 28:7 32:18 36:7 45:2 65:6
detachments 17:9
detail 320:4,18
details 6:7,11
determination 36:4 373:13
determinations 81:3 371:20
determine 106:14 354:5
determined 31:22 225:9 284:15
develop 211:15 302:8
developable 263:1
developed 368:21
developing 198:12 365:12
development 3:7 3:10,12,15,18,19 3:21 207:22 365:7 368:18
device 65:18 159:15
diagnosed 325:10
diagnoses 325:10 342:16
diagnosis 325:14 334:14
dialog 166:3
dichotomy 12:11
dictate 134:18 209:5
Dictionary 360:10
Diego 200:1
difference 92:14 99:17 109:1 318:21 329:21 330:4,8
differences 265:1 266:19 289:11 313:4,5 342:2
different 19:17 24:7 25:13 38:8 44:18 45:4 50:22 51:15 56:17 72:10 72:11 74:1 97:17 145:22 148:22 149:2 153:2 157:14 158:22 162:5 193:22 194:20 197:10,13 197:20 228:13 230:3,4,9,10,11 242:8 243:3 248:9 266:5 270:17 285:10 286:1 293:4 307:19 313:6,7 314:20 315:5 316:3,4 324:16 326:12 328:11,21,21 329:12 343:6
differentiate 94:6 226:8
differently 64:19 74:15 324:2
difficult 18:22 19:3 84:7 99:9 141:20 151:3 281:19
difficulties 52:2 189:21 190:1 262:1 316:21
difficulty 34:10 68:11
dignitaries 281:1
dignitary 280:9
diminished 195:16 204:17
diminishing 198:9
direct 239:7,8 264:17 309:14 310:5,6 338:11
directed 344:8
direction 25:13 235:15 286:4 339:17 340:10 365:21
directive 271:8
directly 7:21 89:14 173:1 198:1 258:18
director 1:25 349:13 352:9,10
Directors 307:18 310:7
disabilities 260:9
disability 4:16,26 5:19,22 6:3 9:10 9:16 83:21 124:2 124:16 143:10 234:7 302:21 356:3,5,8,12 358:16 369:16 371:19 373:12
disagree 71:11
disappear 333:20
disappointed 367:12
DISC 76:1 115:21 121:9 233:2 236:15 361:14
discern 224:10
discernment 226:14
discharges 6:13
discipline 19:2
disconnect 238:17
discovered 185:4,6 264:20
discrepancies 71:1
discrete 121:1 170:4
discriminate 71:17
discriminated 195:10
DISCs 55:14 126:1 126:2
discuss 121:2 219:5
discussed 4:15 5:16 77:2 163:3 211:13 220:21 314:11 347:2 352:4 356:19,22
discusses 242:4
discussing 36:1 373:19
discussion 11:18 15:18 35:21 36:16 63:21 71:19 75:19 89:9 117:19 118:20 119:5 184:8 197:7 217:16 219:4 220:16,18 222:15 258:2 264:18 270:10 271:6 272:2 307:9 325:16 338:12 345:22 373:17,22
discussions 54:2 247:13 263:19 342:7
disease 103:10 311:15
disk 371:4
dismissed 15:4
disorder 312:8 314:5,18 328:4 343:21
disparity 66:3 221:9
dispute 6:16 14:18
Disregard 46:17
dissatisfaction 191:20
disseminate 194:16
distance 18:10 33:2 43:3,5 45:18 47:5 51:15 53:1,15
distinct 225:16
distinction 56:4,11 170:4
District 1:14
divided 50:4
doc 239:7 286:13
docs 256:8 279:12
doctor 181:12 272:18,19 277:4 278:13 301:12 326:10
doctors 81:18 293:11 321:2 372:21 373:15,15
document 55:10 57:1 76:1 92:4 96:13 100:5,7,12 100:13,20 101:2 128:21 142:7,12 162:13 167:16 170:8,15 183:10 184:14,22 189:20 246:10 272:5
documentation 65:18 188:3
documented 155:4
documenting 188:20
documents 54:19 167:20 177:5 187:22 220:9 307:4 348:5 351:17
DoD 1:15,19 4:26 5:4 7:22 8:7 13:16 76:6 139:17 142:2 156:14

167:10,21 170:14 189:16,17 190:8 199:7 200:3,6,11 200:15 202:13,22 206:18 207:1 208:4,4 210:7,20 221:10 232:2 233:6 244:1 259:18 261:4 263:7 265:1 266:19 269:20 270:16 330:2,18 338:19 355:5,21 357:9 359:1 360:10 368:3 371:21 375:1
DoDI 56:19,19 64:12 130:2 132:7 136:1 141:17 152:1 168:21 170:12 189:12 209:19 218:21 219:3 222:13,17 227:8 245:2,17 263:13
DoD/VA 233:5
doing 11:6 13:9 37:7,20 39:7 44:4 45:2,7 47:2 57:2 64:15,21 65:2,14 74:15 107:1,13 116:1 138:4 140:22 141:1,13 152:10 177:10 181:9,14 186:21 210:19 215:19 218:13 230:22 236:22 239:15 240:17 244:2,21 249:13 250:2 253:11 255:11 256:8 264:5 267:16 274:6 291:17 304:21 318:9 322:11 324:19 325:2 326:15 327:22 337:10,15 349:22 350:20 356:4 361:11 366:17 368:7 371:7 373:10,12
Dole-Shalala 67:12
dollars 281:13
door 291:12 306:12
doubt 150:2
dovetail 60:5
download 163:18
Dr 9:18 12:22 38:1 52:1 77:4 79:4,17 118:7 120:3,7 122:7,9,12 123:1 123:9 162:6 163:8 163:13 164:4,13 164:22 165:7 166:10,14,18 167:8 168:9 171:6 172:6 180:21 188:22 189:14 193:18 196:4 199:10 200:9 211:7,10,22 220:12 221:14 222:8 230:15 276:1,12 280:6 285:22 292:7,17 293:2 294:17 299:2 307:7 311:6 314:1 316:17 348:9 366:1
DRACH 1:21 324:15
draft 222:19 223:10 263:13
drag 303:22
dramatically 282:5
draw 200:14 353:8 353:14
drawing 204:13 288:10
drawn 101:12
drawn-down 203:15
draw-down 289:16 289:18
drive 37:6 45:18 158:7,21 176:1 206:19 361:15 369:17 370:15
driven 283:9
drives 80:8 242:18 357:21 358:2 361:20 370:16
drop 253:9 311:14
dropout 311:9 339:7 344:2
dropping 206:2 311:13 325:16,17
drove 94:3
dry 35:19
DS&M 325:20,22 326:4
DTM 223:14
dual 325:14
ducks 147:13
due 6:9 7:6 155:16
duplicate 329:20
duplicative 361:6
duration 269:14 298:2 357:5
duties 102:3 118:15 343:1,1,3
duty 12:1 27:21 28:13 29:1 49:17 81:10 84:5,16 85:5,13 110:2,10 111:2 112:15,16 112:21 113:4,12 132:17 133:4 136:16 232:9 249:2 252:7 288:10,11 296:19 296:20 297:8,17 298:8,17 300:4,11 300:12,15,17 301:1,8 302:3,5 302:11,14,20 303:3 308:14 309:9 342:20 347:9 361:19
DVD 362:2,3
dynamic 169:21 320:6
D.C 369:11

E

ear 130:12
earlier 167:3 224:2 235:19 236:5 237:4 243:19 244:21 340:17 346:19,19 352:10
early 61:8 197:21 234:11
easier 48:3 79:20 84:8 120:12 157:15 299:22 310:17
easiest 154:7
easily 206:16 369:21 370:13
east 249:7
easy 19:8 79:6 203:5 238:20 266:18
ECHO 260:10
eCTP 174:5,7,9,12 174:21 175:3 187:4,5,7,9
edges 151:19
educated 308:3
education 25:2,5,8 51:11 78:13 325:6
effect 28:9 323:16
effected 260:17
effective 33:8 50:10 62:22 75:22 91:19 186:3 310:11 311:3 315:18,21 319:5,14 338:18 340:8 341:17 342:6 344:7 357:12
effectively 100:8 357:8
effectiveness 54:18 55:10 142:6 162:12 167:20 177:5 220:9 246:9 307:4 338:4,20 348:5 351:17 352:13 366:17
efficient 154:8
effort 42:17 67:17 76:5 79:10 192:1 251:16 253:20 294:20 346:3
efforts 245:16 246:22 248:8 249:19,21 307:20 308:8 313:16 319:1,13 323:16 344:3
effort's 316:22
egregious 279:4,4
EHR 359:7
eight 103:18 132:2 181:13 299:4 309:10,15 310:1 322:22 372:6
either 31:21 90:15 111:13 133:14 157:11 185:13 225:9 289:9 320:11 344:19
elect 232:18
elections 206:12
electronic 173:6 175:21 187:18,21 188:9,11,16 191:10,20,21 192:1 251:21 352:3,14,15 355:3 356:13,16,18 360:17 370:5 371:1,7,17 372:19 374:3
electronically 188:6
elements 118:9
elevated 278:17
eligibility 58:13 59:6,11 61:15,19 71:8 72:1 73:4 74:4,11 118:16

120:3,5 296:16 300:3
eligible 61:5 73:8 73:17 258:8 296:17 299:11,12 299:18
email 7:3 189:6
emails 6:10
embed 206:18
embedded 33:7 64:13 125:2 317:20,21 333:2
embeds 341:8
emotional 314:19
emphasis 193:17 338:8 376:15
emphasize 50:2 226:20 345:2
empirically 338:2
empirically-based 338:14,17 340:12 341:4,6
employee 48:5
employees 177:18
enabled 358:14
enables 125:7
Enabling 351:20
encourage 330:20 334:2
encouraged 175:20 191:9
encouraging 326:7
ended 118:8
endorse 363:5
ends 289:19
engage 146:14 147:15
engaged 37:8 47:21 152:7 171:21
engagement 65:12 134:17
engages 301:10
engaging 165:16
English 353:20
enhance 306:13
enhancement 64:5
enlisted 5:22 9:16 181:5
enlistment 7:6
enrolled 53:4
ensure 23:18 125:4 128:17 131:2 140:22 142:1 161:12 166:2 183:13 185:22 190:6 191:12 210:7
ensures 360:10
ensuring 29:16 65:8
enter 85:1 104:18 107:11 241:14 258:8 285:6
entered 241:20 301:9
entering 106:6 160:22
Enthusiasms 353:2
entire 353:4
entirely 371:1
entities 227:4
entity 91:21 92:6 92:11 347:15
entrance 10:8
entre 306:20
entries 182:20
entry 31:12 115:1 116:13 117:16 119:11 142:19 143:5,7 178:8 192:13
environment 195:8 198:1,2 290:13
EPTS 9:8,11 10:16 10:22 11:8,14 12:4
equal 195:7,9,10,14 285:3
equally 70:20
equip 247:18
equipment 255:6
escape 259:9
especially 23:21 44:3 100:2 129:2 142:20 147:2 204:4 250:5 283:11 284:8 319:9 371:11
essence 31:13 82:4 300:8
essentially 31:14 42:3 80:17 82:18 102:19 103:4,8 139:5 161:20 183:18 210:19 278:9 295:8 309:14 332:9 336:21
establish 180:3 190:6 210:9 239:14
established 51:14 112:2 183:13 191:12 207:15 214:14 268:16
et 80:9 103:11 125:6 163:14 165:11 196:19,19 260:12 275:12 335:9 342:8 358:17,17
etcetera 76:13,13
evaluate 143:10 145:8,18 181:9 212:18,19 214:15 215:11 232:15 247:3 311:13
evaluated 115:10 145:18 256:11
evaluating 266:22
evaluation 114:5 166:19 167:1 181:6,7,10 375:18
evaluations 256:6,9
Evans 1:22 41:8 55:1 64:7 66:5 70:12,18 91:15 93:13 105:4,11,19 106:12,15,20 107:22 126:18 128:2,5,10 130:9 138:21 139:8 142:14 150:1 167:3 171:10 172:12 179:21 180:10 202:7 203:1 227:11 233:7,14 234:2,15 237:12 242:16 249:7,15 263:2 276:16 305:2,12 305:20 306:4,9,14 331:11 337:16 339:20
event 155:17 290:21 291:5
events 96:5
eventually 271:15 360:12 368:15
everybody 21:18 23:2 54:9 67:9 77:6 79:7 80:2 82:3 86:9 88:2 91:1 96:8 99:14 130:13,18 162:22 163:10 175:10 185:5,16 211:22 213:6 221:22 231:15 240:10 242:3 263:17 289:14 290:7 296:5 326:7 327:8 328:4 355:16,20 367:9
everybody's 268:1 377:14
everyone's 116:6 337:20
every-other-year 171:14
evidence 10:12 11:9,10 324:8,14
evidence-based 341:17
evolution 243:14
exact 276:8 339:21
exactly 98:8 107:22 123:10 171:6 180:21 190:16 208:16 228:17 285:18 293:8 322:5 326:14 347:1 359:15
exam 372:10 373:10,12
example 64:12 65:4 70:16 136:7 141:14 154:17 218:4 245:13 339:22
examples 212:10 216:1,2 277:18 372:3
exceeding 53:9
excellence 3:20 348:3 349:20 350:11,17 351:7
Excellent 184:6
exception 99:5 103:4
exchange 170:12
excited 213:2
exclude 102:22
excluded 9:12 73:18 104:7
excuse 45:13
exec 216:17
execute 218:19
execution 290:8
executive 1:25,26 216:11 317:6 331:2
exemplify 6:11
exercises 251:5
exhibit 339:14
exist 84:2 94:9 277:10 311:21
existed 61:4
existence 241:11
existing 203:7
expand 9:15 120:9 125:7 132:8 181:11
expanding 119:18 308:13

expansion 60:10,20 120:15
expect 42:13 48:4 180:13
expectation 352:11
expectations 335:8
expected 37:18
expects 288:11
expensive 309:7,22
experience 18:19 48:16 49:8 62:14 216:6 316:12
experiences 316:13 327:11
experimenting 326:11,19
expert 51:1 267:6 286:5,7
expertise 199:7 202:14 203:21 204:6 214:21 258:14 353:8,10
expertises 215:16
experts 270:3 340:9
expires 303:16
explained 27:3
expletives 176:12
explore 41:21
explored 243:19
exposure 101:11 315:8
expressing 366:11
extend 346:16 373:9
extended 223:15 300:16
extender 183:17
extenders 23:13
extends 262:9 282:6
extensive 27:7 315:1
extensively 357:1
extent 81:1 83:2
extra 135:11,12
extreme 50:15
extremely 63:2 337:7 358:21
eye 50:12
eyes 366:9
e-benefits 358:12 358:13

F

F 1:25
face 319:18 373:14
faced 112:3
facets 270:17
face-to-face 170:9
facilities 39:3 198:13 201:3,7 202:1,8,15 251:11
facility 17:10 38:18 200:12 201:12 202:11,17 257:5 328:16
fact 4:22 57:3 76:4 83:5 100:10 103:22 133:2 135:4 141:22,22 167:3 177:4 183:2 213:5 308:9 343:15
factor 25:3 33:2 179:16
factors 195:12
factual 268:11 299:1
fail 353:3 354:4
failure 311:14
fair 15:7 89:17
fairly 46:21 114:17 115:12 124:17 203:5 205:6 248:15 267:7 307:13 311:9 322:8,14 324:18 330:1 362:6 364:10 369:21
fairness 376:4
faith 320:20 341:1
fall 68:13,19 197:5
falls 54:21 162:10 220:10 307:5 348:7 351:19 373:18
familiar 23:6 26:5 73:14 249:4
families 51:5 64:16 97:14 98:3 101:12 176:4 238:19
family 24:3 63:22 66:1 70:9 78:7,17 93:9,14,15,22 94:1 98:2 112:4 124:12,13,14 127:11 131:15 149:7 165:16 169:4,9,11 171:3 171:8 175:18 176:6 180:18 191:7 192:8 221:12 228:1 240:14 242:5 309:8 310:2 323:3
fan 37:6
fantastic 44:20
far 66:7 92:18 123:6 134:2 142:14 235:11 276:16 302:9 324:12 350:13 352:14 369:14
farm 94:1,2
farther 177:20 232:21 297:4 364:15
fascinating 99:9
fashion 290:8
fast 291:13,13
faster 316:15 335:15 365:13 373:2,2,6
father 287:13
fault 278:2
fax 231:18
February 6:21 140:21 164:8 184:11 212:5,16
fed 139:19
federal 137:16 202:10 229:5 256:17
feed 186:10
feedback 46:19,21 66:12 79:18 171:19 172:9,10 172:13 177:14 183:12,21 188:16 190:6 191:11 192:5 235:2 339:9 344:11
feeds 175:3
feel 21:21 27:20 83:15 88:7 158:12 181:8 256:10 273:21 274:1 281:9,12,20 282:16 283:5 284:4,12 289:20
feeling 30:10 166:6 352:5 377:2
feet 257:19
fee-basis 370:4
Fell 155:8
felt 39:17
fidelity 339:1,14,15 340:16,19 341:12
field 66:20 97:16 202:14 264:20 344:12
fifth 201:17
fight 22:1,1 38:7 336:22 337:2
fighting 13:12
fights 329:11
figure 34:19 98:13 158:7 228:14 311:4
figured 41:5
figures 204:14
filled 179:17 181:18 190:13
filling 72:11 181:20
final 276:19 331:19 369:1
finally 115:4
financial 112:3
find 13:19,21 14:4 50:9 52:8,12,13 57:1 79:14 82:9 92:9 102:22 122:20 128:4 173:3 174:17 176:18 179:9,11 185:6,7 195:21 196:20 200:11 258:22 285:5 291:13 294:7 319:8 323:7 329:10 372:14 373:2
finding 5:6 6:17 7:11,15 13:13 51:2 140:2 253:11 263:21 326:21 357:12
findings 5:8 54:3 118:2 164:17 167:19 216:15
fine 164:22 192:18 252:18 343:20 344:20 347:21 359:13
finish 77:8
finished 17:1 163:5
fire 107:2,2
first 1:14 5:22 16:2 20:21 22:1,5,13 25:11,12,19 35:9 39:12 44:16 63:7 69:10 102:5 111:5 120:1 131:1 162:3 178:21 228:20 231:13,14 236:18 238:2 257:18 261:14,15,20 262:1 264:2 290:19 300:3,7 301:20 302:2,8 303:1 305:10 324:22 343:16 352:4 374:1
fit 6:12,16 7:11

12:19 14:13,16 15:2 88:22
fits 194:2 326:22
fitting 7:6
five 59:16,17 80:16 122:9 141:4 201:16 216:8 227:21 252:4
fix 8:11 13:19 14:3 38:18 62:20 145:13 328:7 341:16
fixed 6:6
fixing 190:1 194:19
fix/address 185:21
flaw 15:8
fledging 213:8 246:7
fleet 93:13,15 94:2
flexibility 339:4
flight 82:7
flip 155:21
FLO 70:15,21
flock 49:1
FLOs 70:9,16
flow 204:16,16
flows 198:9
fly 255:8
focus 38:22 43:7 44:16 66:14 150:21 163:1 171:18 182:4 265:15 284:18 285:7 287:11 288:13 295:18 329:8 338:10 373:11
focused 25:13 151:4 161:18 356:16 363:2
focuses 99:15 367:15
focusing 162:17 287:8 290:5 375:21
folded 374:15
folder 183:2
folks 11:22 12:7,16 16:10 18:15 19:1 19:9 20:13,18 32:17 33:16 36:18 39:7 48:4 54:1 57:21 62:19 68:21 70:9,10 73:19 75:2 76:9,10 79:21 82:5 83:15 86:18 88:15 89:18 90:6 95:8 96:17 96:22 101:14 102:21 110:14 115:17 123:17 128:16 129:12 135:13 136:19 138:13,19 143:2 145:15 158:22 159:15 160:14 251:8,12 265:22 268:19 285:15 288:9 294:20 295:9 308:4,10 309:3 318:11 320:13 322:3 323:3,18 328:14 329:22 354:6 355:18 371:19
follow 8:7 12:14 38:1 41:1 261:21 269:21 272:14 273:6 274:20 275:10 309:20 311:7 340:19 350:13
followed 91:3 131:21 273:3 339:2
following 8:3 10:15 12:6 98:17 114:9 119:9 171:2 194:9 240:7 254:18 272:15 279:22 339:15
follows 95:10 151:16
follow-on 198:20 276:19
follow-up 16:3 87:10 140:6,17 182:20,21 213:20
foot 236:8
footnote 102:13,14
force 1:4,13 3:7,10 3:12,15,18,19,21 6:20,22 11:20 12:9 16:1 22:21 23:22 42:15 63:5 63:8 64:15 69:4 81:22 91:1,2 95:13 124:11 129:5 138:9 142:4 142:9 162:9,20 194:6 203:2,13 232:12 240:17 242:17 247:6,14 248:16,22 276:10 289:19 295:21 305:4 307:16 319:9,19 324:20 329:20 340:14 342:17
forces 1:6 259:5 308:2 346:3 347:1
forcing 251:19
forever 45:2 49:5 269:12,15 281:8
forget 134:16 326:20
form 176:8 178:19 183:7
formal 5:12 6:16 14:10,13,17 15:2
formalized 307:21
format 189:9,11 371:21
formation 284:11
formula 46:10
formulas 266:19
Fort 341:9,9
forth 20:11 24:21 44:5 163:18 189:7 196:16 211:18 213:22 224:21 286:4 294:21 306:12 319:14
Forty-two 110:2
forum 3:3 4:7
forward 8:10 16:8 203:19 237:7 258:17 264:6 330:19 348:15 349:7 350:13 354:9 355:1 358:9
found 4:8,18 5:17 9:11 14:11 15:1 17:2 18:20 44:3 44:15 54:19 91:18 91:19 100:4 128:10 185:15 220:10 259:6 307:5 318:13 348:6 351:18
four 59:16 60:3 78:14 139:11 141:4 227:20 250:12 255:5,14 270:20 370:10
fractures 87:9
frame 81:14 262:20 288:17
frames 247:20
frankly 91:13 127:9,15 141:19 193:8 275:9 279:16 343:9
FRC 69:16 70:4 88:8 92:3 105:6,6 105:16,20,20 221:22 229:1,5 231:4,10,16,17 232:6,7,13,16,20 233:4,5,10,12 234:1,3,11 235:6 235:9,11,18 236:4 236:5,10,13,17 237:17,21 238:22 239:3,10,11 240:11 243:15,18 245:6 263:9,19
FRCs 105:9 228:17 229:2 235:19 236:1
free 280:14
frequency 87:13 88:14
frequently 89:15 131:17
fresh 54:9 376:22 377:7
friends 367:11
front 75:20 86:7 112:6 244:20 280:10 375:9
FRP 229:5
fruit 14:22
frustrated 74:21 178:6
frustration 318:11 350:9
full 15:7 158:13 289:9,9 302:18 321:14 343:2 345:8 362:4 377:7
fully 229:17 305:15 348:21 359:16 370:22
fun 250:15
function 91:17 92:1 92:12 123:11 125:4 126:15 136:22 143:12 149:15 154:22 162:11 171:22 172:1 210:8,12,21 220:11 307:6 347:10
functional 231:1 266:3
functionality 103:17
functioning 17:13 17:20 50:12
functions 64:10 130:7 209:10 285:9 348:8
funding 141:21 246:13 349:3,5

further 6:7 125:7 135:20 213:20 233:22 247:3 263:21 273:7 274:21,22 277:17 369:4,16
future 195:2 202:22 206:10,20 214:14 241:1 328:9 335:18 351:20
futures 51:4 244:20
fuzzy 151:19

G

game 58:19 313:9
gap 66:19 67:4 91:12 92:19 100:2 108:2 128:11,15 139:13 141:3 229:2 231:2 245:20 246:14 255:20 259:8
gaps 89:12 91:19 140:14 212:9 245:12
garrison 126:20 127:2
gatekeeper 239:16
gathering 313:19
gears 300:19
Gen 1:15,19
general 15:16 16:7 29:8 44:19 144:14 153:13 172:16 202:3 266:10 321:9 356:10,18
generally 123:14 159:21
Generals 276:4
generated 297:17
gentleman 173:21
gentlemen 4:6 46:18 52:18 56:12 117:21 121:20 206:7 211:3 212:7 264:17 296:15 304:22
geographic 112:4
getting 13:16 18:8 26:6 33:3 34:10 36:9,10 41:1 42:21 49:12 52:4 52:9 54:2 58:18 64:17 68:6,22 72:6,12,21 74:8 82:18 86:20,22 90:10 95:20 96:8 102:2 106:7 111:11 129:9 143:20 172:15 182:13 188:15 226:15 231:19 234:7 236:14 244:19 255:10,12 255:15 256:22 257:1 266:1 284:7 284:19,19 288:21 308:9 313:15 318:5,6 325:13 327:12 332:9 333:12,14,20 336:7 337:12 342:15 344:15 350:4 363:1 370:2
get-go 236:7
gist 221:21
give 23:6 33:21 40:17 42:17 46:18 54:5 55:6,7 63:19 71:15 104:1 151:16 191:17 215:22 263:15,16 264:7,10 265:17 267:1 300:8 303:3 309:22 310:2 318:2 319:22 342:14 359:5 361:18
given 12:13 57:15 200:20 246:17 250:19 281:14 322:9 342:22
gives 223:16
giving 85:21 216:2 275:5 334:12,17 362:2
glad 16:22 180:6
glasses 365:2
global 316:20
go 8:6 19:7 21:4,20 22:4 23:13 24:5 30:3,4,12 41:15 41:17 52:11 58:8 62:16 69:9 79:20 82:6,13 86:16 89:18 92:20 99:7 101:3,7 105:5 106:17 109:12,19 110:1 111:1 113:21 118:11 125:21 126:19 128:13 129:9 131:15 133:13 135:1 137:10 138:15 141:5 144:7 146:10,11 146:20 156:7 159:20 166:17 175:9 180:13,20 182:11 183:3 192:21 194:14 196:9 197:22 206:16 208:2 214:18 216:14,17 216:18 224:7 234:18 251:19 253:12 254:9,12 260:7 263:16,18 264:6 265:4 269:1 269:4 271:5 273:22 274:2 279:9,19 281:8,10 281:16 282:8 283:12 286:19 290:21 294:12,14 295:10 297:7 300:21 301:16,20 309:10,14 313:18 323:5 324:13 326:8,9 328:15 330:11 333:4 335:1 340:17 344:15,20 345:6 347:16 348:1 349:14 352:18 358:15 360:6 364:1 365:12,21 367:10,18 370:11 372:3 373:4 376:10,21
goal 53:10 92:18 104:13
goals 135:20
goes 33:3 77:1 82:1 93:22 123:6 129:7 134:3 147:8 167:17 172:3 205:17 236:19 258:1 269:15 274:15 277:7 287:8 323:4 327:21 343:19 351:20 370:1
going 8:9,10,11 11:7 12:17 17:16 18:4 19:11,15,16 20:6 21:4,4,7 28:4 28:22 29:6 30:5 33:9,18 34:1,21 37:11 38:9 44:13 45:1 51:17 54:4 55:12,13 56:7 58:10 59:18 60:2 60:3 61:21 63:9 67:5 69:2,8 72:14 75:7 80:18 83:7 83:16 84:13,22 85:16 86:6 87:11 87:16 92:17 95:8 95:17 99:20 101:4 103:19 104:1,3,5 104:5,5 105:5 108:14 110:10 112:5 118:4 120:14 124:15 130:6 132:5,7 133:5 135:8,11 137:8 138:5 140:10,10,11 145:22 146:8,20 147:4,12 148:2 149:14,17 152:6,8 152:9 153:5 154:2 155:9 156:1,11,21 157:5,9,10,13,15 158:20 159:6,9 160:14,15 161:12 162:19 163:22 164:16 165:7 167:11 169:8,15 171:17 177:15 178:1 179:6,7,7 183:19 184:11 185:1,11 186:4,4 187:16,19 189:6 190:8 191:22 197:15,17 199:7 199:20,21 200:5,7 202:19 205:4 206:2,8 208:8 218:8,18 220:4 222:22 225:1 231:1 232:5 234:10 235:3 239:16 240:1 243:21 245:1 246:13 247:3 248:9 249:17 251:1,18 258:22 259:22 260:16 263:2,3 264:11,12 270:21 274:9 277:5 279:9,11 283:12,13,19,20 283:22 284:1,2,15 284:16 287:10 288:4,5 289:5,10 289:21 290:12 294:15,17 296:13 300:10,20,22 304:12 306:12,18 306:22 313:20 314:14 316:10 317:3 318:1,3

319:2 320:6,15 326:3,4 330:2 332:2 333:14 336:1,16,19 338:1 342:5 343:8 344:20 348:17 352:17 355:4,19 357:5 359:15 364:5 365:18 367:1 368:10 369:1,6 371:10 372:9 375:4
good 4:4,14 10:3 16:10,11 24:12 25:7 37:10,17 38:14 42:21 50:12 53:12,22 59:19 70:15 79:18 89:22 108:10,18 117:19 117:22 121:10 123:22 126:16 135:1 140:19 154:17 162:15 182:7,11 184:14 203:22 215:16 217:7 233:13 244:9 245:13 250:15 252:9 257:13 259:12 262:21 267:19 270:2 280:12 286:11 294:10 303:22 311:5 338:1 339:17 347:20 350:2,3,5 352:5 359:19 360:2 363:7 365:5 372:1 377:3,11
goodness 182:19 351:9
Google 324:21
gotten 81:7 158:16 183:8 223:15 265:8,9 283:16
government 326:6
go-around 167:9
go-to 222:6 239:22
grab 347:5
grabbing 32:20
granted 6:2 71:7 286:7
granting 6:16
graphical 359:21
gray 75:13 223:10 286:7
great 10:21 33:15 45:3,12 51:12 249:9 284:2 320:16
greater 51:9 80:19 85:12 202:20 303:6
greatly 33:1
green 1:15,19 4:4 7:14 8:14,21 15:12 16:7 30:2,5 31:2,5,9,11 33:4 34:18 35:4 37:1,5 40:11 41:20 43:17 45:16 46:11,14,17 54:1 58:8 59:12 68:10 69:19 70:1 70:15,19 71:11 75:17 80:5 86:3 87:5 90:22 91:5 92:13 93:15,20 98:11 102:13 103:21 104:11 105:2 106:10,13 106:18,21 107:4 108:12,21 109:21 110:4 111:4,7 113:13 116:7,21 117:14 119:15 120:5,8,20 121:4 124:3 125:19 129:19 130:11 132:3 135:22 137:6 138:21 148:13 151:22 157:22 159:11 160:7 161:4,17 163:22 168:14 172:7,17,21 173:8 173:15 175:5 177:8 178:17,21 179:3,5 183:11 187:15 189:5 190:4,18 198:5 199:15 200:18 201:5 202:12 203:4 204:1,15 205:3,12 209:4,11 209:21 210:14,18 214:12 216:13 217:13 219:10,13 220:16 222:13,18 223:9,19 241:7 243:12 244:14 246:1,15 248:7 249:11,17 253:2 258:13 260:8 262:14 263:11 266:11,17 267:17 267:20 268:5,7 269:16 270:13 271:7,18 272:11 273:16 274:14 276:7,13,21 277:2 278:4 282:18 284:14 286:12,21 288:8 293:11 294:16 295:2,14 297:13 299:21 301:22 303:1,9 305:9,13 306:7 307:10 314:10 317:11 318:17 329:13 331:13 334:4,8 335:20 336:9 341:20 345:10,20 346:1 346:10,14,17 347:7,19 348:12 349:8 350:6,8 351:12 356:10 358:4 365:3 366:19 370:22 374:10,21 375:11 375:16 376:2,4 377:13
Green's 153:13
grievance 310:5
gripe 179:14
ground 15:15,20 245:14 257:19
group 110:8 157:9 161:19 162:5 171:18 208:18 209:13 237:6 244:2,11 257:15 270:14 288:5 306:3,5,11 314:16 327:4,5,6,7 328:15,16,17 329:1,3,4 356:9 364:8
groups 43:7 66:14 182:4 265:15 270:19
Guad 247:16
guard 11:17,21 12:9 108:13,14 109:15 159:19 246:6,12 247:6,18 249:2 258:5,6,20 308:17,19 309:5 319:11 320:11
Guards 11:20
guess 12:5 13:2 15:12 24:10 33:11 37:11,12 50:18 52:11 55:1 80:5 87:21 88:11,17 154:10 159:1 177:19 180:6,16 208:10,14 271:9 309:21 326:8 348:12 356:15 364:2 375:11
guessing 42:8 87:16
guests 251:19
GUI 359:20
guidance 18:9,22 26:16 170:18 223:8
guide 48:6 282:4
guideline 269:18 269:20 270:1 271:2 337:18
guidelines 198:12 312:2 315:4 317:18
guiding 61:9 339:12
guilty 280:14
gun 277:21
gunnery 25:20 26:4
guy 35:19 36:8 185:15 238:21 240:3 269:2,9 292:22 329:6
guys 11:17 15:4 28:12 45:12 47:9 48:9 58:5 62:19 62:20 76:10 125:17 126:4 150:16 185:9 189:22 276:14 291:16 341:2 357:13

H

H 4:8
half 363:20
hall 312:9
hammer 272:2
hamstring 313:20
hand 61:11 234:19 260:3,3 267:1
handbook 197:3,4
handle 274:6
handled 238:12 329:5
handling 44:6 257:20
handoff 230:8 234:13 236:6
hands 78:5 239:5 363:4
hands-on 64:16
hanging 14:22
happen 22:14 82:10 83:13

128:20 230:2 285:12 287:20 289:5 348:19
happened 30:16 80:16 84:18 98:8 241:10 278:11 362:8 372:16
happening 11:22 12:15 15:3 66:20 96:6 102:12 114:11 135:9,17 140:1 277:12 337:6 363:12 364:10 365:5
happens 84:17 89:15 146:22 199:21 240:4 275:21 291:3 335:5 342:16 358:20 368:8
happy 55:7
Harbor 55:15 93:18 142:9,10 162:8 167:11
hard 32:14 151:19 160:13 176:18 179:9,11 212:18 212:18 214:8 235:21 252:14 266:6 289:2 291:15 293:19 295:1 307:14 310:16
harder 19:9 92:22 102:21 158:6 203:7 260:15 279:15
hardest 84:4
hard-to 295:21
harm 273:2 277:17 279:15
harmed 275:11 280:18
harping 240:16
hate 209:4
haven-nots 22:6
have-nots 17:22 24:11
head 150:4 353:21
headed 288:15
headquarters 12:3 258:21
heads 256:7
healed 282:8 283:19
healing 17:17 297:5
health 9:22 13:5 20:17 24:14 33:7 96:17 207:5,9 208:13,20 240:19 262:1 266:9 270:6 307:19 308:14 309:10,15 310:1,8 310:21 311:18,22 317:18 321:6 322:1,13 323:9 327:16 340:4,13 343:17 344:9 352:3,15 355:3 356:13,17 357:22 358:21 359:2 360:10 362:11,19 372:19 374:3
healthcare 224:16 233:3 252:4 270:15 283:17 323:4 335:14,21 335:22 336:2,7 371:9
hear 21:17 57:16 57:21 58:6 140:12 179:12 180:14,19 190:8 192:19 193:6 273:21 276:8 281:9,16 327:7
heard 30:17 45:17 58:21 133:8 174:18 180:22 181:4 188:7 215:19 226:12 265:15,19 280:7,7 281:1 286:18 325:18 353:1 354:2 356:4 359:9 360:20
hearing 15:8 40:16 40:18 41:7,9 42:9 42:15 43:7 77:13 94:13 156:1 321:5 324:15 350:13
heartburn 124:10
heartened 354:17
heat 14:16
heatstroke 14:15
heavily 100:7 152:7
heavy 281:5
heavy-duty 78:4
helicopter 269:9 329:6
help 17:17 35:14 59:13 79:21 87:15 109:9,14 127:14 143:17 150:20 176:13 187:1 190:19 227:21 238:1 251:13 253:20 254:8,13 255:18 257:18 258:22 259:4 295:9 301:21 307:10 310:3 316:8,14 338:9 355:4,10 358:8 367:1
helped 148:15 171:7
helpful 18:14 68:11 355:14
helping 48:5 266:1
helps 69:6 150:21 268:5
heroic 245:16
hesitancy 145:11
hesitant 181:22 260:18 318:8
hey 32:6 44:13 63:4 86:18 101:4 129:6 129:8 146:18,20 190:9 250:14 277:4 290:20 291:4 292:22
Hickey 369:20
high 87:13 88:13 88:14 112:21 311:9 342:19 364:20
higher 12:3 40:5 44:22 89:17 139:19 140:6 157:9 189:18 248:17
highest 89:17 161:13 349:17
highlight 121:6 246:16 320:17
highlighted 318:16 318:20
highlighting 267:10
highly 236:18
high-risk 364:19
high-speed 361:16 371:3
hint 253:9
hints 265:8
HIPAA 169:14,17
HIPAA-protected 169:20
hire 125:14 349:6 349:10,14
hired 216:7 259:19
hires 321:7
hiring 52:2 143:2 259:17 349:3,15
historical 69:3
history 289:17
hit 264:2
HL7 360:3
hoc 207:17
hold 59:2 74:20,21 75:1 223:5 265:5 288:6 299:7 328:10
holding 233:20
Holiday 1:14
holistic 196:17 198:1
hollow 196:13
home 39:11 109:19 248:4 278:9 285:12 323:1 362:17
homework 217:9
hone 41:13
honestly 68:11,15 99:20 261:7 309:12
hope 17:17 18:1 37:19 49:21 311:4 317:8
hopefully 229:20
hoping 19:12 20:1 110:9 374:8
hospital 32:3 37:14 53:4,16 295:8 326:21 339:21 340:3 341:3
hospitals 200:21
host 38:7
hour 55:18 117:19 120:19 121:3 211:4
hours 90:13,14 105:22 106:5 135:12
house 107:2,2 308:2 345:13
houses 23:1
huge 66:3 85:3 98:6 101:8 128:11 157:19 158:7 271:1 278:10 314:10 317:15 338:13 353:2 362:9,22 365:16
hundred 5:10 53:6 142:15 280:14
hundreds 136:5 205:5
hundred-day 53:10
hurried 289:20
hurt 300:15
husband 287:12

hyperbaric 326:16 329:15
hyperbarics 330:4 330:7

I

ID 300:19 303:15
idea 28:16 33:21 37:10 61:4 66:14 108:18 127:12,15 153:13 168:1 203:22 208:3 215:16 226:3 236:4 242:3 312:18 322:21 323:6
ideal 203:12
ideas 168:8 255:6
identification 351:3
identified 80:17 98:20 107:6,7,10 114:2 135:13 151:1 158:10 163:15 212:9 297:18 348:11 350:12
identifiers 211:18 212:15
identify 43:2 85:7 88:15 103:3 165:13 182:5 189:3 318:4 346:18 361:16
identifying 42:12 106:8 235:19
identity 358:8,11
IDES 8:15,17 19:16 19:16 20:2 46:13 52:21,21 53:4,14 104:12,18 107:11 107:14 109:18 114:2 115:1 116:14 117:16 119:11 122:1 123:17 126:8,15 136:3,19 142:18 142:19,21 143:6,7 144:15 145:5 151:1,2,9,12 154:6,13,15,16 155:12,22 156:11 156:15,21,22 157:7,17,20 159:3 159:7,9 160:9,10 160:22 161:10,13 192:12 205:4,6,19 205:20,21,22 209:20 217:13 241:15,21 283:12 284:17 285:7 287:11,15,15,16 287:22 288:2,5,7 288:14,19 355:19 356:1,12 358:1 370:1
IDESes 108:15
idle 285:15
iEHR 366:21 368:15
IG 142:3,4,12 167:4,10,12,17,19 167:21 171:13 172:2,3 176:21 181:8
ignore 83:5
ignores 99:14
IG's 142:1
IHR 359:11
ill 1:5 17:12,15 18:7 19:11 68:18 71:6 80:12,14 81:22 86:12 96:13 100:2 205:9 229:10 230:5
illness 77:15,19,20 87:2,20 98:19 114:20 116:10 119:10 147:11 155:13 195:17
illnesses 101:1
illuminated 8:12 12:18
illuminates 5:13 7:3
imaginary 284:4
imagine 148:2
imaging 353:13
immediate 188:15 288:20,22
immediately 148:6 173:2 372:6,8
Immunizations 363:21
impact 199:4
impetus 186:15
implementation 165:18 212:13 214:16 375:7,17 375:19
implemented 142:10 214:17 348:21
implications 82:9
implied 85:22
important 30:1 129:18 188:14 209:2 217:2 274:13 276:3 284:8,9 311:18 351:6 374:20
impossible 20:7
impressed 47:1 337:14
impression 174:1,8 174:15 226:1 323:14 374:16
impressive 205:7
imprint 314:21
improve 194:8 345:13
improved 30:18 31:1 163:21
improvement 331:8 356:12
improves 95:2,9 323:22
improving 323:20 323:20
inability 163:17 339:8
inaccuracy 299:1
inappropriately 268:15
incapacitated 297:6,7
incentive 332:15,19 333:3,12
incident 107:1,16 107:17 155:2,5,7 155:11,13
incidents 335:18
include 4:8 55:12 55:14 59:19 73:9 99:11 121:5 191:16 345:12
includes 55:21 123:7
including 308:1
inconsistency 144:12
inconsistent 58:14 59:1 61:12
incorporate 167:18 167:19 358:6
incorporated 210:2 253:8
increase 143:1 185:21 357:22
increased 32:19 35:13 204:8 205:1 321:12 356:7
incurring 357:19
indicate 169:2 175:15 191:3 344:1
indicating 79:5
individual 7:9,20 65:13 67:13 79:11 86:18 112:18 113:8 126:7 127:5 127:7,19,22 134:20 138:16 148:9 221:11 222:4 238:7 239:4 291:1 300:17 310:21 327:15 334:18 339:4,8 341:13
individualized 339:1
individuals 112:3 124:1 138:11 154:14,15 161:12 213:17 214:1 272:8 298:16
individual's 291:21
industry 365:6,11
ineffective 100:13
influence 287:19
influenced 286:3
information 45:19 62:21 82:6,12 83:3 101:8,13,19 102:9 111:20 124:8 128:12 134:11 139:19 146:12 153:2 176:3 185:5 188:10 218:2,2 230:12 239:17 305:4 313:19,22 314:8 323:9 331:21 358:15,16 358:17,19 359:5 360:22 362:21 364:9 372:22
informed 63:22 64:1
initial 95:4,7 124:15 173:10 302:3 329:19 330:5
initially 95:5 232:9 234:16
initiated 232:12
initiative 308:2 345:13
inject 83:7
injured 1:6 17:12 17:15 18:7 19:11 48:14 68:18 71:6 80:12,14 82:1 86:12 94:14,20 96:14,20 97:12,12

97:22 100:3 150:14 151:8,10 151:15 205:10 227:19 228:19
injury 63:16 77:16 77:19 87:2,20 95:4 98:19 103:2 106:16,19 114:6 114:20 116:9 119:10 155:3,13 195:17 230:7 273:7,14 274:21 302:21 314:17,19 314:20
Inn 1:14
innocent 280:15
inpatient 87:6 234:17
input 30:20 172:22 174:13,13 175:11 176:4 178:11 190:11,12 248:3
inputs 71:15 183:15 191:14
inputting 174:4
ins 185:9
insert 84:20,21
inside 24:13 137:12
insider 364:9
inspect 142:5
inspecting 167:13
inspection 141:16 141:18 167:7,12
inspections 167:11 167:22
Inspector 172:16
inspectors 176:22
installation 17:2,6 166:6 214:4 226:1
installations 57:12 145:15 179:12
instance 87:7 130:5 132:15 177:21 182:14 258:14
instant 372:21
instituted 66:4
institutionalized 208:6
institutions 198:16
Instruction 56:14 102:4 128:14 130:20 139:17
insurance 127:7 334:16
intake 125:11 146:9 147:5,8
integrate 200:10
integrated 23:21 202:8,17 209:13 215:14 270:6,15
integration 17:18 199:13 363:8,12
intent 38:15 67:11 67:12,16 274:15 274:16 285:4
interacting 94:4 180:17
interaction 18:3 26:1,9,19 27:5 28:1,11 29:3 43:13 44:7 63:21 171:8 187:22 188:3 201:1 316:5 329:3,3
interactive 170:15
interagency 3:22 351:14
interdepartmental 264:21 373:21
interest 376:9
interested 170:13 214:20 347:13 365:12
interesting 13:6 17:3 27:18 28:10 93:4 97:4 99:10 132:13 169:21 244:5 248:8 323:6 328:13,21 342:12 365:4
interface 188:12 359:20,21 375:2
interfacing 62:18
interfere 275:17 285:16
interim 352:9 355:10,11,16 357:2,8
internally 8:1 283:9
international 377:15
internship 209:19
interpret 298:3
interpretation 30:15 298:11
interpretations 55:20
interpreted 64:19
interval 188:17
intervene 278:20 315:12 318:1 346:19
intervention 6:14 8:2 135:3 145:16 153:3 376:1
intolerant 363:16
introductory 55:11
inundating 240:13
invest 162:16
invested 335:16
investigate 9:21
investing 108:5 248:1
investment 250:17
invitational 97:14
invite 251:4
invited 251:19
inviting 251:6
involved 29:9 84:14 105:12,22 132:10 224:5 234:5,17 236:14 240:12,12 243:7 288:22
involvement 83:10 248:4 290:17 291:11
involves 7:8
Iowa 108:17 245:13 253:6 254:13 257:11
IPEB 4:19 5:8
IPO 305:1 365:19 369:12 373:21
issue 5:3 10:5 13:12 13:15 18:15,17,21 24:18 30:18,19 37:4,22 47:10 57:19 58:11 61:4 85:18 109:7 119:4 131:20 145:3 150:17 154:12 158:1 160:17,18 163:16 169:14 194:20 210:5 214:19 221:17 223:20 269:17 276:3 278:13 280:18 282:11 299:6 308:22 331:17 335:11 336:1,13,15 349:3 349:3 369:22
issued 327:13
issues 18:10 20:22 24:14 33:9 34:1 42:7 57:10 58:4,7 59:8,22 69:4 77:20 78:7 94:17 106:9 118:12,14 126:5 163:15 189:3 193:3,7,12 196:15 207:18 219:6 229:19 254:7 266:12 299:15 305:13 316:22 319:17 323:8 333:16,18 335:5 337:3 348:16 371:11
item 163:13 167:7 206:6
items 4:8 117:5 162:18 220:16 283:17 340:6
i.e 36:9 284:16 339:1

J

J 1:22,24 76:1,3 162:13 196:10
Jack 266:11
JAGGER 118:7 120:3,7 122:7,9 122:12 123:1,9
JEC 208:18,21 209:6,13 210:3 237:10 374:5,15
Jess 118:4
job 18:8,22 19:3,8 29:16 38:22 39:4 47:17 50:3,7 62:19 67:1 85:16 92:14 133:6,9,10 133:13,22 137:2 141:1 143:18 177:10 226:5 239:15 251:14 288:12
jobs 50:4 128:1 133:18 134:6
John 2:12 41:8
join 49:2 248:2 377:17
Joining 308:1 346:3 347:1
joint 8:16 9:1 215:15 349:9,13 350:15
jointness 213:12 215:13
Jones 15:18
JTTR 350:15
judge 279:15
judgment 31:16
judicial 280:13
July 305:16
jump 21:10,13 25:9 163:9 241:2
junior 241:17 275:7 286:2
justifiable 266:18

K

K 220:10

Karen 1:23 88:20 234:16
Keane 1:22 90:10 94:13 137:16 145:4 146:3 147:22 162:6,17 173:16,19 174:19 181:11 186:18 187:3,11 192:21 194:4 205:8 211:8 217:6,18 219:8 220:13,19 227:7 229:7 231:8,13,15 232:7,14 233:1 235:16,21 252:10 307:8 317:5 320:20 348:9,10 350:7
keep 5:14 24:3 32:1 32:6 37:8 38:15 46:3 56:5 57:1 58:10 59:7 60:2 69:2 84:15 91:1 97:1 104:8 114:16 121:20 122:18 176:18 231:1,3 271:10 295:4 297:10 306:12 322:13 330:16 331:5
keeping 17:15,16 26:21 37:9 38:13 47:6 114:11 140:4 153:4 230:21 240:6 330:13
kept 35:6
key 25:5 44:10 273:4
kick 301:19 351:22
kicking 290:9
Kinberg 4:25 5:11 8:4
Kinberg's 4:16 9:2 10:20
kind 18:2 22:4 28:11 37:6 39:20 41:13 42:9 43:21 46:6 47:10 52:19 53:8 55:10 56:7,9 57:3 59:13,21 60:9,16 67:17,20 69:6 72:21 76:5 80:22 82:5,8 85:5 88:17 89:7 95:17 95:21 99:14 102:5 110:17 117:20 118:5 133:12 147:22 150:18 156:20 162:2 164:8 170:13 176:14 177:1,16 184:4 185:17 198:20 199:16 200:22 216:4 218:1 219:2 223:20 224:9 226:12,13 229:10 234:9 235:12 240:10 242:9 243:21 247:3 255:9 259:21 260:18 262:4 264:1 284:17 285:2,14 289:8 293:13 305:18 306:12 310:2,9 313:5 316:2 326:12 328:20,22 331:17 332:14 338:9 366:13 376:14
kinds 191:17 216:3 358:15 368:16
knee 296:22
knew 185:7,15
know 8:9 10:20,22 11:13,13 13:18 16:21 19:5,6,22 23:2 24:2 25:6,12 25:21 26:11,20 27:6,7,9,13,20,22 28:3,15 32:17 34:22 35:10,19 36:6,12,18,21 37:4,20 40:22 42:19 44:14,22 45:11 47:8,11,14 48:7,8,11,12 50:6 50:8 51:5 52:22 53:1 57:17 58:3 59:10 61:18,19 62:10,16,19 63:4 63:5,7,10,13,14 63:16 65:16 66:17 66:17,18 67:3,4 68:19,21 69:14 70:22 72:2,10 77:6,12,16,18 78:1,4,4,7 81:7,11 82:14 83:14 84:1 84:6 86:2 87:14 88:5,6,8,12,13,13 90:20 92:20 93:12 94:15 97:3 98:8 99:17,19,20 100:6 100:6,12,19,22 101:2,11 103:10 103:14,17 106:1,4 109:9,16 112:1,9 115:16,20 117:19 124:3,19 125:12 126:13 127:14 128:3,6,7,13,15 129:1,3,6,8,17 132:13,19 134:17 134:21 136:2,8,10 136:22 137:15 138:2,5,9,10,15 140:10,20 142:3 144:6 145:19 146:10,12,16,19 147:4,6 148:16,21 149:20 151:2 152:5,14 153:10 159:4 160:15,16 164:5 166:8,12,19 166:21 167:4,15 168:13 169:18 171:13,13 174:16 175:22 176:11,13 177:6,13 179:11 180:12,14 182:22 183:3,20,22 185:1 185:12,18 186:3,9 188:17,18 190:14 192:8,14 194:1,11 195:12 198:3 199:6,20 200:11 207:6 208:11,16 209:1,1 210:4,6 211:19 212:8 215:9,13 217:10 218:18,19 221:3 221:10,22 222:9 223:6 225:10,15 226:7,13 228:9,16 229:13,22 230:17 237:3,15 238:14 238:21 239:1,2,9 239:16 240:5,9,22 241:1,5 242:5,9 244:18 247:4,17 248:11 250:10,14 250:14,16 251:13 251:18,18 252:4 252:14,16,19 254:10,13 258:13 258:21 260:6,17 260:21 263:20 264:1,2,2,5,6 265:10,12,15,21 266:11,15 268:9 268:10,16 269:3 270:13 271:10,13 271:21 272:8 273:17,22 274:7 274:18,19 275:6 275:13 277:4,8 279:2,3,19 280:11 280:12,16 281:8 281:10,11,20 282:3 283:11,12 283:16 284:6,10 285:9 286:10 287:9,19 288:3,19 289:7 290:1,1,1 290:17,19 293:18 294:14 298:17 301:5,7 302:10 304:19 305:3 308:9 309:2,17,19 309:20 310:20 311:3,11 312:11 313:12 315:17 316:2,17 319:16 320:7,21 321:6 322:5,13 323:3,8 326:1,4,5,22 327:20 328:3,10 328:13,18,19,20 331:20 332:11,22 333:10 334:10 335:10 342:3 344:5,16 347:10 351:3 352:8 353:18,18,22 354:10 355:6 356:4 367:17 368:6 369:6,10,16 369:18 370:3,9 372:15 373:5,18 376:14
knowing 229:17
knowledge 43:14 91:12 299:14 377:14
known 40:4
knows 13:17,17 62:14 68:1 86:9 127:7 180:16 254:6
knuckledraggin 269:9
Kyle 6:15 14:12

L

L 2:12 307:5 317:14
label 78:10 153:12
labeling 71:10
labels 95:5
lack 37:16 72:10 101:8 225:7 327:15
ladies 4:6 46:18

52:17 56:12 117:21 121:19 206:7 211:2 212:7 264:16 296:15 304:21
laid 212:15
Lakes 249:9
land 22:2
Landstuhl 248:19
lane 236:2
lanes 225:17 237:13
language 75:12,18 116:9 130:3 144:19 145:3,14 146:1 147:17 150:4,6 210:22 211:15 223:7 299:17 343:12 347:6,20 353:20 360:4 376:12
languages 360:5,8
large 34:9,20 98:16 203:5 248:12 284:18 364:18 370:10
larger 206:5 345:15
largest 123:17
late 58:19 293:13 313:9 333:21 377:16
lately 324:16,17
Laughter 187:14 223:12 271:17,22 286:14 351:11 373:16
law 9:9 14:10,18 15:1,8
laws 7:10
lawyer 82:17
lawyers 82:14,18
layers 187:5
lead 15:18 24:19 48:22 49:2,3,13 55:2 204:5 225:11 234:20 236:3 243:4
leader 49:8 65:6 69:13,13 70:13 123:14 130:6 174:22 175:1 185:11 236:9 290:20
leaders 18:18 22:20 22:21 25:6 48:15 49:4,12,16 50:10 50:20 51:3 55:22 56:1 124:5,7,9 175:6 185:22 186:1
leadership 22:19 25:18 45:9 48:10 48:19 50:3,4,11 196:17 206:17 210:5 272:9 290:17 291:2,6,18 292:6,16
leading 51:12 342:7
leaning 203:19
learn 188:10 351:5
learned 278:22
learning 185:9 287:12
leave 27:1 46:20 99:11 109:1 153:15 181:17 193:14 255:7 303:13 304:12 317:1 320:15 353:18
leaves 147:2 220:20
leaving 109:19 114:6 304:15
led 227:2 304:2,5,7
leeway 54:4 99:12
left 301:3
leg 155:9
legislation 7:4 14:2 150:5,7,14 153:8 153:16,19,19 156:5,17 157:5 206:16 207:16 208:9 210:4
legislative 150:9,13 208:22 244:11 262:11,15
legislatively 244:12
Lejeune 31:13 37:7 40:13 47:2,19 52:9 175:8 182:14 205:7
length 121:3 134:20 249:12
lesson 278:22
letter 11:3 285:3
letting 251:17 260:7
let's 54:7 80:10 86:5 134:15,16 148:12 162:1 200:13 218:17,18 296:4,21 331:6 340:10 351:9 373:14
level 12:3 23:14 31:16 35:13 40:5 58:18 62:13 69:7 69:15 70:3 72:4,7 72:13 76:20 83:11 137:9 138:2,12 140:4 141:9 145:5 152:17 184:13 189:17,17 197:11 197:13,14,22,22 198:22 236:8 247:20 248:3 250:16,19 259:11 278:14,15,17 279:8 286:1 291:2 291:19 295:16,17 298:16 316:3,4 319:4,12,15 374:2
levels 68:16 71:8 189:18 197:11,20 322:7 341:7 349:17
leverage 42:5 60:8
leveraged 45:14
leveraging 200:20 360:18
liaison 238:10
liberty 294:15
lie 100:20 238:17
Lieutenant 211:7 220:13 307:8
lieutenants 49:2
life 64:17 124:13 133:5,6,11,14,16 232:8 282:4,4,11 284:22 333:22 334:15
lifelong 333:16
light 224:12
light-years 364:15
liked 27:4 110:16
likelihood 112:14 112:16 113:11
liking 188:8,9
LIMDU 36:19 277:20 278:1
limited 281:7 283:1 298:2
line 17:15 18:3 25:18 26:17,22 27:2 32:12 35:16 36:2,12,19 41:6 41:11 42:5,6 43:8 43:12,20 89:1,6 89:13,15,19 90:7 90:11,18 91:2,3 126:8,20 210:5,7 223:9 235:11 256:4 259:22 272:13,13 274:4 275:5 279:21,22 281:18 282:13 284:11 288:10 291:18 293:14 294:19 296:19,20 297:8,16 298:7,17 300:4,11,12,14,17 301:1,8 302:3,5 302:11,14,20 303:3 323:21 328:5 333:3
lines 21:3 196:2 239:3 274:18 275:2 294:11 343:12
link 6:7 41:19 299:13
linkage 359:22
linking 124:7
list 98:21 99:7 211:9
listed 99:4
listen 89:9 200:12 335:6
listening 112:12 352:8
listing 350:19
literally 312:19 362:10
literature 315:1,7
little 17:20 18:2 24:7 27:8 30:3,6 32:9 38:2,3 42:10 44:17 48:3 50:10 50:16 54:4 56:8 62:10 67:1 79:21 120:12,22 132:1 137:10 142:18 144:1 157:13 162:1,3,16 170:14 177:20 179:9 180:11 197:13 198:19 203:6 206:5 211:3 215:12 218:18 228:13 251:2 259:14 260:17,20 274:8 285:2,10,20 286:1 288:14,15 296:14 303:21 306:1 311:20,20 318:8 320:3,18 332:1 352:1 354:17 361:9 367:12 377:16
lives 51:6 134:7
living 78:8
loan 358:16
lobbyist 329:18

local 33:5 82:6 252:2
locally 81:3 93:9
located 47:20 200:12
location 18:16 19:17,20 26:2 38:14 45:5 101:3 185:14 193:20
locations 128:20
location-depende... 292:8
LOD 12:2 301:17
LODs 136:14
logging 164:18
logical 200:17
logistics 261:12
LOINC 360:6
long 10:5 17:13 21:5 24:4 57:18 72:9 115:19 134:20 135:14 137:14 202:21 207:21 238:21 252:19 273:19 282:5 293:7 295:10 298:7 305:8 312:19 363:14
longer 31:15 34:1 198:13,17 211:4 284:15 292:18 298:21 315:15 336:11 337:3 343:8 349:15
longevity 20:5
long-term 83:20 200:20 208:4 335:9 341:16
look 19:12 25:17 28:19 41:16 61:2 61:15 89:21 92:6 92:12 95:12 100:12 102:14 116:5 122:12 125:1 127:1 129:10,21 130:3 132:20 135:7,19 138:14 144:8 147:3 148:7 158:11 167:17 174:21 176:22 183:1 189:4 190:9 196:12 204:17 206:10 217:16 224:13 225:17,19 227:6 240:22 243:10 250:4,4,7 253:6 261:11 262:7,21 264:5 266:14 268:3 270:3 277:15 278:19 291:16 317:13 330:19,21 331:11 356:16 362:7 366:5,8 367:7
looked 13:8 44:17 59:14 62:17 80:21 83:11 129:8 243:3 249:19 250:1 253:3 297:2 313:3 334:12 370:9
looking 34:9 48:18 51:4 59:7 77:14 83:19 91:13 95:16 95:19 96:1 135:15 136:19 138:8,9 154:21 168:16 186:22 187:20,21 188:2,19 190:10 190:11,13 196:9 214:6,7 215:5,8 216:21 221:13 222:20 225:12,13 228:12 234:15 270:14 277:21 287:18 306:15 320:18 355:1 359:17 369:15
looks 167:17 171:13 178:14 328:22
looming 282:11
loop 172:14 183:22 190:6 341:15
loops 183:12 191:11
loosen 290:12
lose 199:7 208:1 283:4 332:13 333:8
loses 332:9
lost 247:10
lot 13:4 36:2 38:9 45:3,21 46:19 57:2,16 64:16 65:3,4 77:7,9 91:11,18 92:4 93:8,18 96:16 98:7,7 99:11,22 101:14 106:22 109:14,15,20 115:21,22 122:2 126:20 133:8 136:5 167:21 169:13 177:4,12 188:6 193:22 201:6 202:20 203:20 208:11 210:16 218:16 221:1,15 224:1,9 227:18 235:1 236:19 239:15 242:18 245:10 248:8,20 254:7 264:13 270:21 275:6 278:21 287:22 293:4 307:17,22 308:3 315:3,5 319:18 320:15,16 322:15 324:15 344:11 350:14 353:8,19 358:18 360:12 365:6 366:21 369:18,20
lots 130:11
Louisiana 329:17
love 21:19 47:13 52:11 200:9 262:5 281:22
loves 21:18
low 14:21
lower 333:9,10 334:9 370:17
Lt 1:15,19
LTCOL 1:22 90:10 137:16 145:4 146:3 147:22 162:17 173:16,19 174:19 181:11 187:11 192:21 194:4 205:8 217:6 217:18 219:8 220:19 227:7 231:13,15 232:7 232:14 233:1 235:16,21 252:10 317:5 320:20 348:10 350:7
luck 241:13
lump 334:12,17 335:13,17
lunch 3:14 219:9 294:13
lying 102:3

M

M 348:6
Mac 254:19 295:7 366:11
MacKenzie 15:21 25:9 35:11 36:15 44:2 62:8 65:15 75:15 76:8 86:15 94:22 97:11 100:4 100:16,18 108:10 111:12,18 116:19 121:15 124:22 127:4 128:3,6,19 131:19 132:20 134:15 137:21 146:7 147:19 148:4 165:1 167:2 170:17 176:16 178:15,19 179:1,4 182:12 184:6 185:3 213:5 221:7 221:19 224:13 226:17 230:1 238:4 247:12 250:9 268:8 276:18,22 277:3 290:3 292:14,18 298:10,14 318:15 318:19 327:21 349:2,18 356:22
Mac's 197:15
Madigan 332:2 362:10
magic 318:14
magnitude 330:15
main 118:12 216:20
maintain 96:5 198:11 199:20,21 202:19 210:8,20 361:22
maintained 86:9 114:5 204:10
maintains 202:13
MAJCOM 278:19
major 15:22 17:9 17:11 54:22 78:6 111:19 132:22 201:22 352:16
making 37:18 40:21 42:12 63:14 94:10 95:19 102:20 114:10 135:1,16 139:15 143:17 149:9 152:20 155:15 170:15 189:22 241:14 243:16 244:10 268:2 269:21 272:5 280:2 282:22 289:1 321:16 339:13 350:10 363:6 371:19
Malebranche 1:23 72:16 73:13 74:12 77:13 87:21 97:3

105:14 108:16 110:11 155:20 156:14 157:18 186:8 201:13,21 202:3,9 203:10 207:3,10 208:10 210:11,16 228:16 236:16 240:15 242:12 251:1 252:12 266:7 270:4,11 305:22 306:10,17 320:21 321:4 331:4 346:20 351:21 355:22 365:22 369:3
malingering 195:18,22
manage 64:8 91:17 151:15 246:22
management 1:4 3:7,10,15 41:16 43:16 44:5,9 45:18,21 46:8,12 46:16 54:15 55:12 55:17,19,21 56:3 56:8,13,19,20 57:3,10,14 58:7 58:12,13,19 59:6 59:15 61:5,16,22 62:6,11 63:2,20 64:13 65:3,5 68:3 69:7,11 70:4 72:5 72:8 76:19,21 78:4 87:19 90:2 92:17 96:1 97:1 97:20 114:12 121:11 142:11 152:17 160:2,2 169:16 196:19 208:5 209:14 211:6 218:6,11 220:5,14 221:6,11 222:17,17 224:18 226:4 245:1,2,8 245:15,21 246:3 246:18 247:9 250:11 253:13,14 253:15 258:3,4,14 259:16,20 260:12 260:19 272:3 297:11 301:3 304:10 358:8,11 367:4,19 368:12
managements 93:19
manager 42:11 44:6 63:8 76:12 79:1,2 86:19 87:6 87:8,11,12,18 173:21 175:2 222:1,2 225:5,8 225:13 227:13 228:21 230:6,7 233:2 237:21 238:10 239:2 242:17,18,20 245:19 261:3 301:6,7
managers 30:11,20 37:20 40:19 41:4 41:10,22 42:4 43:2 58:22 92:3 98:1 224:3 228:22 245:14 251:10 259:18,18 260:3 260:12 265:20 298:16
manages 91:22
managing 239:4
mandate 149:3
mandated 244:13
mandates 260:11
manger 230:8
manning 60:12 98:13
manpower 158:7 350:4
March 235:17 375:19
marine 2:12 15:14 15:19 21:21 22:14 24:2 35:16 38:5 39:10,11,15,22 43:20 48:19 56:1 65:4 90:11,16,17 95:5 137:17 140:20 141:15 142:4 162:8 167:12 183:3,7 184:9 195:16 212:4,20 213:13 232:11 235:2,17 236:5,14 276:10 279:7,10 319:2
marines 19:15 21:6 21:9 22:8 23:14 23:17,22 24:3,13 26:5 27:21 28:3,6 28:14,21,21 29:19 29:22 36:5 38:6 43:8 44:14 45:10 48:6,12,13,14 49:4,9,16 51:4,12 51:16,17 70:2 88:21 89:16 90:10 106:2,4 159:13 204:3 240:11 243:20 276:14 310:16 317:20 337:8 341:7
Marine's 231:9
mark 47:3 53:8
markers 342:10
marketing 184:17 251:3
match 43:21
matched 367:8
material 245:10
math 122:1,6
matter 45:4 54:11 65:12 100:10 130:15 135:4 213:6 219:15 286:5,6 296:7 329:10
max 81:1,6,7
maximizing 284:20
maximum 81:19
Mayer 2:12 16:8,10 16:13,18 21:12,16 25:4 28:17 31:21 35:1,8 39:9 47:15 50:18 52:6,20 88:20
ma'am 21:12 47:17 49:22 50:19 53:20 122:7 193:5 220:20 252:10
McCoy 248:12 250:5 253:19 259:6
McDill 129:4
McDonald 5:17
McDonalds 6:5
McDonald's 9:4
MCKENZIE 1:23
mean 10:20 28:10 29:20 32:4 35:9 39:9,20 40:8 43:4 45:1 48:17 49:1 51:13,19 52:3 62:3 65:16 66:13 72:21 73:19 74:20 75:3 84:7,8,17 86:20 87:3,11 90:3 91:1,5 93:5 99:8,19,22 102:16 103:13 104:12 110:5,13 114:15 115:22 117:19 125:8,13 127:9,10 132:21 134:15,19 136:7,8 137:21 139:5 142:14 144:14,19 147:19 149:21 150:16 152:16 153:18 156:1,6,21 157:19 158:18 159:12 164:4,10 166:21 167:9,10 168:16 169:20 170:17 171:7 172:10 175:7,22 176:18 176:18 177:1,4,11 178:5 179:16 181:1,4,8 182:1,6 182:13,13,19 183:1,16,21,22 189:1,9 191:19 192:2,3 193:21 194:10 198:18 199:11,19 200:16 200:21 201:6,9 203:11,18 204:7 204:12,20 205:5 208:11 210:18 212:20 213:8 214:16,22 216:1 216:16 219:1 224:8 225:1 226:6 226:9,10,12 232:22 235:12 236:19 239:6 240:20,22 242:5 242:13 244:15 249:11 251:14 252:17 253:9 254:11 260:8,21 262:8,16 265:13 269:6 272:17 273:3,15 275:1,20 275:21 276:5,10 276:13,14,14 277:11 279:16,17 280:13 281:9 282:14 285:10,14 288:20 291:15 292:8 293:9,12 307:13 309:16 312:14 314:6 317:13,21 318:10 318:14,17,19 321:11 324:5 325:18 328:6 331:5 334:6 335:18,21 342:3 342:12 343:1 344:5 349:18 355:11,15 360:12 364:12 370:11 372:4
meaning 186:2
meaningful 166:2

169:3 175:16 191:4 197:1
means 58:17 61:20 84:6 143:7 152:3 180:6 231:18 275:19 282:2 284:18 302:2 324:1 342:21 343:7 344:18
measure 366:16
measurements 171:11 331:7
measures 352:13
MEB 53:6 85:1,4 161:3
MEB/PEB 7:9 12:17
mechanism 172:13
mechanisms 339:9
med 44:4,12 59:2 63:9 74:20,21 75:1 89:18 147:12
MEDCOM 278:16
MEDCON 246:3 253:14 258:15 305:14
medical 3:15 19:14 30:11,20 35:2 39:13,16,17,18 40:4 46:15 52:8 55:18 56:3 57:14 62:13,18 63:2,8 63:19 64:3 76:14 78:15 81:4,7,8,11 81:19,20 85:8 92:17 95:1,8 96:1 97:16,22 104:21 107:18 111:14,15 112:10,18 113:1,6 113:10,14,16 114:12 115:6 116:18 119:13 131:4 143:7,9,11 143:14 144:14 203:11 211:5 218:6,11 220:5,13 221:10 222:1,16 224:21,22 225:4,4 225:5,14,21 226:4 226:4 227:12,13 227:15 229:14,19 233:9,15 234:12 235:8 239:7,8,19 242:17,20 243:4 244:22 245:8 246:4 254:21 256:4 257:5 258:3 258:4 260:1 264:19 272:3,12 274:20 275:5,7,20 287:9,17 288:1 291:7,20 294:5 297:11 303:16 304:10 308:21 342:13 344:22 346:17 357:9 358:19
medically 103:9 113:5 116:16 133:11 230:9
medical-wise 86:18
medicated 266:2
medication 265:18 268:13 269:7,10
medications 266:20 267:21 268:20,22
medicine 39:21
medics 82:11 279:5
meds 269:2,5,12
meet 31:19 68:8 73:8 74:4 145:15 156:12 258:7 260:1 287:16
meeting 1:8 3:23 4:15 35:5 49:19 53:12 134:22 138:13,15 140:21 184:11 213:21 244:7 287:15 319:5 342:17 349:9 377:14,19
meetings 29:7
meets 35:20 67:9 83:15 90:15 138:4
member 1:20,21,22 1:22,23,23,24,24 28:6 92:8 119:11 128:17 145:6,8 165:14 176:6 180:16 192:8 256:6 343:8
members 1:6 9:16 42:16 109:16 131:15 165:10,13 165:14 166:8 169:4,9,12 170:21 171:3 203:21 258:6,6 309:8 310:2 361:19
memory 101:15
mental 24:14 33:7 262:1 266:9 270:6 270:15 308:14 309:10,15 310:1 321:6,22
mentioned 65:17 97:11 186:19 229:8 262:22 266:11 286:11 301:6 311:8 321:9 322:20
mentioning 271:4
merit 28:18
messaging 360:3
met 1:13 34:5 59:18 81:18 119:9 135:19 139:22 140:18 165:4 168:10,11,15,22 193:4 194:19 196:6 211:13 212:6 214:8,9 215:4,4 216:14,14 263:4,16 264:11 264:12 283:21 287:1 307:11 348:10,11,13,22 352:2 353:16
methods 341:5,6 363:13
metrics 311:4 317:9 331:6
MGAGCC 3:4
mic 69:18 76:2
Michael 2:11 4:11
migrated 299:5
military 10:14 12:13 17:10 52:14 64:17 82:7,7 134:1 161:14 280:3 290:14 312:1 324:20,21 324:22 325:3,4 342:22 343:2
mind 56:5 57:1 73:15 121:20 122:18 231:3 297:11
minimal 26:3
minimizing 294:6
minimum 240:6
Minneapolis 201:17
minute 88:21
minutes 154:14 173:22
misinterpret 332:18
misjudged 256:10
missed 25:14 61:3 111:11 287:20 294:11,13
misses 293:15
missing 175:12 209:8 292:19
mission 39:1 196:18 249:1 275:15,18 285:11
misunderstanding 37:22
misused 275:7
mitigated 152:15
MOAA 13:8
mobilization 254:17 255:1
mobilizations 255:14
mobilize 255:5
modalities 338:3 338:15
modality 339:11
model 195:5 196:3 243:10,11 246:20 306:1,15 368:22
models 243:1
modular 352:21 353:6,7
moment 55:8
money 13:13,20,22 14:8 108:5 248:1 289:5 366:21
monitor 243:22 344:1
monitored 341:13
monitoring 66:9 344:2
month 5:16 141:4 232:21 236:10,11 293:17 297:20 366:2
months 31:15 33:17,20 34:2 75:5,9 80:4 153:6 155:10 192:13 232:21 236:11 242:2 247:17 250:12 255:5 261:13,17,22 262:2,17 288:4 296:21 297:3,22 298:5,8,22 299:4 300:2,5,8,13 301:19 302:4,8,18 302:18 303:2,16 326:10
morale 17:16
morning 4:6,10,15 12:22 16:10,12 97:18 162:21 325:19 377:7,11
morphed 237:10
mother 287:13
motivation 223:16
motorcycle 87:9
mountain 357:4

move 28:13 54:2 129:2 162:5 168:10 200:14 211:11 232:18 239:22 259:19 291:13,13 296:10 297:5 319:3 349:19 354:9 358:9
moved 200:15 207:8
moves 96:13 301:14
moving 20:18 45:4 53:12 108:8 170:14 207:5 297:3 305:17 323:21 348:15
MRI 353:13
MRMC 348:18
MSC 157:1
MSGT 1:23 25:9 35:11 36:15 44:2 62:8 65:15 75:15 76:8 86:15 94:22 100:4,16,18 108:10 111:12,18 116:19 121:15 124:22 127:4 128:3,6,19 131:19 132:20 134:15 137:21 146:7 147:19 148:4 165:1 167:2 170:17 176:16 178:15,19 179:1,4 182:12 184:6 185:3 213:5 221:7 221:19 224:13 226:17 238:4 247:12 250:9 268:8 276:18,22 277:3 290:3 292:14,18 298:10 298:14 318:15,19 327:21 349:2,18 356:22
MSN 1:23
multiple 75:8 76:13 94:18 128:19 354:3 360:7
M.D 1:19,24
M.S 1:24

N

N 351:18
name 81:11 314:15 326:14 367:5
narrow 44:17 67:22
nation 346:5
national 11:17,20 159:19 203:8 246:12 247:16,18 319:10
nationwide 18:13
nation's 22:1
nature 143:6 264:19 311:11
Naval 53:4 339:21 340:2
Navy 5:3,14 6:12 7:4,10 39:21 44:12,13 55:15 59:2 74:21 75:1 81:21 142:4 167:11 203:10 276:9,14,16 279:6 279:10 337:7
Navy's 93:12 249:5
nay 312:10
NCO 27:8
NCOs 48:18
NDAA 9:17 10:17 13:3,8
near 17:15 103:17 323:1
nearly 35:19
nebulous 102:16 104:9
nebulously 102:20
necessarily 29:13 37:16 41:22 70:21 73:20 83:4 89:22 96:20 100:22 101:21 136:11 202:16 206:11 210:9 268:2 273:13 288:21 317:9 325:11,14 329:9 358:19 366:20
necessary 73:1 131:17 366:15
need 6:6 9:15 20:19 21:1 23:17 29:13 30:6 31:14 33:15 38:17 40:21,22 41:12 42:19 44:13 45:9,20 46:5 50:16 52:19 59:9 60:9 61:15 62:22 63:3 66:8 67:9 72:5,20 73:20 75:13 77:11 78:5 79:1,2,15 82:5 83:16 88:7 90:6 93:1 94:10 96:9 96:22 97:19 103:13 104:6 112:14 113:9,10 115:8 120:11 122:20,21 123:21 126:19 127:12 129:10,20 132:10 134:3,20,22 135:5 135:6,10,13 139:18 143:2,21 145:16 147:12 148:5 158:12,15 163:21 167:5 168:6 174:16 176:13 180:10 187:16 188:18 194:5,6 195:2 198:10,22 199:9 202:18 206:8 208:3 213:4,21 214:3 216:12 217:11 218:14,21 225:3 226:18,20 230:4,6,7,11 231:16 242:22 243:9 248:21 254:1,1 255:20 260:19 261:21 262:13 263:13 265:9 266:8,16 271:15 280:4 284:20 290:21 291:4,5,21 292:22 294:3,3,10 295:5 295:14,20 296:13 297:10 298:21 299:19 302:4 304:18 305:3 306:8 308:6 309:16 310:3 316:18 320:8,17 323:19 324:10,13 329:13 330:16 340:12,22 341:6 347:14 354:19,21 355:15 357:7 358:6 359:7 362:1 364:3,22 369:9 372:21 374:18 375:22 376:14,15 377:2
needed 30:12 37:13 40:5 147:15 148:10,11 184:13 192:19 228:21 280:10,21 319:16 327:17 349:7
needs 39:14 45:5,6 45:6,14 72:3 73:11 79:10 82:3 86:19 96:5,12 117:12 120:10 128:18 131:18 132:4 138:4,13,15 145:9 147:10 153:1,3 177:6 193:16,17 213:19 236:15 238:13 239:4 240:7 256:16 262:19 263:8 287:11 299:17 301:4,7 319:6 320:10 330:22 331:16 341:10,12,14 347:2 354:19 365:21
needy 77:22 80:2 129:14 150:22 151:5
negative 177:13,22 178:3 179:17 180:5,22 186:5 242:6 290:6
neither 370:3
Nellis 201:4,5
nerve 5:18
net 111:11
network 346:9,9,11 370:4
networks 368:10
neurologists 312:5
never 19:9 49:3 103:12 104:4 105:16,17 127:9 127:10 128:20 139:11
new 5:8 7:10 8:15 16:1 22:18 38:10 60:16,21 68:3 119:8 143:18,18 143:18 145:18 206:16,17 207:1 212:19,19 213:9 241:22 245:2 265:17 305:15 311:2 319:10 322:15 326:4 330:21,21 337:16 354:15 368:14,15
news 294:10 325:18 360:2
nice 83:17 172:17 172:22 237:12 271:14,16 355:17 363:15
nicely 347:5

NICO 350:19
Niemyer 41:17
night 196:9 247:13 254:20
NIH 314:8 359:9
Nine 348:10,11
nix 104:5
NMCM 118:15
NMCMs 118:16
nominated 231:16
non 48:20 56:2 57:13 63:1,1,7 95:22 227:11 229:13 258:2
nonclinical 169:16 229:4
nonfit 19:19
nonmission 155:16
non-clinicians 315:19
non-deployability 109:7
Non-DoD 1:16,20
non-medical 3:7,10 18:17,22 54:15 55:11,16,21 56:8 56:12,18,20 57:2 57:10 58:7,12,13 58:18,22 59:5,15 61:5,15,22 62:6 62:11,13 63:20 64:4,10,13 65:3,5 68:2 69:7,10 70:3 70:8 72:5 74:7 76:15,21 78:1 90:2 93:18 97:19 106:8 113:19 121:10 131:4 142:11 208:5 209:14 221:6 222:1 224:19 225:8,11,12,20 227:14 229:18,19 230:10 238:11 239:19 320:12
non-subject 286:6
normal 103:17 133:5,6,6 134:6 143:18
North 201:4,6 202:10 366:12,19 367:5 368:20
note 121:8 321:17 362:14,15
noted 10:7 340:17
notes 22:5 116:5 311:10 362:12,13
notice 20:13
noticed 25:17
noticing 246:21
no-cost 262:8
no-go 13:14
no-show 293:12
number 27:11 33:22 34:9,14,15 34:20,20,21 36:20 46:2 60:7 75:6 85:3 89:18 116:15 119:18 120:16 123:5 128:12 131:15 132:5,8 135:19 137:4 160:8,8 168:16 184:4 190:19 194:2 196:5,5,6 205:14 211:11,12 212:12,13 221:20 222:5 240:6 258:2 263:2 266:8,10 268:19 272:4 303:10 308:13 311:17 312:4 317:15 320:22,22 345:18 347:17 374:4
numbers 34:17 36:18 80:8 161:18 204:3,4,17,18 220:19 246:9 255:17 257:4 321:22 356:7
nurse 46:8 76:12 76:19 86:19 87:5 87:7,18,19 98:1 175:1 225:13 233:2 238:9 239:1 239:6 301:5
nurses 229:3 321:1
nursing 346:18
nut 165:22

O

objections 268:7,9
objectively 135:7
observations 219:7
observed 186:20
obstacle 20:12
obvious 87:1 203:14 335:6 345:11
obviously 76:19 241:6 248:11 276:2 326:1 342:9 352:1
occupational 241:19
occur 89:9 251:18
occurs 140:5,16
October 246:8 348:19
odd 332:1
OEF 265:19
offer 110:11,14 187:1
offered 110:15 145:11 146:2,3,17 149:10,19 364:7
offhand 166:21
office 3:22 206:15 207:1,8,8 208:1 208:11,19 209:14 209:15,16,17,18 209:20,22 300:21 351:14
officer 1:26 4:16,25 5:11 6:14,19 29:14 48:21 272:13 275:5
officers 70:7 181:5 275:7
offices 208:12
official 167:1
offset 13:14 14:4
oftentimes 97:22
oh 150:1 179:13 180:14 181:17 182:19 185:16 354:12
OIF 265:19
OIPT 97:6
okay 4:4 15:12 33:4 34:18 37:1 38:16 46:11 47:14 52:20 53:20 54:1,13 58:9 61:1 68:12 68:18 69:13 70:16 70:19 80:2,20 81:10 83:1,7,18 84:7 85:3 86:4,11 87:14 95:7,15 99:1,15 100:17 102:6 103:5,7 106:21 109:1 115:7 116:4 117:2 117:18 120:20 121:19 128:14 129:7 131:10 136:4 140:13 148:18 149:13 150:16 151:21 161:3,10,16 163:13 164:22 166:16 173:1,13 175:13,14,21 176:10 178:8 183:17 184:9 190:9 191:2 192:2 192:14,15,16 199:22 200:1,5 202:2 204:7,20 207:10 211:2 214:16,19 219:13 224:14,17 231:14 232:2 233:17 234:9 235:20 238:8 256:20 257:1,6,6,13 259:12 262:14 263:16 264:5 265:11 267:2,14 267:17 268:4 271:19 272:21 273:4 278:10 279:15 284:16 289:20 290:6 291:14 294:10 296:3 298:14 299:16,19 303:12 303:17,19 304:16 304:20,21 305:12 306:9 318:22 333:1 343:5 346:2 346:12 348:6 350:8 351:8,10 358:4,5 363:9,20 373:15 375:10 377:3
old 207:2 223:15 368:14
older 373:15
omniavailable 363:3
once 13:10 20:3 28:18 48:10 51:14 57:17 133:11,12 139:10 140:5,16 146:8 185:6,18 187:13 220:3,12 253:19 260:1 269:13 284:14 285:6 287:16 330:3 340:15 355:4 361:16 368:8 371:14 372:2
ones 8:11 49:18,18 59:14 71:9 98:17 98:22 104:3 176:20,21 184:13 217:7,10,19,19 228:20 243:3 252:21
onetime 153:1
one-on-one 11:19
One-seventy 123:1

one-to-ten 50:20
one-year 81:13
ongoing 9:3,3,4 59:20 153:3 211:17 263:19
online 170:4,9 175:4 325:5 358:15
open 90:5 291:12 306:12 352:21 354:5 365:3
opens 323:10
operates 95:22
Operation 209:17
operational 22:21 23:7
operations 216:5 319:3
opinion 28:19 57:20 352:15
opinions 57:21
opportunities 51:11
opportunity 15:19 147:14 195:7,9 199:16 219:5 252:9 285:3 292:3
opposed 38:16,20 280:10 324:3
Ops 319:8
optimistic 360:16 364:4,15,22 365:15
optimize 39:6
optimizing 38:13
option 262:9
options 83:22 143:22 284:2
order 58:17 69:10 86:8 127:14 165:5 214:5 266:2 272:17 301:1 314:4 344:6
ordered 5:3
orders 97:14,14 108:4 109:18 110:6 112:10 115:5 116:18 119:12 158:2,3,5 247:1,16 260:21 261:1 297:13
org 209:5 210:14
organization 29:14 195:18 206:9 210:13
organizational 142:6
organizations 206:9 215:7
organized 372:11
organizing 243:5
original 86:16
originally 270:19
Osborne 257:11
OSCAR 23:5,6,13 32:2 33:6 341:4,5
OSD 66:18 140:5
ought 130:2 198:18 200:5 203:13 334:1
outcome 5:2 145:20,22 166:19 171:10 181:6,10 195:3,4
outcomes 126:3 194:22
outlined 130:19 189:12
outpatient 234:6
outreach 253:20 254:5,14 308:14
outs 185:10
outside 8:2 14:15 126:12 159:8 248:18 370:2
overall 26:7 205:22 269:11
overarching 92:15 124:8 127:6 240:8 242:18 328:7
overcome 10:11 186:5
overinvolvement 157:1
overlap 232:10
overlapped 162:2
overlooking 153:4
overreach 111:10
overriding 39:12
oversee 149:7,8,15 237:2
overseeing 64:22 65:11 177:12 183:17
overseen 261:4
oversees 149:5,6
oversight 56:14 57:4 67:7 72:2,19 72:20 73:9 74:10 78:3,6 94:7 101:18 152:2,3 153:14 156:12 177:6,17,19 180:1 180:3,4,11,12 206:8 208:4,4 237:2
oversimplify 226:7
overutilizing 129:22
overwatch 112:1 239:21
overwhelmed 46:3 256:19
oxygen 326:16
o'clock 161:22 219:12

P

PA 183:17
packages 189:19
page 3:3 71:18 75:22 76:1,3 162:13 196:10 233:3 264:18 272:2 338:11 340:6 343:12 345:19 347:17 373:22
Palms 3:4 15:15,20 17:3 19:21 20:3 20:14 21:18,19 22:7 23:1,4 29:4,5 38:5 39:16,19 40:15 41:10 45:1 47:18 50:15 52:11 52:22 53:5 193:22 197:16 277:18 279:3 292:11 293:3
Palo 201:17
panel 267:6 338:2 340:8
paper 170:12 173:7 173:9 175:21 187:21 188:6,17 191:10 357:11 361:17 370:7,12 370:17 371:20 372:17 373:3,6
paperwork 370:14
parallels 6:18
parentheses 114:21 116:10
Parker 2:11 4:11 4:11,14 7:18 8:19 9:2 10:2 13:7 15:9,10
parsing 150:19 154:22
part 7:19 25:15 44:10 49:15 63:18 75:3 84:4 89:4 98:16 160:13 168:21 169:2 176:17 187:4 212:5 216:11 230:15 240:21 248:13 252:8 260:15 265:20,21 268:17 270:7 273:8 284:19 295:6 316:2 325:3 328:4 343:10 348:1 356:20,21 358:10 359:18 360:13 361:10
partially 168:10,11 168:15 211:13 212:6 214:8 263:3
participating 341:14
particular 25:20 30:9 36:4 63:12 68:19 79:11 178:11 254:10 329:17
particularly 50:3 106:4 118:13 245:6 367:11
parties 192:15 376:8
partners 254:8
parts 242:10 305:18
pass 16:4 362:16,18
passed 162:21 274:11
passes 297:3
passing 276:2
path 79:19
pathway 51:10
patient 103:7 106:1 106:9 190:11,12 234:5 237:22 242:14 262:18 359:5 362:4,16 363:2
patients 205:14 233:9 234:18 266:20 326:20 339:16 344:4 350:21 367:15,16
pay 45:20 65:8 127:2,2,22 279:12 332:6
paycheck 288:10
paying 223:18
payment 334:13,17 335:9,13
payments 336:11
PC 360:15
PDBR 9:5,7,12
peace 115:7 250:15
PEB 5:3,12,13,17 6:15 7:7,11 8:6

11:4 82:17
PEBLO 46:7 53:1 82:13 157:1
peg 204:21 206:7
Pendleton 19:18 40:7 48:2 51:8
people 13:15 19:4 20:11 30:12 31:18 33:22 34:5,10 37:8,9 42:12 43:2 45:19 46:2 47:5 52:3,4,4,13 62:2 67:8 68:12 70:20 72:11 79:22 80:8 81:9 83:2 85:3,7 88:5 91:2 94:18 111:10 113:22 114:2 115:2,19,22 121:22 124:15 125:20 126:5 127:22 130:12 132:6,11 134:4 135:11 136:4 151:1,2 158:1,5 159:3 160:17 166:5,12 169:17 176:8,20 177:19 178:5 182:15 185:18 186:11,16 186:19,20 188:7 197:21 202:15 221:20 222:5 223:22 224:4 227:21 228:4,10 228:11,15 229:18 230:4,16 233:18 235:3 238:17 239:13,20 240:1,6 240:19 242:8 244:20 248:17 249:22 252:20 257:20 258:17 265:6 267:4,5 277:1 280:14 289:7,20 290:9,13 299:14 308:3 311:14 312:5 313:14 314:3,7 316:8,12,14 318:4 318:6 319:11,19 321:3 322:1,2,10 323:1 324:1 329:21 332:6,17 333:8,15 334:22 336:21 337:2,10 341:3 342:15 349:6 351:4 353:9 353:19 355:4 361:21 367:10,12 369:11 370:1,5 373:8,9,12
percent 5:10 6:3 48:12 75:3,10 85:11,15 103:22 110:1,2,9,22 142:15 183:18 241:15 301:15 342:18 343:17 347:9
percentage 184:1
perception 24:18 24:19 26:12 42:19 185:17 186:5 205:20 279:17 343:5,6
perceptions 184:19
perfect 43:21 270:5
perform 118:15
performance 179:17
period 296:18 297:15,18,19,20
periods 337:11
permanent 207:11 207:14,15 333:10 334:2,3
persistent 20:22
person 27:21 52:12 70:11 72:3,13,18 77:22,22 78:6 84:12,16 88:9 90:15 111:22 112:2 113:8 131:16 137:3 146:19 147:10,13 148:7 149:3,5 152:18 177:15 178:13 179:1 185:7 201:15 222:6 225:11,19 226:9,11,19 227:8 228:14 229:22 238:11 239:5,19 274:9
personal 328:18 329:2,4 359:1 362:11,19 372:3 376:16
personalities 206:17
personality 112:17
personally 52:10 328:19
personnel 27:15,18 80:9 82:7,8 97:11 98:3 200:15 204:5 225:7 240:19 305:15
person's 76:17 77:20 282:4
perspective 98:1 132:21 187:19 192:11 224:14 228:13 269:10 309:21
perverse 332:14
Petty 4:16,25 5:11 6:14,19
pharmacological 264:22
pharmacy 264:22 266:9,12 353:12
phase 53:6 239:18
phenomenal 321:21
Phillips 1:24 9:18 12:22 38:1 52:1 77:4 79:4,17 162:6 163:8,13 164:4,13,22 165:7 166:10,14,18 167:8 168:9 171:6 172:6 180:21 188:22 189:14 193:18 196:4 199:10 200:9 211:7,10,22 220:12 221:14 222:8 230:15 276:1,12 280:6 285:22 292:7,17 293:2 294:17 299:2 307:7 311:6 314:1 316:17 348:9
philosophies 328:11
philosophize 208:3
philosophy 233:21
phone 90:15 238:20
phrased 222:10
phrases 150:14
physical 10:8 104:17 133:19,20 286:17 297:2 314:20
physician 241:19 346:4 347:4
physicians 241:17 286:2 356:8 371:18
physician's 300:21 362:15
pick 63:15 103:1 238:20
picking 126:15
picture 231:7 234:4 237:20
picturing 197:7
piece 25:14 43:18 44:4 45:12,13 55:17 62:12 63:17 64:4 100:13 132:4 138:20 157:20 158:6 161:11 162:3 193:4 198:20 233:19,20 251:17 266:10 285:21 289:2 299:4 301:3 303:19 331:19 366:1 369:16,17 370:6 372:17 374:19 375:1
pieces 45:8,9 72:19 78:1 151:11 229:11 242:10 301:13 322:4 362:14
pill 318:14
pilot 200:10 240:22 246:8,11 306:1 321:13
pilots 253:16
place 30:7 32:4 49:12 51:21 65:20 84:21 101:2 104:17 127:21 138:18 139:3 159:20 162:15 165:6 168:4 171:17,20 184:14 188:4,21 197:5 256:12 270:9 290:11 301:13 313:13 335:1 338:8
placement 18:9
places 50:9 52:7 100:7,8,11 170:1 189:2 242:8 252:13,13 301:10 311:17
plan 56:16 57:6 64:9 66:3,6,10,15 67:7,15 85:19,22 91:18 92:4,7 95:18 96:7 100:15 106:8 108:7 114:10 115:16 121:18 125:5,10 127:18 132:13,18 134:22 139:16,20 141:6 143:13,18

144:6,7,9 145:1,2 149:12 152:10 153:1,5,21 157:2 159:10 160:12 161:15 165:18 166:2 168:20 170:11 171:4 190:22 191:1 200:21 223:4,11 224:22 225:4,5,21 229:6 238:22 259:4 268:14,21 269:4,8 344:13 375:18,19
planned 252:17
planning 47:22
plans 92:3,5,10 167:15 189:7 251:21 253:1 368:18,19
plate 235:10
platform 17:11 164:11 352:17
platoon 69:11 185:11 186:1 292:21
platoons 49:2
play 63:17 105:7 121:2,16 138:20 198:22 222:4 234:4 240:5 241:9 252:8 286:16 305:7,10
player 320:2
players 271:3 305:16
please 132:1 292:22 332:18 377:16
pleased 20:9
plug 78:18
plus 60:10 136:3 349:2
PMP 1:25
podium 16:15
point 35:12,21 49:7 50:18 52:19 62:9 63:16 76:15,18 84:21 87:3 104:18 104:21 106:14 107:10,14,15 108:4,11 109:12 110:12 119:1 123:22 126:18,22 135:5 140:19 147:9 173:7,16 174:6 175:12 197:15 217:7 222:15 225:2 228:2 229:15,16 234:20 252:3 260:2 276:6 287:9 287:17 288:2 290:8 296:13 309:6,22 312:15 320:8 333:2 359:7
pointed 155:8
points 7:21 36:16 71:19 143:5 145:8 217:16 219:4 220:18 230:3,11 231:5 258:2 264:18 272:3 338:12 373:18,22
point-type 95:7
POIs 215:10
policies 206:13
policy 24:2 39:10 156:4,7,11,15,21 156:22 157:8,10 157:16 168:4 206:15,19,22 207:4,22 209:13 209:15,15,16,18 209:19,22 210:6,8 210:20 218:8,9,12 262:10
political 271:9
poll 101:3
polytrauma 201:14 201:20,22
poor 111:21
population 32:20 46:13 111:3 122:21 126:10,12 134:10 142:15,17 160:17 204:10 205:22 355:12,18 355:20 358:2
populations 150:22 151:5
pop-ups 324:22
portability 357:22
portion 174:12 187:7 301:15 305:10
Portsmouth 76:9 339:20,21 340:3
pose 77:4
position 6:1 26:14 26:15 96:4 239:22 283:4
positioning 280:21
positions 215:20
positive 90:9 186:14 216:2 242:7 290:5,6 308:7 317:15 321:16 323:16 336:4,17 337:7 345:12 353:17 364:11,13 368:19
possibilities 261:12
possibility 246:18 262:7 366:14
possible 24:4 38:19 39:12 53:19 131:17 275:1 291:5 306:16 312:15 355:2 370:22
possibly 59:19 217:4 253:15
posttraumatic 104:4 299:6 312:8 314:5 328:2 333:19 343:21
post-heart 81:12
potential 83:20 147:2 207:19 208:1 270:1 354:11
potentially 213:11
powerful 349:19
practice 59:2 182:1 191:22 269:18,20 270:1 271:2 312:1 315:4 317:18
practices 121:7 267:3,11 331:12
PRC 70:4
preceding 8:15
preexist 5:7
preexisted 4:20 5:18 11:9
preexisting 4:25 9:20,21 83:6
premature 168:5
premise 17:14
prepare 247:18 250:17
prepared 284:21
preparing 38:6 248:1
preponderance 325:9,13
prerogative 275:13
prescribed 189:12
prescription 267:11
presence 203:6
present 1:18 2:10 85:8 233:3
presentation 313:5
presentations 312:20 313:6
presented 188:10 232:1 240:17 312:18 313:1
presenting 44:21
presiding 1:16
pressure 273:18 281:4 282:21 283:5 284:3,5,12
prestigious 215:20
presumed 10:8,10
presumption 10:6 10:18
pretty 61:10 80:21 102:5 110:22 111:2 153:16 222:11 273:9 281:5 282:10 284:4 313:9 315:10 322:9 347:5 349:19 351:13 357:1
prevent 7:4 337:3
previous 97:6
pre-IDES 8:22
pre-the 9:1
pre-Wounded 82:15
primary 57:5 85:16 131:1 231:18
principles 337:1
printed 371:14
prior 80:15 287:14 287:15,21 288:7
priority 280:8 330:15 354:20
proactive 236:1
probably 14:7 33:8 37:14 59:7 74:13 74:15 77:10 84:12 88:15 103:19 126:19 133:6 136:4,5 160:18 187:16 188:14 202:11 208:9 216:11 245:21 255:20 266:8,13 269:17,17 273:8 279:9 285:19 286:11 292:10 344:8 365:17 367:3 371:5
problem 11:2,16 13:17,18,19 14:2 14:4 41:4 68:21 81:12 82:2 85:2,8 97:2 98:6 99:9 100:21 111:20,21 113:13 119:2 144:19 159:12

161:18 184:2,2,17 190:10,14 230:16 237:21 238:6 253:20,21 254:2 259:10 265:17 272:11 298:19 302:7 315:13 318:14,18 327:9 327:10,12,12,13 328:7 329:2 330:15 332:5,8,10 332:12 343:10 345:15 371:9,13 371:16
problematic 282:19 300:18 309:1
problems 24:19 70:20 169:14 174:2,2 187:17 248:12 267:10 328:17,18 354:11 371:5
procedures 5:5 8:7 10:15
process 7:15,17,19 7:19 9:13,20 12:17 19:20,22 22:13 25:6 41:13 41:16 53:4 55:8 62:12 64:2,6 65:11 67:21 72:14 81:6 86:17 113:21 115:10 116:14 117:16,21 124:16 125:21 126:8,16 129:15,16 152:18 153:4 186:2 231:9 232:13 234:1,8,11 235:19 236:17 237:14 256:12 265:21,22 273:20 274:4 284:6 296:14 305:5,17 311:16 357:3
processes 250:8 253:4
processing 315:8
produce 324:14
producing 195:13
product 195:12
productive 343:8
productively 37:8
professional 226:22 238:14,15 240:2 280:4 316:6
professionally 240:2
professionals 227:5 291:20 327:16 340:14
profile 80:17 81:1 272:12,14,16 273:3,6,10,11 275:4 278:5,7 286:17 288:18 290:18
profiles 272:4,10 274:20
program 3:22 8:15 18:7,13 20:2 24:12 32:3 55:13 55:13,15 58:16 63:6 91:16 95:19 98:12 107:21 115:22 121:9 140:12 141:8,12 142:8,9 168:2 184:16 205:6 231:17 232:16,20 233:4,5,6,10 235:18 246:7 247:6,7 248:13,19 249:5,13,14 260:9 260:10 265:20 307:21 339:9,10 340:21,22 351:14 365:16
programming 352:22 353:7 360:18
programs 3:12 24:21 56:6,9 64:14 67:3 78:17 115:19 120:18 122:18 162:2,5,9 162:10,12,14 193:2 212:19 260:13 309:4 310:20 311:3 323:15 324:13 338:20
program's 209:19
progress 37:15,16 37:18 40:21 42:13 59:20 120:10 169:5 175:17 191:5 243:16 264:13 283:3 320:16,17 322:17 349:1 350:10 355:2 358:7 362:9 362:22 363:7 366:3,5,7 377:17
progresses 5:15
progressing 243:15
progression 362:8
project 353:5 364:18
projects 353:3 354:14 364:20
prolonged 315:8
prominent 315:7
promoted 48:20 283:7
pronged 374:14
pronounce 326:14
proper 13:16
proportion 136:10 205:15,18
proposed 13:3 325:22
pros 334:20
prospective 203:19
proven 314:3
provide 11:8 14:19 26:15 27:22 28:7 55:14 64:9 79:15 102:9 126:20 127:12 171:19 179:22 196:16,18 223:8 260:11 297:8 311:21 327:17
provided 6:7 55:22 127:3,4,6 157:3 172:4,5,8 339:21 348:17
provider 94:8 344:3,9,22 345:7 346:4 363:3 370:4
providers 78:16 311:19,22 321:11 338:13,21 339:19 340:4 341:11 343:18 344:12 345:14 370:14
provider's 363:4
provides 53:18 64:5 82:22 93:18 158:12 291:10
providing 29:8 56:2 124:8 128:12 234:12 239:7 340:7
Psychiatric 314:12
psychiatrist 23:9
psychiatry 34:12 336:21 337:2
psychological 307:19 310:7 314:13 317:18 327:16
psychologist 23:10
psychosocial 77:19 78:7,12,14 79:1
PT 279:19
PTI 103:4
PTS 10:9 33:9,13 99:2 100:22 103:5 261:16 312:14 318:21 319:6 332:7 337:3
PTSD 3:18 4:19 5:8 5:9 7:2 103:16,19 160:18,21 161:12 267:6 296:10 301:15,17 304:3,6 304:8 305:1 307:1 310:19 312:14,22 313:15 314:15 315:4 318:21 320:7,22 321:12 322:2 324:16 325:1,3,6,11,14 325:19 326:1,20 330:14 335:6 337:4 340:1,7,9 341:22 342:6,16 343:7,14
PTS/TBI 308:22
public 3:3 4:7 6:9 343:5
publish 195:8 218:7,13,15 219:2 223:7,10 263:13
published 222:19 223:6 263:17 312:3 314:2
publishing 222:16 245:2
pull 19:4 50:6 59:16 118:1 130:2 189:19 372:5
pulled 134:7 304:10
pulling 184:12 240:18
purple 215:15,15
purpose 196:11
purposed 197:3
purposely 102:19
purposes 196:12
pursuing 247:7
push 19:5 32:18 36:8 50:5 55:6 198:19 338:13
pushed 20:2 107:20 274:2 283:20
pushing 19:7
put 18:1 27:8 47:22 56:5 75:19 79:10 79:22 97:15 108:6 108:13 109:5 110:17 114:20

116:10,16 118:2 121:9 132:11 146:1 156:15 159:21 163:9 167:5 168:3,7 172:22 173:4 178:12 179:6 181:2,12 186:19 187:16 194:6 200:18 209:6,9 210:5 217:2 218:17,21 220:8 223:6,6,6 235:10 237:16 243:21 244:4 245:1 250:6 270:2,9 273:10,18 274:17 278:7 319:14 331:2 335:17 353:17 358:14 361:19 365:1 367:5 374:19
puts 177:22 178:3 277:19
putting 160:3 192:7,9 202:14 241:9 261:8 272:1 286:22 306:11 320:7 370:14 374:3
P-R-O-C-E-E-D-... 4:2
P.K 1:22
p.m 219:14,16 220:2 296:6,8 377:18

Q

QTC 256:8
qualified 81:16
qualifies 67:3 112:11
qualify 58:17 95:14 96:18 111:15
quality 5:3 11:4 52:13 141:3,11,19 184:12 189:17,18 213:22 214:15
quantification 113:6
quantities 21:6
quarter 304:22
question 8:20 9:18 10:3 22:5 26:11 27:19 35:2 38:12 39:2 43:22 47:6 49:11 52:1 60:14 71:12 73:14 74:18 75:16 76:8 80:6 83:8 89:20 91:15 93:4 94:9 96:11 100:18 103:14 108:12 119:16 128:8 132:14 141:2,15 148:16 158:4 165:1 169:7 169:10 172:10 178:7 192:4 237:8 238:3 253:22 269:18 276:1 279:14,22 283:2 300:10 343:22 375:5
questionnaires 356:5
questions 7:13 22:3 25:21 89:8,8 109:15 115:18 310:3
quick 122:1,5 134:21 296:12 329:14
quickly 38:19 118:19 156:9
quit 269:1
quite 11:18 31:12 78:10 100:7,8 127:9,15 141:19 229:10 230:13 254:20 268:15 337:9 343:6 372:19
quote/unquote 222:6

R

race 195:11
raise 279:6 334:9,9
raises 278:14
raising 5:2 7:20
ramble 117:20
ramping 213:7
ran 169:13 238:4
range 9:5
rapidly 355:2
rarely 233:14
rate 311:10
rated 4:23
rates 90:18 293:13 344:3
rating 9:10,11 58:17 334:3,5,7 336:8,10
ratings 5:9
ratio 46:7,8 50:20 53:2,12 122:2 136:1
ratios 45:22 60:12 80:7 88:13 152:14 152:19,20
RCC 50:21 56:14 56:15,20 58:21 64:22 65:10,18 66:7,10,16 67:2,2 67:10,14 68:7,12 69:16,17 70:12 72:3,17 73:8,18 77:6 79:2 82:3,22 83:7,16 84:13,20 85:15,20,22 86:1 86:6 88:2,7 89:2 90:14,14,18 91:3 91:6,16 92:9 93:19 94:7 95:6 95:15 99:16 101:17 103:13 104:1,6,18,22 105:6 106:2,5 107:8,21 108:7 109:13 110:7 111:16,18 112:11 112:14 113:10,17 114:9 115:9,12 118:21 121:16 122:21 123:15 124:15 125:4 127:17 128:12 129:21 130:3,6,7 130:20 137:1,9 138:3,14 139:7,10 139:15 142:8,9,20 143:1,5,12 144:12 145:5,9 146:15,18 146:19 147:6,6,15 147:17 148:17,20 148:21 149:5,6,9 149:11 150:6,15 151:17 152:1,2,3 152:4,7,8,22 153:13,20 156:22 158:11,12,13,15 161:15 165:19,20 168:19,19 170:10 170:11 171:22 172:9,11,12 177:10 178:10 179:16 180:15 183:14 188:1 190:12,21,22 191:13 222:1 227:8,10,11 229:8 229:21 231:5,10 231:13 232:8 233:22 234:14 235:5 236:2,9,13 237:21 243:15 245:7 258:8 263:9 263:20 320:12
RCCs 55:12 56:13 57:2 58:22 65:2 67:6 68:22 79:15 80:7 90:6,11 93:1 96:3 98:14,15 101:20 105:21 118:16 122:2,3,10 122:17 123:2 124:19 125:1,14 128:14 138:1,10 141:1 146:10 149:14 158:8 177:12 179:12 229:13 234:12
RCC's 64:7 83:9 92:14,18 144:2
RCP 65:14 100:16 169:18 170:18 177:22,22 209:15
RCPs 141:4,12
RCT7 23:5,9 24:12 29:10 37:13 40:3 42:2,7
reach 256:17 290:8
reached 328:3
reaching 287:11,21
reach-back 28:9
reacting 190:12
read 13:1 163:11 185:18 220:20 223:10
readily 97:10
readiness 23:8 64:14 70:10 93:10 94:1 124:14 127:11 149:8
reading 181:15 327:14
ready 21:12 54:2 92:20 129:9 218:13 234:7 255:17 344:15 347:15 363:18 364:1
read-in 320:1
real 20:12 24:19 83:8 101:14 124:9 150:17 165:22 178:7 199:18 296:12 334:14 335:11
reality 213:18 300:1 362:19
realize 295:15 316:21
realized 25:13 307:12
really 13:1 20:14

20:19,20 23:1 24:22 26:8 39:4 42:17 45:3,3 52:19 59:8 60:1 61:12 62:2 64:5 65:18 66:8 72:21 81:15 85:14 89:14 93:1 99:8 102:2 103:18 118:19 120:13 125:19,22 126:22 129:20 130:8 132:3 148:21 149:1 159:11 163:17 172:9 184:16 187:20 192:16 198:4 199:12 201:8,22 202:20 211:12 214:17 215:19 216:18 220:7 223:22 226:5,20 227:3,22 228:1 230:22 236:6 238:16 241:16 242:1,7 249:1,18 252:14 254:5 260:18 261:20 262:8 264:14 267:12 269:19 272:22 274:6,9 282:3 284:18 285:7 288:19,22 289:13 299:17 305:5 308:22 310:19 313:21 320:5 323:17 332:12 334:21 350:2,2 354:8,15 355:4 358:6 365:5,15 369:3 371:14
realm 161:21
reason 21:19 86:7 113:17 114:9 186:11 188:2 216:21 275:14 288:13
reasonable 111:9
reasons 30:8 322:19 365:15 376:10
reassuring 360:14 361:13
recall 270:7
recapture 215:3
recapturing 340:1
receipt 231:17
receive 66:17 343:18
received 7:1
receiving 76:11
receptive 186:11
recognize 17:7 23:17 186:21 193:16 237:7 263:12 330:17 338:19
recognized 97:10 347:12
recognizing 21:3
recommend 66:6 68:3 156:14 194:12 195:1 200:10 211:17 217:20 265:10 305:3 324:12
recommendable 213:11
recommendation 3:7,10,12,15,18 3:19,21 14:8 71:4 73:5,7,10 112:8 118:3 150:9 155:22 156:3 157:11,12 163:19 166:1 167:6 189:22 193:15 194:5,10,21 203:2 216:12 218:5 223:7 226:18 243:1,11 252:2 261:8 262:6 268:2 272:12,19 274:17 275:9,22 277:5 282:1 285:6 286:6 286:8,17,19 287:16 297:12 298:20 304:11 307:3,9 313:13,19 316:18 317:10,12 330:13,16 331:1 331:14 339:13,17 344:7 348:4 349:21 351:16 352:1,6 353:16 356:15 357:2,7,15 369:15 374:9,11 374:14
recommendations 54:17 58:2 162:20 203:18 215:3 220:6 257:8 313:21
recommended 267:8
recommending 190:17 271:14
recommends 68:5
record 46:7 49:18 54:11 130:10,15 176:10 184:8 219:15 270:10 271:6 296:7 345:22 352:3,15 355:4 356:2,14,17 356:18 362:3,4,11 362:20 368:14 371:7 372:2,11 374:4
records 9:22 10:3 183:19 340:18 358:1 359:2 367:6 367:13,17,19 369:20 370:3 372:19
recourse 277:8,9 277:13
recov 32:7
recover 228:14 283:2 288:4
recovering 1:5 19:1 71:5 102:15 131:8 131:9,18 166:7 168:20 169:3 170:2,5,19 171:19 174:14 175:16,18 183:15 188:1 191:2,4,6,14 192:9 221:12 224:6 226:3 227:1 228:9 238:18 263:22 265:16 268:12 273:19 274:11 281:6 282:11 355:11,13 358:1
recovery 21:9 50:22 56:16 57:6 62:12 64:2,6,8 66:3,6,10,15 67:15 91:18 92:2 92:5,7 95:18 96:7 100:15 108:7 111:14,15 112:10 121:18 125:5,9,10 127:18 129:15 131:11,12 132:12 132:18 134:22 139:16,20 143:13 144:13,15 145:2 153:21 159:10 165:10,14,15 167:15 169:18 170:10 171:7 176:11 225:5,21 229:5 238:22 239:18 254:2,4 268:14 273:14,20 274:4,22 275:12 279:17,18,20 280:1 285:8 291:7 291:9 294:2 305:5
recruitment 10:1 215:18
RECT 42:3
recur 333:17
recurrence 333:21
recycled 219:2
redefine 67:18
redo 8:6 196:21
reduce 222:5 225:1
reduction 321:19
redundancy 92:5 224:4
redundant 92:10
Reed 193:21 199:21,22 237:15 292:9 293:5
reek 270:11
reemphasize 300:16
reenlist 15:5 109:3
reevaluate 269:4
refer 233:7,9
referral 233:11 237:14 301:11 307:20
referrals 161:11 237:16 256:5
referred 19:19 22:14 35:9,10 161:2 350:22
referring 9:6
reflect 152:20 179:16
reflected 352:12
regard 30:19 348:16 359:10 366:10
regarding 54:3 58:22 120:2 171:10 177:13 187:17 223:21 263:19
regardless 210:12 272:6 347:11
regards 308:8 342:15
regiment 2:13 17:8 22:9 23:2,11 24:6 24:11 26:1,10,13 26:19 28:14 29:4 29:18 30:13 36:3 36:7 48:13 53:17 90:13 142:8 205:1

206:3,5
Regimental 22:11
regional 12:4 307:20 308:13 359:14
regionally 359:16
regions 260:16
register 251:8
registry 350:10,20 351:2
regularly 222:20
regulation 290:12
regulations 142:2
rehab 47:22 48:5 199:13 200:11 201:8,11,15 202:1 202:21 297:1
rehabilitation 108:8 198:17 200:21
rehash 304:18
Rehbein 1:24 88:19 91:9 112:12 143:3 144:1,10,20 215:17 221:1 227:16 257:7,10 257:14,17 286:15 286:22 293:6 330:12 351:21,22 354:12,21 364:14 366:10 373:17 374:12 375:4
reinforce 338:8 340:11
reinforced 23:1
reinforcement 101:11
reinforces 374:4
reintegration 129:15
reiterate 235:16 263:7 274:19
rejigger 296:14
rejiggered 218:1
relapses 347:11
relate 19:10 316:3
related 13:4 38:8 54:18 189:3 220:6 221:17 223:20 280:9,17,20 307:3 348:4
relates 94:15 325:1
relating 351:16 356:2,13 364:7
relationships 203:8
relatively 120:22 189:12 241:17 360:11
release 239:17
released 349:11 375:12
relevance 281:4
relies 58:16
religious 195:11
rely 96:11 227:12
remain 88:22 216:4
remains 32:15
remember 36:22 150:12 158:15 202:12 227:16 267:9 288:8 326:13
remembered 267:5
remind 129:11 231:15 236:2
remission 81:11
remote 18:16 19:20 38:14 39:3 52:7 197:17 198:2
remoteness 52:3,5
removal 337:18
removing 337:10
repeat 17:6
repeatedly 119:4
repetitive 279:1
report 32:7 97:17 107:1,16 155:2,2 155:5,11,14 187:18 223:17 250:6 253:3 267:15 270:2 322:7 366:2 375:5 376:9
reports 107:17,19 155:7 366:5
report's 375:12
representative 82:8 147:7 359:9
represented 27:14
request 88:3,6 105:20 118:22
requested 26:18 136:15 209:10
requesting 292:16
requests 105:16
require 14:8 20:4 76:18 132:6,12,18 133:19 135:2,4 156:11 173:6 195:20 210:3 269:7 319:13
required 7:10 11:5 32:11 38:9 60:11 102:8 116:1,2 146:14 148:17,20 149:12,13 150:5 167:6 210:22 239:9 345:3,3 366:5,6
requirement 48:19 49:20 74:11 122:22 141:17,18 145:7 150:13,17 301:9
requirements 32:13 34:11 74:4 122:5 133:20 139:21 140:18 150:19 212:3 245:3,18
requires 13:13 117:9 170:9 370:5
requiring 87:10 95:6 145:4 146:4
reschedule 274:5 293:1
rescheduled 291:4
rescheduling 293:3 293:4
research 150:3 312:17 313:18 324:19 329:15
reserve 11:17 108:3,13,14 109:16 116:19,22 119:11 123:13 134:3 142:16 145:6 147:4 151:6 151:8,12 154:5 157:4 159:17,19 160:2 245:12,21 249:3,16 258:6,21 302:13 308:16,18 309:5
Reserves 12:5 109:6,9 111:1 114:4,7 133:10 157:19,19 247:9
reservices 228:4
Reservist 115:9
reservists 57:15 115:4 116:17,20 117:16 118:14 132:15,16 133:9 136:6 156:19 157:9 160:7 246:4 246:19,22 253:16 301:16 303:14
resilience 23:16
resistance 79:19 375:1
resolution 57:22
resolve 33:19 334:22
resolved 30:21 31:2 31:3 258:19 278:15 352:17
resonate 78:14,15 78:16
resonates 265:4
resource 59:11 72:4 74:5 128:7,8 129:11 145:16 259:13 319:15 320:8
resources 18:12 20:4,17 26:16 36:7 38:13 39:6 43:9,14 64:21 65:9 67:8 72:13 74:7 78:18,20 89:4,22 95:20 96:2 101:8,13,19 127:5,8,19,20 129:4,13 134:11 134:14,17 143:19 150:18,21 151:13 154:2 213:13,14 213:15 228:5 246:14 247:20 250:12,17 255:4 256:18,18 258:10 258:12 319:4 338:10 357:10
respect 195:19
respects 6:19 196:15
respond 313:6
response 7:1 166:22 181:3,3 212:12,13 226:14
responses 214:10
responsibilities 56:18 130:19,21 144:2 147:18 228:8
responsibility 56:15,16 57:4,5 64:8 66:11 85:21 131:2 139:14 140:3 142:1 168:18 190:21 291:20 296:1
responsible 137:8 148:7 149:9 165:15 168:19 191:1 221:20 275:15 344:2
responsive 183:14 191:13
rest 221:3,17 255:7 374:17
restate 264:15
restoring 54:21 162:10 220:11

307:6 348:7
restriction 85:9
restrictions 349:5
rests 258:15
resulted 5:6 6:15
resulting 5:19
results 5:13 146:15 330:6,19
resume 377:10
resumed 54:12 130:16 219:16 296:8
retain 200:3 289:13
retained 85:13 103:19,22 104:3 111:13 112:9 114:15 119:12 133:4 284:16 320:13
retention 101:15 104:6 215:18
retirement 6:3 61:11
return 84:5 110:2 111:2 112:15,16 113:12 116:13 248:4
returned 85:5 103:16 113:4 115:5,8 116:17 119:12 278:9 303:6 347:9
returning 110:10 133:21,21 134:5,6 161:14 342:20
returns 112:21
revamped 350:1
revamping 168:4 215:10
reverse 156:4
reversed 271:20
reverted 12:4
review 3:7,10,12,15 3:18,19,21 5:3,22 7:15,16,18 8:16 8:17 9:1,8,16 11:4 15:14 50:11,16 54:14 84:10,11,12 85:4 131:16 142:6 183:13,18 184:1 184:13 191:12 220:4 231:20,21 306:22 307:9 340:18 347:18 348:2 351:13
reviewed 10:20 12:19 81:5,14 173:11,12 293:12
reviews 171:4 190:7
revised 184:16 374:5
revising 223:2
revisit 80:3 214:5 216:12 217:5,11 226:16 245:5
revisited 212:8
revolved 227:18
reward 364:20
reword 73:5
rewriting 227:7
re-book 292:10
re-booking 296:1
re-engage 344:3
re-look 226:18
re-looked 88:1
re-voice 354:19
ribbon 280:22 307:21 310:7
Richmond 201:18 203:6
rid 54:8 197:17
ride 292:12
rides 294:21
right 8:3 21:16 23:10 25:4 30:17 35:1 45:17 46:2 48:17,22 49:12,12 49:15,16 52:12,20 53:3 59:9 63:11 66:16 70:18 72:13 86:7 93:20 99:17 100:16 103:6,21 103:21 104:2,11 105:19 110:3,13 111:11 112:5 116:1 117:2,8,14 118:7 122:1,3 123:2 128:2,5 132:9 135:8 137:14 139:10 140:1 141:2 147:10 154:11 165:9 166:10,14 170:17 172:10 173:1 176:7,9,13 176:16 179:3,21 180:9 187:3,13 189:14 196:21 201:3,21 202:4,7 204:22 209:11 210:15 212:7,10 216:16 217:14,19 220:22 223:22 225:18 230:18 234:2 235:14 239:16 241:2 244:3 246:21 257:2,16,16 259:1 266:8,12,16 281:5 291:8,17 295:2 296:3 303:8,17 304:2,5,7,8 306:14,22 314:11 314:16 316:13 325:4 326:14 328:11 331:13 332:4 333:7 335:4 335:11 336:20 337:6,19 345:18 346:12 350:19 355:7 364:17 365:9,18 369:13 369:21 370:15 371:3 372:16 373:20 375:13,16 376:2
rights 15:7
ripe 269:19
risen 76:20
rising 335:15
risk 248:17 357:19
risks 363:7 364:18 365:16
RN 1:23
road 164:16 170:14 232:21 265:5 297:4 306:13
robust 18:8,14 20:2 164:11
role 228:11 234:20 243:18 244:16 246:20 247:15 259:15,20 291:1,6
roles 57:14 222:4 222:12 228:3,7 230:17 235:5,13 243:14,17 244:12 245:5,6 263:4,9 263:19 271:20 319:10
roll 131:22 219:1
rolled 164:8 368:3
RONALD 1:21
room 106:6 235:3 237:22 238:18
rose-colored 365:1
rough 372:15
roughly 104:13
route 237:18
routine 284:9 285:9 295:13 308:21
routinely 253:7
row 147:14
RT 131:7
rules 8:3 171:2
run 56:7 118:5 120:21 142:13 231:4 238:13
running 169:16 233:19
runs 29:9 107:21 209:16,17
RW 165:16

S

Safe 55:15 93:17 142:9,10 162:8 167:11
sailor 195:15
SAMMC 200:2
samples 182:13
San 200:1 201:9,16 203:4,12
Sandy 6:19
satisfaction 191:21
save 373:7
saw 31:9 40:13 60:20 165:3 169:22 177:12 186:12,14 213:10 253:6 319:9 326:12 342:19,19 345:17 349:4 362:10 369:4 376:10
saying 8:2,6 12:13 16:21 35:3 38:16 61:19 72:2 73:7 76:14 79:5,14,16 79:19 80:2 88:20 93:1,2 129:20 137:7 139:6 146:22 147:1 148:5,20 149:11 156:4,10 164:18 172:8 179:13 183:5,6 195:9 206:1 207:11 209:22 210:6 227:14 232:4 243:14 246:19 249:20 260:22 265:16 268:3 272:20 282:20 283:8 292:22 293:22 295:7 312:7,9,9 314:1 314:16,22 324:9 324:10 330:7 332:16,18 333:6 343:19 369:17
says 9:9 15:1 42:10 78:22 99:16

102:15 103:2 116:16 123:14 126:14 130:3 136:1 137:11,12 142:5 144:15 146:19 150:5 165:9 258:5 267:15 277:4 284:6 290:20 338:18
scan 361:17
scanned 362:1
scanners 361:16
scanning 371:8
scheduled 5:11
school 183:4 346:17,18
schools 347:3
science 342:9,13 351:7
scientific 316:9
scientifically 314:2
scratched 162:22
screaming 290:9
screen 130:21 173:3 367:8 373:4
sea 22:2
seamless 29:17
SEAN 1:22
seat 16:9
second 7:3 25:12 25:15 36:18 59:6 80:11 165:8,9 196:10 215:17 235:17 264:4 277:20 278:1
secondary 94:12 354:8 371:16
Secondly 352:20
second-guessing 33:5
secretaries 363:16 369:6 374:2
secretary 369:19 375:6,6
section 4:7 18:18 48:14 50:20 56:1 56:6 68:13 175:1 267:15 290:20
sector 203:11 312:5
secure 231:17 358:3
secured 361:21
security 319:17,20 319:22 357:20 360:17
see 16:2,18 34:4 35:2,7 42:7 55:17 57:20 58:3 59:1 61:18 62:5 65:2 65:19 66:2,12,19 74:20 75:22 79:16 80:4 91:20 94:12 100:1 101:7 104:16 105:14 106:21 112:21 113:1 129:6 131:20 133:1 137:11 140:10 144:1,11,18 145:21 156:20 163:10 166:4,19 167:1,21 173:2,14 176:20,21 181:7 183:19 186:22 190:18 195:3 198:9 200:13,22 213:21 216:5,22 217:11 218:12,16 218:17 223:17 238:4 241:3 244:4 246:19 250:2,7 253:7,9 254:16,21 265:14 269:14 279:7 283:8 289:11 296:4 302:1 303:19 304:1 305:21 306:6 309:19 313:16 315:18 321:21 324:13 326:3,10 328:13 330:2 333:5 345:20 350:3 351:9 357:16 365:10 367:14,20 369:7,10 374:15
seeing 20:22 37:15 50:9 67:7 89:13 145:20 231:1 234:10 252:11 264:6 267:2 325:9 351:4 367:16
seek 309:15 326:8,9
seen 47:11 57:11 58:12 59:10 60:16 74:15 105:16,17 128:20,22 144:11 177:4 216:3 248:11 266:4,6 310:15 370:2
sees 63:7
segue 346:21
select 141:4
selected 354:7
self-identifies 88:16
sell 110:1 111:5
send 40:6 258:17 284:10
sending 269:1 370:16,17
sends 226:11
senior 138:3,14 241:19
sense 14:14 17:21 26:8 49:21 114:13 124:4 202:6 210:17 236:22 237:1 240:18,20 282:1,12,13 333:11 373:13
sensitive 169:17 332:3
sent 370:11,12
sentence 117:15 165:8,9 166:1 171:11 192:20 221:2,16 324:4
separate 96:18 110:2 157:11 181:10 224:15 229:19 235:13 303:15 308:21 347:15
separated 4:26 77:3 103:9 108:22 113:5 114:3 116:16 132:18
separately 152:13
separating 325:2
separation 5:19 17:21 235:5 312:13
separations 7:5
September 375:15
sergeant 15:21,22 25:19,20 26:4 54:22 69:12 97:11 111:19 132:22 185:12 230:1 290:19 292:21
serious 24:5,16 67:4 70:20 77:15 77:21 78:8,9,12 78:14,22 98:19 103:2 105:10 106:16,19 107:17 112:22 114:19 116:9 119:9 151:9 155:10,13,13,17
seriously 94:14,14 94:19,20 96:19,20 97:12,12,21 150:14 151:8,9,14 153:20 155:1,1 227:19 230:5 232:18
serve 124:16 143:13 263:22
service 4:20,22 5:7 5:18 6:2 10:9 11:10,11 12:1 58:14,15 61:8,10 68:15 74:2 83:1 84:5 86:9 94:7 113:2 131:4 137:19 138:6,16 140:4 141:9 142:4 158:17 161:14 166:8 172:1 214:11 232:3,18 232:22 233:19,21 235:8 259:3 274:16 281:14 283:22 307:18 308:20 338:21 340:9 341:18
servicemember 9:19 64:1 80:15 102:9,16 139:22 147:18 170:20 171:20 172:22 173:3,10 176:5 179:8 232:5,8,19 240:14 280:17 291:9 296:17 299:13 301:12 309:10 344:14 345:1
servicemembers 49:9 184:19 193:13 238:7 286:3 299:18 326:7 327:6 340:20 344:12
servicemember's 131:18
servicemember/f... 175:19
servicemember/f... 191:8
servicemen's 334:15
services 3:18 24:8 43:18 55:14,22 61:6,12 64:20 67:18 68:5,5,7 70:9 76:6,12 80:22 81:20 82:21 84:2,9 94:9 115:16 126:21 128:17 132:4,6 137:12,18 138:8 139:14 140:2

141:9 145:7 148:2 149:10,13 150:18 158:9,13,19 164:2 172:12 197:13 198:21 199:3,5 208:2,15 212:2 214:13,20 231:4 233:15 234:11,13 235:6,7 239:13 243:3 246:2 251:12 274:18 278:16 289:6 302:13 307:1,15 308:1,10 310:17 318:5,7 323:19 327:22 338:1 348:15,16 357:13
service's 142:1 341:19
service-connected 12:8,10,12
service-related 249:21 333:18
service-specific 70:8 139:12
serving 350:16
session 162:18 328:15,16 329:1
sessions 327:4
set 53:9,13,20 56:17 104:12 274:1 373:21
sets 254:3
setups 251:21
seven 59:17,17 132:2 136:15,17 246:8 248:14 250:14
seven-day 249:14
severe 77:21 107:2 107:3
SFAC 60:1,1 74:9 93:11 199:1
SFACs 134:13
SGLI 334:15
shaking 353:21
shape 260:19
share 43:13,14 189:7
shared 181:2
sharing 176:3
sheer 255:17 257:4
shifts 288:15
short 19:22 54:5 135:15 322:8,9 336:22 337:11
shorted 14:1
shorten 370:20
shortened 352:11
shortfall 299:15
short-lived 155:8
shot 80:3
show 155:2,4 188:4 295:12 300:22 301:18 331:7 369:11 373:6
showed 329:20 376:11
showing 98:10 188:20 204:2
shown 48:22 326:17
shrapnel 299:5
SI 90:11 97:16 103:13 119:10 161:7
side 19:14 25:8 52:8 106:3 226:22 227:1 229:4 233:9 234:17 242:6 243:4 271:10 280:19 288:9 331:22
sidebar 247:12
sidebarring 221:14
sides 80:1 357:20 367:20 374:6
sight 18:2
sign 173:10
significant 21:6 25:14 27:11 133:16 136:10 200:8 222:22 243:16 268:19 313:4 356:11 358:7 359:5
significantly 30:19 132:8 267:7 273:14 292:2 358:9
sign-on 367:4,18 368:11
similar 118:3 186:18 242:15 254:17,22 256:15 315:15,16 316:13 337:9
simple 14:6 45:16 45:20 86:5 114:17 262:16 307:13
simpler 368:2
simply 7:8,11 46:1 79:7 109:2 152:3 152:9 158:16 188:8 295:19 309:7 367:18 371:6
single 128:4 229:15 231:21 249:6 353:4,9 359:17,20 365:19 367:4,18 368:11
single-limb 86:5
single-point 182:20
singular 196:18
sir 4:14 8:20 25:9 34:16 44:3 46:5 52:18 71:10 75:21 100:4 106:20 107:1 116:5 120:7 130:9 133:2 147:21 184:7 193:5 205:20 217:1,6 223:13 246:6 262:12,22 287:6 302:12 317:6 330:12 345:19 375:14
Sisson 14:12
Sisson's 6:15 9:3
sit 16:13 146:11 148:9 285:20 365:4
site 15:13 30:9 140:8,9 167:13 171:1 176:19 180:20 214:14 248:14 249:6,8,9 249:10 250:5,7 253:4 258:17 329:17
sites 175:9
sits 147:7
sitting 353:21
situation 6:22 20:6 76:20
situations 98:2 112:4
six 29:1 31:15 33:17,20 34:2 59:17,17 75:5,9 80:3 132:2 153:5 155:10 182:15 261:13,17,22 262:2,17 278:3 296:21 297:3,19 297:22 298:5,8,22 300:2,5,8,12 301:18 302:4,8,17 302:18 303:2,16 326:10 345:2,6 372:6
six-month 296:18 297:15 303:19 320:11
six-week 315:14 344:13,18
size 204:2,9 205:2 205:13,16,17 326:22 330:14
sizes 204:21 206:3
SI/VSI 98:21 99:4 99:7 103:1,3 106:19 107:6,8,10 114:18,21 116:11 117:15 160:15 161:21
skill 211:18 212:15
skilled 72:18 213:17 236:19 238:9,10
skills 202:19 342:22
skip 164:13 284:10
sleep 154:16
slightly 101:17 280:1 333:9
slim 133:7
slow 292:3
small 22:20,22 28:20 32:4 34:20 34:21 111:3 174:5 243:6
smaller 289:6 334:2,2 355:12,18 355:19 371:11
smallest 160:8
smart 185:7 354:8
smarter 255:12,15
smartly 53:12
Smith 29:8
smooth 355:7
SOBOTA 1:26
SOC 207:19 209:10 210:2 237:9 373:20 374:14
social 229:3 233:12 329:3
society 54:22 321:20 343:9
SOCOM 1:23 27:10 63:15 112:22 137:22
SOC's 237:10
SOF 27:15
soldier 174:22 181:12 195:15
soldiers 174:3 196:17
sole 66:11 91:17
solely 64:8
solid 267:12 330:7 337:22
solution 14:6 79:6 104:12 176:1

329:10 355:12 357:3,8 369:2
solutions 189:4 263:21 355:10,16
solve 42:14 47:7,11 159:12 161:17 185:2 210:4 211:1 253:21 290:2 326:5 336:14
somebody 37:17 40:20 63:7 83:16 83:20 87:14 88:16 93:2 96:4,9 112:1 124:7,13 135:6,15 152:4 158:16 177:21 178:3 192:11 242:4 254:6,12 269:3 273:7 278:6,8 288:15 293:15 316:1 319:22 353:11,12,13
someplace 99:3
somewhat 61:18 194:2 282:19 289:6 322:15
soon 80:6 105:22 135:19 201:9 291:4
sooner 14:9
sorry 8:19 12:20 14:17 30:3 46:5 46:14 69:13 93:10 94:2 116:21 123:19 131:11 150:16 178:1 271:8 303:22
sort 18:21 20:10 21:2 24:19 39:2 58:5 60:10 61:2 88:14 107:18 156:12 165:19 181:6 186:14 194:20 207:18 228:4 266:5 310:18,21 313:10 324:11 333:5 372:20 374:13
sound 283:1
sounds 7:16 42:1 42:22 72:22 76:17 87:22 137:5 243:13
source 352:21 354:6 365:4
sources 266:5
spares 29:15
speak 24:4 40:15 58:1 196:3 245:3 287:7 296:22 363:12 374:21
speaker 353:1 354:2
Speaking 69:18 76:2 272:1
speaks 90:15
special 18:11 50:16 319:3,8
specialist 37:15
specialty 20:15 32:10 34:11 86:22 294:2
specific 25:21 46:21 68:9 71:15 73:12 114:19 115:12 116:3 128:1 133:19 137:19 155:17 160:21 161:3,5,19 164:1,5 191:16 192:5,6 198:8 311:20,21 343:20 344:6
specifically 9:7 51:1 137:1 244:3 343:14 374:22 376:6
specified 84:6 259:1
speed 57:18 370:19
spend 164:17 224:9
spending 104:15
spent 151:13 221:1 221:15 366:21
spinal 230:7
spinoffs 367:1
split 56:21
spoke 110:15 173:20,22 186:16
Spoken 286:12
spondylitis 4:19
spot 199:12,12
squad 23:14 55:22 65:6 69:13,13 70:13 123:14 124:5,7,9 130:6 174:22 175:6 185:11,22 236:9
stabilized 143:8,12 143:15,20 144:16
stable 192:12
stack 359:13
staff 27:21 28:7 29:14 48:18 150:3 349:9,13,13
staffing 57:13 59:11 118:13 119:16,20,22 230:16,18
staffs 186:1
stand 16:14 207:19 242:9 280:17 312:21
standard 10:7,16 11:14 12:7,14,21 72:12 145:3 249:12 250:8 253:4 337:9
standardization 99:21
standardize 228:6 308:15
standardized 61:6 306:16 317:17
standardizing 61:16
standards 10:18 53:13 59:22 141:7 163:14 194:16,18 196:7 214:14
standing 16:19 213:19 280:10
standpoint 175:14 191:19 200:7
stands 23:7 165:9 291:8
start 16:21 68:17 96:19 105:7 121:13 154:22 162:4,15 163:7 255:2 256:18 261:19 283:13 284:5 300:2,3 302:1 307:8 308:6 328:8
started 29:12 60:6 71:13 91:16 93:8 120:1 242:1 248:16 270:16 274:3 300:7 302:15 321:13 331:18 333:18
starting 106:6 136:9 255:15 261:13 338:12 348:19
startled 276:8
starts 261:10 283:18 286:11 303:20
state 134:12,12 246:12,12 248:11 253:19 254:8,8 255:8,21 258:16 258:18 259:10 298:16
stated 4:20 5:8 11:3 277:11
statement 6:8 8:6 159:17 195:9,14 307:14 308:7
statements 6:10
states 9:7 170:18 171:4 246:8 255:17 256:2,21 258:5
stating 276:15
station 39:11
status 29:8 95:4,9 168:9 218:11
stay 34:3,7 35:16 60:5 81:9 87:7 116:8 236:2 251:9 263:3 330:22 333:15 344:17
staying 30:14 198:2
stays 210:12
steady 366:4
stemmed 315:5
step 131:20,22 179:6 263:18 276:19
stepped 20:14 141:2
steps 79:21 156:22 294:4 330:18,20 330:21 334:19 345:12 352:16
Steve 261:6
STEVEN 1:20,24
Stewart 341:9
sticking 62:2
stigma 321:19
Stone 15:16 44:19
stood 207:19
stop 74:8 129:10 218:13 271:16 289:15 333:12
stopped 129:6 181:14
stops 67:6
store 359:14
stored 362:21
straightforward 351:13
strategy 270:6 359:10 361:10
street 1:15 223:8 264:3
stress 23:8,15 33:2 80:1 93:22 104:4 299:6 312:8 314:5 328:2 333:19 343:21
strictly 113:10

striving 322:14
strong 367:21
strongest 365:17
structure 51:21 209:5 210:14
struggle 14:5 32:14 171:12 285:19
struggled 235:12
struggling 38:20 99:1
studies 372:5
study 329:19 330:2
stuff 44:12 62:13 82:18 86:12 94:3 95:18 128:21 129:1,10 135:16 177:14 183:8 186:20 225:12,14 285:14 293:12,14 316:10,11,14 319:17 325:7 328:1,5 329:4 333:3 350:2
subject 81:4 91:11 286:5
subjective 86:13,14
subjects 286:16
submissions 4:9
submit 81:19
submitted 6:21
submitting 7:9
subsequently 215:11
subspecialties 293:19
subspecialty 295:22
subtle 274:8
success 243:7 245:9 247:5
successes 326:17
successful 63:19 64:2 241:12 339:5
sudden 320:1
suddenly 136:9
suffice 139:2
suggest 121:8 165:12 188:22 193:19 253:2 312:13
suggested 181:6
suggesting 202:13
suggestion 28:20 99:21 116:8 211:14 261:5
suggestions 264:8
suicidal 182:5
Suites 1:14
sum 119:14 334:13 334:17 335:13,17
summarize 118:19 304:9
summary 216:11 216:17 317:7 331:3
summer 29:2
supercedes 286:8
supervisor 127:13 288:20 289:1 292:21
supervisors 294:1 295:20
supervisory 295:17
supervisor's 289:4
support 29:21 44:13,22 45:7 135:20 306:20 309:5 310:22
supporting 45:10
supposed 12:14 39:8 55:2 64:21 65:10 73:22 85:19 106:7 131:14 166:9 171:5 209:18 229:1,8,15 229:16 230:20 282:7 294:12,13 348:18 373:19
sure 29:11 31:1 32:22 33:14 41:9 55:3 57:20 62:21 65:21 78:10 90:20 92:18 94:10 95:20 96:1,8 106:3 111:12 116:6 124:18,20 125:15 127:18 128:15,22 135:1,8,16 137:4 138:3 139:15,18 140:8,15 141:5 155:22 160:16 163:5,8 164:15 177:8 193:14 208:17 220:7,8 221:17 230:13 240:1 243:22 249:15,16 250:13 262:11 265:8,9 276:5 280:2 281:21 291:17 294:21 305:6 306:7,19 312:17 313:8 317:2 350:18 356:3 368:4 369:14 371:15 374:18
surgeon 255:21 276:3 279:7,10
surgeons 276:10
surprised 260:20 310:12,13
survey 172:15
Survivor 162:9
suspect 47:4 154:11
sustained 198:13
Suzanne 1:16,20 30:17 71:13 72:16 268:10 271:18 286:18
swelling 297:6
sword 280:5
symptoms 301:18
system 8:18 40:8 40:12 47:3 49:10 53:13 66:9 69:3 80:21 81:15 82:4 85:1 90:21 92:7 104:13 108:22 109:22 115:1 143:7 160:22 165:6 171:17 188:11 237:17 280:13 284:17 300:19 301:4,10 309:14 310:5,6 333:4 335:14 356:14 366:13 368:9 370:4
systematically 142:5
systems 361:7
S-E-S-S-I-O-N 220:1

T

T 1:23
Tab 4:8 54:19 55:9 76:1,3 196:10 220:10 307:5 348:6 351:18
table 29:13 153:10 245:1 250:4 253:5
tabled 217:8,11,20 218:4,6
tabulating 189:16
tackle 58:4 152:13
tactical 236:8
tail 158:8
take 16:9 18:11 19:12 26:15 31:15 35:15 38:10,22 50:20 54:4,7 57:18 80:11 91:22 92:17 110:13 127:21 129:12 130:13 135:6,7 142:7,12 153:5 157:10,16 169:5 170:5 177:9,20 183:11 196:4 217:15 242:22 243:4 246:13 263:20 273:19 294:3,4,15 296:2 298:17,17 306:4,5 317:11 330:22 334:18 345:5 349:16 350:12 352:6 357:5 361:17 363:8,14 365:10,20 368:12 371:7
takeaway 14:22
taken 34:12 125:18 138:6 140:3 277:22 317:16 330:18 352:16 364:5
takes 71:3 82:4 104:13,20 154:22 156:5 246:13 255:5 272:15
talk 13:10,10 16:22 17:4 22:17 41:17 42:6 52:8 60:21 65:7,8 69:4 80:10 82:6,12,13,17 119:19 120:10,10 120:15,17 126:6 136:6,9 146:8 148:1 152:19 160:21 162:1 163:6 164:20 171:18,18 182:22 193:6 198:9 201:15 210:1,21 214:18 216:18 218:9 247:5 249:18 259:17 266:8 270:3 317:12 319:20 327:8,9,11 331:15 335:7 338:2 347:14,22 354:3 356:1 364:6,8 367:10 369:19
talked 11:19 32:2 60:17 120:13 121:7 126:3 130:18 140:20 152:16 186:19 212:20 218:3 244:15,18 253:14 267:7 305:22

306:19 308:12 322:22 336:17 340:7 341:5,8 349:9,12 360:15 361:9,12
talking 15:14 25:10 27:17 46:19 60:9 86:4 100:14 104:20 133:15 136:3 152:13,19 158:1 159:13 162:4 163:5 166:7 178:16,17 190:17 195:2 201:7 204:8 205:9,12,13 207:12 218:10 221:16 224:2,17 225:16 228:17 229:20 238:22 239:1,2,20 242:13 244:3 253:5 254:5 256:13 264:9 267:5 274:13 278:12 285:13 287:14 292:15,15 314:8 325:19,20 336:10,10 342:5 346:2
talks 82:17 162:14 222:16 264:22 272:4
Tamp 201:17 261:9 261:12 262:10 296:16,18 297:8 297:16,21 298:2 298:18 299:11,18 300:1,6,16 302:16 303:5,20
Tampa 201:9
tap 218:20,21 220:15 226:11 376:10
tapped 90:1
targeted 96:22
task 1:4,13 3:7,10 3:12,15,18,19,21 6:20,22 16:1 42:15 162:20 194:6 203:2,13 247:14 324:20
taught 152:14
TBI 3:18 99:2 104:4 160:19,21 161:11 230:7 296:11 307:1 314:4 325:10 326:15,18 329:16 341:22 342:4 347:15
TBIs 325:13
team 22:11 23:5 62:14 131:11,13 162:11 165:11,14 165:15 175:11 217:9 240:13 254:5,15,21 255:22 256:14,16
teams 23:8 27:12 33:7 254:2,4 317:21
technical 163:16,20 174:2 189:3,21 190:1
technically 81:13 86:6 87:13 149:4 164:2
technician-type 321:2
technique 7:8
techy 367:22
telehealth 322:12
telepsychiatry 322:12
tele-mental 322:12
tell 8:12 47:1 85:1 101:4 149:6 175:10 183:21 187:13 189:21 218:7,13 237:22 294:9,12,14 309:4 310:10 322:1 365:18 376:5
telling 8:5 12:9 210:9 233:17 338:19
temporarily 38:16
temporary 333:7
ten 9:10 54:7 80:16 130:13 182:4 183:18 205:16 289:12 324:17,22
tend 70:16 113:3 271:9 315:14 341:22
tends 367:14
term 78:9 115:19 149:18 198:13,17 207:22 238:22 268:14 336:11 337:3
termination 298:6
terms 30:12 60:11 68:11 71:2,16 80:18 82:1 95:1 98:9 99:12 114:16 148:14 158:8 160:9,11 169:15 225:7 241:20 243:12 244:19 245:4 249:13,21 267:2,10 278:11 278:12 279:11 280:8 285:3 307:11 310:4 317:16 335:5,7,8 337:9 343:6 350:20 358:7 361:10 363:1 364:9 371:2
territories 258:5
test 200:11 354:7 373:5
testimony 332:5
thank 4:14 15:9,10 16:5,6 53:22 57:7 132:1,2 210:19 219:8
Thanks 21:17 54:9 130:13 184:7 219:13 296:5 377:13
theater 255:8 296:20 301:17 302:15 336:18 337:6,15 350:16
theirs 278:2
theme 42:9
theoretically 79:3
theory 359:18
therapies 99:8 315:6,9,14,20 316:16 326:12 342:5 347:13
therapy 297:2 300:5 302:4 326:16 327:4,5,6 327:7
thereof 178:20
they'd 139:6 159:14 164:10
thing 15:13 22:13 27:6,8 30:1 40:2 41:21 48:10 58:5 59:6 83:7 87:22 88:18 89:3 94:12 95:8 99:16 119:21 120:2 121:5 129:14 155:21 176:15 181:18,21 187:15 213:10 218:20 223:20 224:19 235:21 246:16 251:2,3 252:15 253:14,18 263:17 264:15 266:18 270:2 276:11 279:1 282:18 283:18 291:15 307:14 311:1 315:18 327:3 330:10 336:3,16 343:16 345:11 350:14 358:22 360:1 363:15 365:17 367:21
things 10:19 13:6 16:21 21:1 25:16 27:10 33:13 37:7 44:2 45:3 46:22 58:6 59:9,19 60:8 61:3 64:22 65:21 71:1,9 72:11 78:8 80:15 84:14 86:15 86:20,22 93:21 95:10 97:9 98:4 113:20 114:17 115:11,22 117:6 121:11 135:8 138:5 145:12 161:6 179:6 181:2 181:13 183:2 185:21 188:7 191:17 192:9 193:1 197:4 203:14 213:7 216:2 221:19 224:15 237:5 238:12 244:18 248:9,20 255:3 259:9 261:16 264:8 269:6 283:16 285:11,12 285:17 286:10 289:4 292:2,5 307:22 309:2 312:6,21 314:9 315:3,20 317:14 317:15,19,22 318:15,20 319:7 320:5 323:19 324:16,18 328:22 329:4,14 331:15 332:3 333:17 335:2 336:19 337:6,15 338:7 348:14 349:1 359:8 361:8,12,22 365:5 368:2,3,16 373:2 376:6
think 8:5 9:6 14:21 19:9 21:2 28:17 29:12,15 32:14,16 32:22 33:7 34:8 35:22 37:9,21

39:5 40:9,11,13 41:3,18,18,20 42:15,20 44:10,16 44:18 47:3,9 48:1 49:19 50:7,10,16 51:13 53:16 54:14 57:9 58:6,11 59:8 60:6 61:2,14,14 61:17 62:8 63:1 63:20 64:5 66:2,5 66:8,16 67:4 68:10 71:12,16,21 73:3 75:13 76:22 79:2,12 80:12 81:21,22 84:15 85:11,11 87:17 88:10 89:12 90:8 90:9 92:13 94:6 94:16 95:3 97:1,7 97:9 98:5,7 100:21 101:16,20 104:7 105:4,15 106:3 108:1 109:4 109:4,14 110:14 110:21 111:2,9 112:13 113:3,9 117:20 118:10 120:9,16 121:6,9 121:15 124:4 125:8 126:1,16 129:18 134:2,4 137:11 138:7,22 139:2,9,13 142:16 142:19 143:17 145:19,22 146:3,8 146:13 147:3 148:1 150:4 151:22 156:16 157:17,22 158:8 160:10 161:9 163:14,19 165:21 165:22 166:5 168:5,6,13,14,15 168:17 169:5,19 170:1,22 171:15 171:16 172:2,12 174:10,19 175:11 175:12 177:6,11 177:19 178:9 179:19 180:2,10 182:2 185:14 186:4,8,10,15 189:1,10 190:5,8 192:18 194:14,20 195:7,13 196:22 197:4,10 198:7,18 199:2,10,14,15,17 200:16 202:18 203:4,22 204:1 205:3,8 209:2 210:1,11 211:1,11 213:10 216:16 217:7 218:14 220:14 221:8,12 221:21 222:3 223:16 224:10 225:3,17 226:14 226:16,17,20 227:2,18 228:6,12 229:12,14,21 230:12,15,20 231:8 233:18 235:11 239:12 242:14,21 243:9 243:20 245:11,20 247:1,8 248:5 249:7 250:18 251:16 252:9,15 255:19 259:8,13 261:6,7 262:10 263:11 264:10 266:7 267:12,20 267:22 270:19 271:13,20 273:13 274:12,14 275:3,8 275:12 276:11,18 276:19,22 280:6 282:14 283:3,11 285:4 286:15 289:10,11 290:4 290:15 291:18 292:1,7,13 293:20 294:7,18 295:3,14 296:9 297:10 299:19,21 301:22 302:12 303:11 304:18 305:2,7,20 306:3,10,17 308:6 309:12 310:15 311:1 313:3,20 317:11 318:2,9,11 318:16,20 320:4,9 320:17 321:4,8,15 321:20 322:13,17 322:20 323:10,15 323:17,18,19,20 323:21 324:6,6 328:7 329:7,8 330:6,16,17,22 331:4,9,13,17 332:17 333:9 334:1 335:4,19 336:14 337:5 343:15,19,19 344:1 345:10 347:4 348:13,18 349:8,10 351:8 352:12 354:14,18 355:15,17 356:1,3 356:10,10 363:6 364:19,21 365:22 366:2 367:14 368:5 369:22 373:1,22 374:4,18 374:20,22 376:7,9 376:13 377:1

thinking 33:16 38:3 72:17 77:5 82:21 83:21 84:22 88:4,18,20 110:14 119:17 129:19 147:20 156:6 179:7 200:6 201:14 207:21 208:12,17 236:17 270:4 271:5 286:9 299:22 343:13 354:16

third 55:18 151:7

thoroughly 266:22

thought 39:22 40:1 69:19 70:1,2 73:22 78:11 86:17 94:19 121:14 156:17 168:2 174:21 175:4 181:15 187:4,10 209:6 211:14 216:20 229:7 262:4 296:14 310:18 317:5 323:11 349:19

thoughts 28:15 77:14 224:8

thousands 312:20 312:22

three 29:2 48:2 51:7 92:10 114:17 115:11,15 117:5,5 117:9 118:9 136:15,17 139:11 148:22 149:2 158:10 181:18 187:6 207:1 227:20 241:8 255:13 256:2 270:20 278:3 300:5 338:2,14 340:5,8 374:13

threshold 193:9

throw 197:6 247:14 250:10,21 258:3 341:22,22

throwing 198:3

ths 83:12

thumb 357:21 358:2 361:14,20 369:17 370:15,16

ticking 283:13

tie 59:5 73:6 112:13 113:9 114:13 161:5

tied 42:1,4 61:18 74:10 76:16 161:11 297:16 298:7 323:8 334:1 336:7

ties 320:10 360:18

tighten 111:20 290:11

tighter 289:6

time 6:9 8:7 10:6 12:15 16:2,7 17:5 25:15 29:5 44:8 47:14,15 57:15,18 58:5 63:7 81:14 82:13 84:6,11 106:14 108:5 115:7 116:4 118:5 118:15 134:18,21 162:16,16 164:17 170:6 181:17 190:9 193:9 198:6 214:5 215:12 218:19 219:11 221:2,15 224:9 230:4,11 231:6,11 232:9 234:6 236:12 239:8,17 240:4,16 241:10 243:6 247:19 248:1 249:12 250:17 252:16,18 261:13,14 262:19 266:21 267:22 274:1,2 278:22 281:7 283:2 284:3 288:17 289:14 291:11 292:4 297:15,18,19 304:21 306:8 322:8 336:22 337:11 342:13,19 363:14 364:16 367:13 373:8,9

timeline 281:4,11 281:13,18 282:2,3 282:6,9 291:7,10 291:22 322:10 352:11 354:18

timelines 283:21 370:20

timely 290:8

times 119:1 182:9 238:5 287:7 294:3

313:14 329:11
tink 199:9
tired 190:16
title 108:3,6,19 109:13 110:6,19 111:1,13,14 112:10 114:4,5 115:5 116:17 119:12 133:4 134:8 136:16 145:6 151:12,14 158:2,3,5 159:20 159:21 160:3 247:1,16 260:20 261:1 297:13 320:14 352:9
today 4:7 15:17 83:13 84:18 159:13 220:21 244:7 302:9 309:9 342:18 371:1
told 15:5 76:6 109:22 123:9 133:13
tomorrow 356:1 377:7,11
ton 317:22 325:7
tone 28:2
tons 273:18
tool 65:16 96:8,10 96:12 166:2 169:2 169:3 170:19 175:15,16 178:9 180:7,16,18 182:7 183:14 185:8,18 191:3,4,13,20,21 230:20 231:1 360:18
top 148:17 150:3 338:12
topic 25:10 54:15 54:18,21 77:1 220:4,7,10 306:22 307:3,4,5 348:4,5 348:7 351:14,16 351:17,19
topics 54:19 195:6 296:10 376:18
total 53:3 202:10 248:22 307:16 309:4 357:3
totally 240:10 290:16
touch 229:4,15,16 376:16
touched 221:3
tough 32:16 50:3 164:18,19 215:10
tougher 267:4
toughest 132:4
toying 309:3
track 46:4 49:18 126:16 169:4 175:17 191:5 196:8 230:21 333:19
tracked 36:19 65:22
tracking 40:20 67:7 115:19 125:16 162:22 311:4 351:4
train 131:1 137:3,7 247:17 338:21 340:13
trained 23:15 50:21 90:4 123:13 124:21 138:2,11 212:14 215:9 315:11 340:14,16 341:3
trainers 255:6
training 18:8 21:22 23:16 47:17 60:4 60:7,11 66:18,21 119:19 120:9 137:11,12,13,15 137:17,19 139:1,7 139:9,12 140:5,16 143:18 158:17,18 165:2 168:4 185:22 211:17,18 212:3,9,21 213:12 213:15,16,18 214:13,15 215:8 215:14 236:19 245:18 311:18 316:14 317:17 325:5 338:4,13 339:18,22 341:10 343:18 344:15,17 345:14 346:3,18
train-up 247:17 345:4
trans 106:7
transfer 24:16 357:8,11,12,14
transferred 26:6
transient 87:20
transition 1:5 48:7 50:22 51:2,8 61:20 70:7 85:19 85:22 89:14 90:1 126:3,9 131:9 136:20 143:9,17 144:3,5 145:1 149:12 152:10 157:2 160:12 161:15 198:15 199:6 206:15,22 207:4,22 258:9 266:21 267:22 285:8 355:5,6,7 367:2 368:18
transitioned 72:15 75:10
transitioning 51:16 51:17 52:5 124:1 265:1
transparent 29:17 301:11
transport 20:15
transportation 36:10 53:18
transporting 20:11
trauma 107:3 197:11,12 350:16
traumatic 334:15 334:16
travel 32:11 33:2 107:17
traveling 99:22
Travis 201:5
treat 195:19 308:4
treatment 17:10 33:14 99:6 224:22 225:4,21 257:5 268:18,20 269:4,8 269:11,13 282:6 311:15 313:16 324:1,3 325:1 326:8,9,17 327:1 327:17 329:22 333:12 335:18 338:3,14,22 339:1 339:11 341:12 344:13,18,21 345:3,9
treatments 267:8 313:7 337:22 338:18,22 339:15 340:12,15,19 341:17,18
tremendous 322:17
trend 206:10 268:12
TRICARE 259:19 259:20 260:3,5,11 261:2 298:15,18 300:21 301:5,6,10 346:9 370:3
TRICARE's 259:15
tricky 43:17
tried 67:18 164:2 164:20 234:22
trigger 78:20 107:14 108:4,7 143:4
triggering 107:19
triggers 68:8 83:9
trip 25:11,12 68:8 108:17
troops 38:14
trouble 101:14 227:22 228:2 321:8,9,10
troubled 286:1
troubles 258:16
truckloads 357:11
true 81:21 111:4,7 286:12 299:7 302:11 342:16 343:9 350:19
truly 28:3 38:13 41:18 92:2 238:2 368:20
truncated 344:19
try 37:8 38:15,21 71:19 79:21 103:4 115:13 153:8 183:12 226:8 237:14 244:3 250:4 258:22 259:19 293:22 294:5 295:7 303:2 306:15 307:20 308:2 310:4 318:1 337:3 351:6
trying 24:10 33:12 34:19 36:22 37:2 37:6 46:3,20 62:20 82:20 87:14 97:8 98:13 102:22 109:4 113:5 120:8 125:22 126:9 145:13 150:20 153:7 154:8 158:6 168:7 176:1,2 177:20 180:2 195:6 196:20 221:8 222:3 224:9 226:19 228:14 235:22 239:14 243:13 251:5 252:14 255:18 282:20 288:18 289:13 290:7,10 292:3,4 293:10 300:11 301:20 307:22 308:14 309:13 314:13 329:9,20 334:8 336:13 345:1 353:4 364:2

365:10
TSGLI 334:16
turn 232:5 256:9 259:6,11 348:8 372:16 375:5
turned 105:17,17 148:6 344:19
turning 260:2
Twentynine 3:4 15:15,20 17:3 19:21 20:3,14 21:18,19 22:6,22 23:4 29:4,5 38:5 39:16,19 40:15 41:10 45:1 47:18 50:15 52:10,22 53:5 193:22 197:16 277:18 279:3 292:11 293:3
twice 15:21 30:7 218:10 223:14
two 5:9 6:11 45:8,8 59:9,16,21 69:21 97:7 99:22 118:12 129:9 151:18 163:15 187:5,5 194:10 201:2 223:14 224:15 225:15,16 226:9 226:21 227:4,5,9 229:18,20 232:21 244:12 255:13 261:15 264:2 265:2 266:5 293:8 294:11 305:18 310:9 345:19 352:16 357:13 363:17,22 371:5 374:1,13 375:21
two-day 249:13
two-edge 280:5
two-say 248:19
tying 61:17 155:12
type 23:16 171:16 180:3 186:13 247:8 264:15 314:17 336:3 341:10 350:19
types 34:16 64:22 68:7 195:6 308:13 341:6,11
typically 80:20 81:3 308:18 361:18
tyranny 47:5 51:14

U

ubiquitous 190:2
ultimately 159:16 348:18 358:20
unable 340:20
unclear 62:1
uncomfortable 146:6
uncommon 91:6,8
underestimate 33:1
underevaluated 256:11
underlying 28:2
underneath 116:12
undersecretary 322:9
understand 17:14 38:2 47:10 65:19 73:16 90:20 92:22 113:18 154:4 186:1 198:6 217:1 217:4 222:9 227:3 228:11 236:16 263:17 269:8 271:11 273:16 282:20 286:2 293:6 295:20 303:20 313:17 316:20 326:18 334:5 336:12,12 364:3
understanding 20:10 24:22 28:4 101:17 227:22 228:2 251:8 316:7
understands 254:6
understood 273:8 357:4
undertaking 98:6
underwent 5:21
undo 122:19
undoable 91:8
unfit 4:18 9:11 14:11
unfitting 5:9
unfortunately 86:11 275:6 290:4
unhappy 176:6,7
uniform 137:13 293:7
unit 12:3 18:3 26:22 27:2 30:15 31:18 32:12 34:3 34:7 35:6,17 36:2 36:12 37:9 38:6 43:20 48:7 51:7 61:20 70:7 89:6 89:15 90:3,7,11 90:18 91:3 126:8 136:21 137:4 162:12 167:13 193:12 204:21 258:9 274:4 280:3 282:13 284:11 285:9 291:18 316:2 328:5 341:7 344:15,17
unites 199:6
units 3:12 17:16 21:7 24:1 26:17 29:4 32:5,6 33:22 36:19 38:10,15 47:6 56:6,9 89:1 89:13,19 91:2 120:18 122:18 162:1,4,10,13 193:2 198:15 282:7 294:5 308:16 310:17,20 317:20 323:21 325:6 333:3 341:4
unit's 272:7
unjust 7:12
unknown 109:15 342:6
unmistakable 10:12 11:9,10 12:7,20
unrelated 324:19
unsuccessful 256:22
unsuitable 6:13 12:19 15:5
unsure 123:10
upcoming 206:11 206:12 214:4
update 6:21 131:16 312:2
updated 218:1,2
updates 29:8 317:17
Updating 168:5
upgrades 368:2
ups 41:2
usable 59:4
USAF 1:19,23
use 21:8 29:17 36:6 47:14 81:20,22 84:10 85:6,7 86:5 87:6,13,17 88:9 113:5 115:17 127:10,16 145:13 149:14 155:17 156:15 166:12 179:13 185:10 204:1,3,13,15 235:7 241:1 268:14 307:18 338:16 360:9,16 361:20 368:11 372:3
useful 46:22 96:8 143:12 181:1 185:8 358:21 362:6 367:3 372:11
user 359:21
users 354:6
uses 97:11 212:1
USMC 1:22 2:12
USN 1:22
usually 70:12,13 105:21 121:5 308:17
utilization 87:15 163:20 183:13 185:17 191:12
utilize 165:5 233:22 255:16
utilized 149:21 182:8
utilizing 371:20
U.S 1:2

V

VA 4:22 5:9 10:6 12:9,12 18:12 20:4 92:6 104:16 105:1 198:16 199:13 200:11,15 202:15,19 208:12 221:10 224:14,14 225:17 237:15 244:2,17 251:4,17 252:2,11 253:7 260:2,4 265:2,20 266:19 269:1,20 270:16 312:6 315:2,5 316:11 320:21 321:22 330:18 346:22 355:6,20 357:9 358:13,16 359:1 360:9 367:11,14 367:14 368:4
valid 366:12
valuable 140:12
value 92:9 281:14 295:13
variable 96:4
vast 189:20
VA's 200:20 201:8
VA/DoD 267:3
VA/DoD/White 345:13
VBA 252:2 358:18
Vegas 201:4
venue 37:17 323:11

335:4
verbally 166:21
version 93:12 123:7
versus 22:9 60:20 113:15 249:2 250:14 280:18 349:3
vestige 43:1
veterans 13:22 252:6,8 326:8 327:5 358:14
viable 355:10
vice-versa 312:10 325:15
Vietnam 315:2 322:2
view 228:3
viewed 324:2
viewing 174:12
vigilant 216:5
violate 272:4,21 275:4
violating 272:9
violation 278:5
Virginia 1:15
virtual 368:1,9
virtualization 367:22 368:7
virtualize 368:9
virtually 357:16
visibility 278:10
visible 358:10
vision 349:20 350:11
visit 15:13,19 16:3 17:3,6 20:21 128:11 171:15 320:11 366:15,15 367:11 375:20
visited 30:7
visiting 31:13 34:22 280:9 281:1
visitor 377:15
visits 17:2 103:18 140:8,9 165:4 166:6 169:2 171:1 175:15 176:19 180:20 191:3 214:5,14 226:2 285:13 309:11,15 310:1 322:22 367:20
VistA 352:18 365:9 367:6,15 371:22 372:2
vital 285:16
VLER 356:21 358:6
voc 48:5
vocal 34:21 314:16
vocational 47:22
volume 88:14
volunteer 312:6
votes 214:6,9
VR&E 18:13
VSI 90:11 97:16 103:13 119:10 161:6
VSI/SI 107:16 136:4

W

wait 77:7 172:3 233:14,22 302:3 313:14 324:13 326:10
waiting 192:12 239:22
walking 64:16 188:7 237:21
Walter 193:21 199:21,22 237:15 292:9 293:5
want 13:19 14:19 16:13,14,21 17:4 21:10 27:1 32:6 40:17 43:9,18,19 50:2 55:5 57:21 58:1,4,6 59:5 60:21 62:4 67:20 67:21 68:3 83:4 83:21 84:20 85:14 94:15 101:7 116:6 119:6 121:13 122:19 128:14 142:5 144:10 145:17,21 146:18 148:21 149:1,16 149:19 153:10,12 154:5,6,14,15 158:9 162:15 163:6,7,8 169:10 171:15,16 172:2,3 172:4 177:9 180:19 187:3 191:15 192:5,6 195:1,3,13 197:19 204:13 206:6,18 208:5 214:22 216:18 217:4 219:11 220:15 224:11,13 230:14 231:6 233:21 243:1 244:14 245:4 246:16 250:2,7 255:15 259:13 263:6,7,15 264:17 265:3,10 271:8 272:22 275:3,5,16 278:20 281:21 284:10 285:15,15 288:1,6 290:13 291:12,16 294:22 295:19 304:9 311:3 313:13,18 323:14 327:9,10 330:10 332:19 343:17 344:14,16 346:21 362:5 365:1 367:17
wanted 28:11 73:18 118:11 124:12 218:5 250:10 270:19 274:17 331:19 362:16 369:10
wanting 227:21
wants 35:16 136:21 183:3 235:8 327:8 369:21
war 38:7 289:12 315:2
Warfighter 209:17
warrant 347:18
warrants 133:3
warrior 2:11,13 3:12 17:8,19 18:5 21:8 22:9 24:6 26:1,7,9,13,19 28:14 29:3,18 32:18 36:3,7 48:13 53:17 65:22 66:9 71:5 78:18 80:11 82:15,20 84:19 90:13 91:22 95:13 127:1 131:8 142:8 146:11 147:7 162:9 168:21 169:4 170:2,5 174:14 175:18 182:16 188:1 191:2,6 192:9 205:1,17 206:3,5,14,22 207:4 209:16 221:12 227:1 228:9 238:19 243:8 274:11 281:6 282:12 358:1
warriors 26:17,21 28:5 38:11 51:20 66:13 125:12,17 175:16 191:5 224:6,18 225:2 226:3 248:2 255:12 263:22 265:16 268:12 273:19 319:5 355:11,13
warrior/caregiver 183:15 191:14
wars 289:15
wasn't 36:1 89:16 112:20 186:16 213:1 237:9 279:2 319:15 356:20
watch 244:1 317:8
watched 107:19
watching 268:18 332:2
way 11:15 17:16 22:4,16 23:13 24:9 33:8 44:21 47:13 49:11 62:16 63:12 71:16 75:4 80:13 95:21 96:14 97:13 98:18 102:17,18 105:3 109:5 113:15 138:8,9 145:18 149:21 154:8 166:5 169:5 179:20 183:6 186:15 188:9,15 188:19 197:7 198:8 208:8 217:9 222:10 223:5 224:20 227:3 237:18 242:20 244:17,21 251:20 252:1 255:2 260:6 260:14 267:1 269:10 275:17 285:5 291:8,13 293:20 294:7 295:10,12 302:6,9 306:18,18 311:5 315:17 329:7,9 341:11 346:2 349:22 352:17 354:4,8 357:12 366:16,20 368:21 372:20
ways 102:22 108:2 151:15 295:1 313:1 329:12 330:21 354:15
web-based 362:19
WEDNESDAY 1:10
weeds 72:22
week 75:8 137:17

137:18 156:2 158:17 182:10 235:17 236:10,10 252:21 292:10 321:5
weekends 252:18 252:22
weeks 181:13,18 268:22 345:2,6 369:5
weigh 256:4,5
weight 281:5 282:1 331:1
Welcome 4:12
Wellness 162:11 220:11 307:6 348:8
well-defined 101:21
well-known 14:2
well-liked 184:18 184:22
well-trained 185:4
well-written 273:11
went 9:14 17:6 25:15 44:16 54:11 80:19 97:6 130:15 182:18 185:5 217:21 219:15 237:18 240:11 296:7 349:12 369:5 370:9
weren't 30:13 110:15 171:1,2 181:15,20 185:9 229:9 278:2 325:19 349:6,16 357:10
west 249:8,10
we'll 4:6 28:19 41:15,15 54:6,8 55:18 62:9 79:18 80:3 118:1 123:21 145:19 165:20 190:5,19 250:14 262:12,21 266:22 268:3 285:19 296:4 306:5 309:19,20 347:21 348:2 351:13 360:11
we're 13:12 15:14 20:22 21:22 25:10 28:22 34:8,8,21 43:7 45:11,15 47:22 49:19 54:2 55:2 60:2,3 63:18 67:5 71:12 83:6 113:5 120:14 123:10 125:8,22 129:22 133:15 134:9 136:2 138:18 139:5 140:11 145:22 146:8 148:11 150:20 156:6 158:1,4,9 161:18 161:19 168:5 175:12,22 176:2 188:19 189:22 190:16 191:21 199:20,21 202:13 204:12 215:8 220:4 221:8 223:2 223:18 225:1 231:1 232:4,5 243:13,14,21 247:2 249:17 250:15 251:19 252:13 255:10,11 255:12 256:13 262:17 263:3 267:2,16 271:14 286:22 287:14,18 289:14 290:4,12 291:17 292:15,15 294:17 303:22 304:20,21 306:11 306:22 313:9 320:7 321:7 322:11 325:9 328:8 337:15 342:5 347:13 351:9 361:11,11 369:18 370:6 373:19
we've 46:19 49:5 55:3 56:5,22 57:11 58:11,21 59:2,10 60:16 63:16 72:9 77:2 80:13 85:18 89:12 94:6,16 96:16 99:22 108:5 121:16 130:18 132:10 135:12 140:9 151:2,4 152:16,19 160:11 163:15 164:20 177:4 210:2 216:2 221:3 222:19,20 226:12 234:3 241:7 246:8 248:11 251:5,6 252:22 253:14 264:8 265:8,8,9 265:15 266:4 271:15 285:2 286:15 289:12 293:12 294:11 305:22 310:15 312:18 321:17 322:15 323:9 328:8 333:2 355:17 356:4 364:5
whatsoever 9:12
whispering 130:12
white 256:1,3,14,16 259:9,10 308:2
wife 170:5 187:12 287:13
willing 137:2
wind 96:17 111:1
wing 278:15,18 307:19
wire 248:18
wish 44:19 89:5
wonder 311:19 356:17
wonderful 359:4
wondering 88:11 172:7 240:21 334:10
word 235:7 293:21 330:17
worded 117:12 194:15 306:18
wording 217:4 285:19
words 34:5 92:16 113:20 196:21 276:9 282:22 293:8 338:17 353:17
wordsmith 155:18 157:16 294:8
wordsmithing 217:5
work 14:15 26:21 27:12,15 32:13,13 40:9,10,12 42:21 45:19 49:10 51:22 77:10 80:7 81:17 97:19 98:7 121:21 122:19 161:9 186:6 193:17 208:18 211:3 227:4 229:3 241:5 244:2 254:6 258:18 264:3,5,14 270:19,21 288:19 294:4 306:3,5 307:17 313:8,11 315:5 318:3 321:17 322:15 327:1,2 328:14 331:16 342:11 350:21 351:1 360:12 363:18 365:8 374:9 375:3
workable 322:7
worked 98:12 368:17
worker 233:12
working 22:20 23:3 27:3 31:5,8 42:22 44:4 48:5 53:7,19 105:21 135:11 138:12 166:20 167:1 175:2 179:19 181:7 209:12 223:21 248:14,18 252:21 260:3 270:14 299:14 310:16 318:10 324:6,7,10 339:3 346:22 351:5,6 365:9 366:12,18 368:6 368:17
workload 69:2 85:15
Workmen's 133:12
works 52:15 80:4 200:13 295:1 339:11 347:5 354:5
world 10:21 14:16 38:9 51:18 178:5 278:18
worried 114:1 142:22 161:19
worrisome 359:10 361:9
worry 115:2 309:16
worse 194:9 289:21
worth 182:7 247:7 262:15,17
worthwhile 285:5
wouldn't 14:7 35:9 39:15,22 48:20 49:9,10 107:13 112:21 133:2 134:7 136:13 300:15 310:12,12 369:8
wounded 1:5 2:11 2:12 3:12 17:8,12 17:15,19 18:4,7 19:11 21:8 22:9 24:5 26:1,7,9,13 26:16,19,21 28:5 28:14 29:3,18

32:18 36:3,7 38:11 43:8 48:13 48:14 51:20 53:17 70:17 71:6 78:18 80:10 82:20 84:18 86:4 90:13 91:22 95:13 96:13 142:7 153:20 182:16 205:1,9,17 206:3 206:5,14,22 207:4 232:19 238:21
wow 185:16
wrap 52:19
wrath 357:19
write 285:5
writes 209:20 375:6
writing 209:18
written 4:9 153:16 192:18 298:11 302:6,9
wrong 94:21 95:3 112:5 178:2 216:1 276:15 277:7 299:3
wrote 114:16 209:15
WTC 272:7
WTU 59:22 159:5 159:6,8,22 162:8 196:11,14 197:2 204:10 206:2 257:1 281:20
WTUs 126:6,11,12 197:10,20 198:11 198:22
WW 167:13
WWCTP 137:14 208:19,20
WWCTP's 141:17
WWR 31:12,19 33:20 35:5 37:13 41:12 42:3,5,6 43:10,12,19 44:12 47:3 69:10 121:10 126:5 162:8 204:8 204:8 272:7
WWRs 198:11

X

X 95:17 101:5 143:21 321:1,1
x-ray 353:12

Y

Y 95:17 101:5 143:21
yah-dah-yah-dah... 292:13
yea 312:9
yeah 28:17 29:22 32:8 37:5 43:17 306:17 311:6 321:4 323:13 336:9
year 17:7,7 25:17 30:9,16 44:16,19 54:3,16 57:15 60:10,18,20,22 61:3 67:19,20 71:4 75:6 79:14 80:4,19,22 81:5,6 81:21,22 84:9,10 85:4,12 118:14 140:5 164:17 165:3 167:13 194:12,12 204:9 204:10,11,22 206:4 213:20 216:19 217:5,8,11 217:12,19 218:3,4 218:20 219:2 220:5 222:11 224:2 226:2,2 250:4 264:15 265:5 266:14 267:1,16 268:18 270:3 274:11 287:7 288:18 299:4 307:2 316:19 321:7 322:18 348:3,19 349:21 351:15 352:5,10 356:21 363:19 364:16 374:11
years 80:16 97:8 100:1 129:9 139:11 194:11 207:2 216:8 223:15 241:8 252:4 261:15 289:12 305:11 324:17 326:15 337:17 352:7 363:8 372:6
year's 215:3 216:15 216:21 217:3 219:6,7 374:13
Yellow 307:21 310:6
yeoman's 318:3
Yep 182:10
yesterday 11:18 74:22 104:21 109:22 162:19 163:3 199:12 200:17 214:7 218:22 244:19 260:1 261:6 263:1 326:13 353:1 359:9 360:1
young 310:19 344:14

Z

Z 95:17 101:5 143:21
Zeh 306:8
zero 9:10

0

07 241:10

1

1 1:1 4:2 71:4,18 75:2,4 76:3,11 94:15 99:11,12,15 168:3 184:15 185:20 194:12 197:11 222:15 272:2 349:21 374:4
1b 153:11
1s 77:7,9
1st 254:22
1:07 219:16 220:2
10 4:12 108:3,6,19 109:13 110:6,19 111:1,13,15 112:10 114:4,5 115:5 116:17 119:12 133:4 134:8 145:6 151:12,14 158:2,3 158:5 159:20,21 160:3 247:1,16 260:20 261:1 297:13 307:3,9 320:14
10s 136:16
10:15 130:14
10:30 130:16
100 53:8 343:17
11 4:14 123:9,12,13 161:22 182:4 220:6,7,20 221:2 221:5 223:20 263:3
11:59 219:14
12 4:15 59:17 60:4 60:7 119:18 162:18 163:2 211:10,12 212:13 288:3 301:18 329:12
13 4:16 54:17
130 3:8,11
14 4:17 54:17 363:18 364:1
15 3:4 4:18 352:7
16 1:11 4:19 59:17 59:21 162:19 163:2,4 194:3 196:22 199:2 211:10,10
162 3:12
17 4:20 123:19,20
170 123:2
18 4:22
19 4:23 162:13
1900 320:22 321:12 322:5
1944 10:6

2

2 2:7 4:3 59:4 61:20 62:3,5 67:13,14 67:22 68:4,14,20 71:14 72:1 73:4 73:11,16 74:13,14 74:19 75:11,12,18 76:21 88:22 90:5 94:16 98:19 99:15 102:14,15 105:13 106:12,14 116:7 117:5,7,8 118:9 119:8 120:4 121:2 145:14 148:18 150:19 153:15,20 162:18 163:2,3 194:2 196:5,6,10 196:21 197:13 211:11 220:6 258:2,7
2a 153:11
2s 150:5,15 154:1 197:22 233:8
2:19 296:6
2:30 296:4
2:36 296:8
20 4:24 9:10 45:22 46:9 123:19 173:22 241:15 351:16 352:1
20,000 159:3
200 13:2
2003 6:4
2008 91:16
2009 10:17
2011 9:17
2012 1:11
2013 13:8
21 4:25 53:6
219 3:14
22 4:26
22,000 121:22

123:18,20 136:3 206:1
220 3:15
2200 136:8,13,14
24 5:12 90:13 105:22 270:16,18 270:19
24/7 197:12
25,000 236:8 325:21 326:2
29th 369:7
295 104:13
296 3:16

3

3 3:1 4:4 54:17 61:20 68:1 94:16 94:20 102:15 105:10 106:11 116:15 194:12 197:14,22 220:6 231:22 233:8 264:20 266:8,15 272:4 338:11 340:6 343:12,12 345:18,19 347:17
3s 98:16 154:2
3:00 304:22
3:55 377:18
30 257:18
306 3:18
31 235:22
33 235:22
347 3:20
351 3:22
377 3:23

4

4 3:3 4:1,6 54:17 120:16 162:18 163:2,5,6,9,9,9,13 163:15 168:16 179:22 184:4 190:19 264:20 266:10
40 6:3 308:20
40-to-one 122:2
400 125:14
42 110:9,22
45 104:16

5

5 4:7 131:15,21 162:18,22 196:5 196:22 286:19 347:17
5,000 321:7
50 75:3,9
54 3:6,7 258:5
550 122:7,9,10
58 110:1

6

6 4:8 54:17 131:22 162:18,22
625 1:14
69 53:5

7

7 4:9 22:11 162:18 162:22 220:6 264:18 373:22
7th 23:21 27:20 28:3,6 29:19 51:16
7:00 377:15
70 85:11,11,15 342:18
72 90:14 106:5
73 48:12
75 104:15,16 342:19 347:8
750 122:8

8

8 4:10 135:19
8:00 1:15 4:3 377:10
8:47 54:10
80 14:16

9

9 4:11 348:4
9:01 54:12
90 53:3 103:22 301:15 342:18,20 347:8
95 44:6 46:7

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Wounded Armed Forces Members Task Force

Before: DoD

Date: 05-16-12

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