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ORIGINAL RESEARCH

Team Red, White & Blue: a community-based model for harnessing positive social networks to enhance enrichment outcomes in military veterans reintegrating to civilian life

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Abstract

Military service assimilates individuals into a socially cohesive force to address dangerous and traumatic situations that have no counterpart in civilian life. Upon leaving active duty, many veterans experience a "reverse culture shock" when trying to reintegrate into civilian institutions and cultivate supportive social networks. Poor social reintegration is associated with greater morbidity and premature mortality in part due to adoption of risky health behaviors, social isolation, and inadequate engagement in health care services. Although institutions like the Veterans Health Administration (VA) do much to address the complex psychosocial and health care needs of veterans and their families with evidence-based care, only 61% of Operations Enduring and Iraqi Freedom (OEF/OIF) Veterans are enrolled in VA care and there are numerous perceived barriers to care for enrollees. To address this gap, a community-based nonprofit organization, Team Red, White & Blue (RWB), was created to help veterans establish health-enriching social connections with communities through the consistent provision of inclusive and locally tailored physical, social, and service activities. This article provides an overview of the development and refinement of a theory-based framework for veteran health called the Enrichment Equation, comprised of three core constructs: *health*, *people*, and *purpose*. By operationalizing programming activities and roles, we describe how theoretical components were translated into a social networking implementation package that enabled rapid national spread of Team RWB. We conclude with future opportunities to partner with researchers and other organizations to understand program impact, and to identify effective intervention components that could be adapted for similar vulnerable groups.

Keywords

Veteran health, Reintegration, Social support, Social networks, Behavioral medicine, Physical activity

Implications

Practice: Implementing theory-based social networking interventions is feasible in diverse community settings across the USA to help veterans and their families achieve healthier reintegration outcomes.

Policy: Governmental and private sponsors should increase funding for nonprofit, community-based veteran organizations to address complex veteran social issues such as reintegration and health promotion.

Research: Academic and government researchers can benefit from collaborations with community-based organizations to better understand how to develop authentic social interventions to reach large numbers of individuals in at-risk groups.

OVERVIEW OF THE EFFECTS OF REINTEGRATION ON VETERAN HEALTH

Reintegration is the process by which a military veteran resumes civilian family, community, and vocational roles [1, 2]. This psychosocial process is personal and dynamic and may involve a struggle between conflicting aspects of military and civilian identities [3–6]. Service members adopt military norms, values, language, and identity through basic training [7, 8], with many experiencing the military as an institution that provides structure, a sense of mission, and close social bonds [4]. Upon transition from the military, veterans are not offered comparable training to acculturate back into civilian life, often resulting in "reverse culture shock" [9, 10], which is experienced by veterans as difficulty finding meaning or purpose, disconnection and/or conflict with people in their communities, feeling let down by institutions from whom support was expected, and being disoriented by the lack of structure in civilian organizations [4, 5]. Although most veterans demonstrate social resilience and positive reintegration outcomes [11], many struggle to retain or build social networks that support health and well-being [1, 2, 12, 13], making it harder to access resources and social support for reintegration needs [2, 12].

Facilitating healthy reintegration is a particularly salient public health issue for the 2.7 million U.S. service members who deployed to Iraq and Afghanistan in Operations Enduring and Iraqi

Freedom (OEF/OIF veterans) since September 2001 [14, 15]. Compared with prior service eras, these service members often served longer and had repeated combat deployments with shorter rotations at home [16, 17] that were disruptive to veterans' social connections with friends and family [15]. Furthermore, upon leaving the military, two in five veterans relocated to new communities other than their hometowns [18] where they found it difficult to build local social connections, especially for the veterans coping with service-related mental and physical disabilities [15, 19, 20].

The burden of visible and invisible health care needs is high among transitioning OEF/OIF veterans. Among those using Veterans Health Administration (VA) health services, 87% report chronic pain disorders [21, 22] while 57% have been diagnosed with one or more mental health conditions [23] including depression, post-traumatic stress disorder (PTSD), sexual trauma, and alcohol/substance use disorders [24]. Nearly one-third reported a service-related disability while some who sustained complex, lifelong injuries will require ongoing surgeries and rehabilitation over a period of years [25]. Coping with such service-related mental and physical health issues can put immense strain on family members and other close sources of social support [26, 27].

Reintegration is associated with adoption of unhealthy lifestyles that result in veterans having poorer health than civilian counterparts [28, 29]. In the years immediately following military discharge, veterans experience significant decreases in meeting recommended physical activity levels [30], increased nicotine and alcohol use [31], and rapid weight gain [32] such that within a couple years of military discharge, 75%–84% of OEF/OIF veterans are considered overweight or obese [33, 34]. The challenge of coping with comorbid mental and physical health symptoms can also be an impediment to physical activity among veterans [35, 36]. The accumulation of these factors put veterans at greater risk of premature mortality compared with nonveterans. Notably, mortality rates among the 38% of OEF/OIF veterans with combat exposure are higher than those for noncombat veterans or civilians due to causes such as suicide and cardiovascular disease [37, 38].

Since 2001, 62% of veterans sought VA health care services [39]. Nonetheless, many veterans with physical and mental health needs who are eligible for VA or a private health provider care do not seek adequate treatment [40, 41]. For example, OEF/OIF veterans with mental health problems infrequently receive an adequate dose of mental health treatment [40] possibly due to stigma or instrumental barriers to care [42, 43]. In addition, among OEF/OIF veterans with at least subthreshold mental health treatment needs, male veterans and those with lower PTSD and depression symptom severity are less likely to access and receive adequate mental health treatment [40]. Moreover, social networks are not universally facilitative of engaging veterans in health care and health promotion services [44–46]. Thus, while health systems such as the VA provide important care for medical and behavioral health care needs of veterans and their support networks, a large proportion of veterans' reintegration and health care needs are not adequately met [1, 2, 13]. Given the complex medical and mental health needs of veterans and the critical impact of reintegration on health outcomes, novel social interventions are needed to help support healthy lifestyles and relationships during this critical transition [2, 4, 10, 47, 48].

Team RWB is a rapidly growing community-based nonprofit organization created to help veterans encountering reintegration challenges reestablish robust social connections with their local communities that serve to support more positive outcomes and well-being. This article explains in detail the theoretical rational and framework for this novel social networking intervention for veterans as well as how these theoretical components were implemented into operational programming at a national level. We will conclude with an overview of current initiatives Team RWB has made to collaborate with behavioral medicine researchers to evaluate this innovative program to improve ongoing programming as well as to establish generalizable knowledge regarding the effectiveness of intervention components that can inform similar initiatives to engage at-risk groups in their health.

TEAM RWB

Overview

Team RWB is a 501(c) nonprofit organization formed in 2010 in Ann Arbor, Michigan by a U.S. Army veteran who observed that many veterans desired social support in building connections with their local communities. Although many government agencies and community-based organizations were addressing the delivery of health care and social services (e.g., employment, education, housing), few offered strategies to overcome the barriers to accessing many of these resources among at-risk transitioning veterans who felt alienated from their local communities. To address this gap, Team RWB leaders sought to create an organization that provided a consistent and *inclusive* support structure for veterans that was embedded within local communities to establish supportive relationships to better address unmet reintegration needs. Team RWB's mission became, "to enrich the lives of America's veterans by connecting them to their community through physical and social activity" [19].

This simple premise enabled Team RWB to grow rapidly since its inception in 2010 to an organization with 123,000 unique members in 2016 and 210 chapters located throughout America. The organization is headquartered in Tampa, Florida

and has 30 full-time professional staff and over 1,900 trained volunteer leaders that provide oversight and support to local chapters located in seven U.S. geographic regions: Northeast, Mid-Atlantic, Southeast, Midwest, South Central, Northwest, and Pacific. National leadership consists of a Board of Directors, Advisory Board, and Executive staff who provide national guidance, resources, and oversight to regional chapters. Most programming occurs at the local level. Membership is free through volunteer support and programming underwritten by corporate, foundation, and private donations (see www.teamrwb.org).

Underlying theory

Team RWB's inception was influenced by the introduction of the positive psychology construct of social resilience into the U.S. military in 2008 and its application to promoting veteran health [11, 49]. Team RWB founders observed first-hand that military service had been pathologized in such a way that many community nonprofits conveyed a message that veterans needed to be "helped," which many veterans perceived as disrespectful, causing them to turn away from these sources of support [50]. In contrast, Team RWB leaders saw an opportunity to employ a strengths-based approach based on key elements of positive psychology which focuses on what "is right" in people—their positive attributes, psychological assets, and strengths that help to prevent negative health outcomes [51]. Social resilience has been defined by Cacioppo and colleagues as "the capacity to foster, engage in, and sustain positive relationships and to endure and recover from life stressors and social isolation" [11]. The construct emphasizes that "relationships matter" through connections with other people, groups, and social institutions and that an individual's capability to work with others enhances the well-being and quality of life not only of the individual, but their community as well [11, 49, 51]. The theory's emphasis on finding meaning, belonging, and seeking growth in personal capabilities (e.g., ability to listen to and empathize with others) and relationships seemed well suited to address the salient social issues related to veteran reintegration.

Team RWB Enrichment Equation theoretical framework

In 2013, Team RWB's leadership established a theoretical framework that defined the concept of enrichment as the primary health outcome to focus programming efforts. Enrichment was defined as creating quality relationships and experiences that contribute to life satisfaction and overall well-being and was based on the importance of relationships and well-being in social resilience theory [11, 49] and a model for veteran wellness [2]. To easily communicate the concept of enrichment to program stakeholders, it was summarized in a formula called the Enrichment Equation (EEq), defined as: **Enrichment = Health + People + Purpose**. Each component of the EEq is designed to contribute to improved quality and longevity of life [50, 52–54]. EEq constructs and dimensions are defined in Table 1. Team RWB is currently testing ways to assess, track, and intervene on enrichment needs of its members [19].

Health

Team RWB defines health as creating frequent opportunities for team members to connect through fitness, sports, and recreation to improve physical, mental, and emotional well-being [19]. Physical activity is a cornerstone of Team RWB's health concept because of the strong evidence base regarding its effectiveness in preventing and managing many forms of chronic disease and disability, improving sleep quality, and extending longevity [55–57]. Physical fitness, athletic competition, and an active lifestyle are all parts of military identity and the warrior ethos shared by service members [58], which provides a culturally sensitive reference point to enable conversations about other aspects of health relevant to transitioning veterans. For example, regular physical activity is an evidence-based behavior that positively affects subjective and psychological well-being, including management of depressive and anxiety symptoms and recovery from alcohol and substance use disorders [59–63]. Team RWB's mental health focus is concentrated on general psychological distress, such as symptoms of anxiety, irritability, nervousness, anger, depression, and impaired cognitive abilities because they are collective indicators of possible mental health problems and functioning [20, 64]. Team RWB leaders deliberately and consistently avoid the narrow focus on post-traumatic stress, depression, and other mental health problems because doing so would interfere with reaching the many who would benefit from Team RWB programming (e.g., those with reintegration problems but who do not meet criteria for psychiatric diagnoses [65, 66]. Moreover, Team RWB avoids language that might evoke stigma related to mental health issues, language that would be counterproductive to Team RWB's goal of creating conditions in which veterans feel safe to discuss a broad range of transition difficulties and if needed, receive support for accessing appropriate mental health services.

Participation in regular physical, social, and volunteer activities is also conducive to positive emotional health. Team RWB activities not only increase opportunities for obtaining emotional social support from team members, but the process of training in a competitive, goal-oriented setting with different types of people can help cultivate emotional states corresponding to life satisfaction and achievement (e.g., inspiration, optimism, gratitude, enthusiasm, and open-mindedness) as well as positive moral emotions of elevation, self-compassion, and self-pride [67]. Furthermore, physical activity has also

Table 1 | Team Red, White & Blue (RWB) Enrichment Equation definitions and dimensions

	Construct
Health	*Exercise, sports, and recreation to improve physical, mental, and emotional well-being*
Physical health	Alcohol in moderation or not at all Appropriate quantity and quality of foods Avoidance of all tobacco products Physical activity: moderate and/ or vigorous activity plus strength training Restful sleep Strength/mobility to accomplish activities of daily living with ease
Mental health	Ability to focus, make decisions, and remember things Anxiety, nervousness, irritability within normal limits Down, depressed, low energy within normal limits Controlled anger
Emotional health	Inspiration, optimism, gratitude, enthusiasm, open-mindedness Elevation, self-compassion, self-pride
People	*Genuine Relationships: Honest, reliable, mentally focused, and emotionally engaged interactions that create a physically and emotionally safe environment to foster trust and minimize feelings of isolation or disconnection*
	Accountability to others Combination of weak and strong personal ties: close, best-friend type of relationships, and broader supportive network to provide emotional support, information, resources Community connection Shared hardship Trusting, loving relationships
Purpose	*Meaningful team and community-based experiences such as leadership and service that foster individual and shared sense of purpose in life, and renew personal identity*
	Direction in life Part of something bigger than oneself Personal goals Role in work, family, community is source of positive self-worth and connection to others Service to others; volunteering and leading Shared goals with others

been positively correlated with desirable affective states including perseverance, positivity, resilience, self-esteem, and self-efficacy [68].

People

Team RWB emphasizes social connections to alleviate the deleterious effects of frayed social bonds. The people component of EEq is defined as creating *genuine* connections reflected in an increased number of close relationships and improvements in teammates' sense of belonging, purpose, and community engagement. A genuine social connection is characterized by being authentic, quality social bonds, and supportive relationships that generate mutual trust and accountability [19]. Social support networks are recognized as a social determinant of health [69] such that strong ties to individuals and a larger social network are positively associated with leading healthier and more fulfilling lives [70]. Moreover, perceived social connectedness to others through secure attachments and social support is a protective factor against premature morbidity and mortality [53, 71] and conversely, perceived social isolation, loneliness, and poor social connections have proven to be strong predictors of negative health outcomes [54, 72].

Team RWB aims to help veterans build stronger people connections through both strong and weak links in their social networks by having an inclusive focus that engages veteran family members, civilians, and community health providers to strengthen the team mission. During reintegration, many veterans possess small social networks [73] that often include a spouse, family members, friends, and fellow veterans [1, 4]. Team RWB's inclusion of civilians as members and leaders distinguishes it from other veteran serving organizations because including those without prior military service puts veterans at greater advantage for strengthening their social networks than if it were a veteran exclusive organization. Specifically, expanded social connections often start as "weak links" [74] between a veteran and community that transform over time into a more powerful network and social capital for addressing reintegration issues. By interacting with diverse nonveteran community regularly through RWB activities, veterans and their families cultivate more social links that translate to greater access to local resources, knowledge, and opportunities in the community. Although veterans are mostly likely to turn to other veterans for support on challenging issues related to seeking health support [75, 76], to be fully reintegrated, veterans must regain a level of comfort with themselves and with their community, not just with other veterans and their military family. Moreover, civilians gain a deeper understanding

of veterans' military experience and culture [74]. Having strongly supportive communities that can provide broad assistance and advocacy through the transition process is essential, particularly for returning combat veterans coping with mental health conditions. Stronger social networks support better mental health outcomes for veterans by mitigating against the effects of social isolation, loneliness, and alienation that can contribute to depression, anxiety, suicide, divorce, and difficulty integrating into civilian roles [47, 48, 77–79].

Purpose

The final EEq component is purpose, defined as engaging members in meaningful team and community-based experiences, beyond physical and social activities, that renew self-identity and purpose in life [19]. On an individual level, purpose refers to direction, goal-directed behavior, and intentionality [11, 52, 80] while at a social level, purpose refers to group cohesion, belonging, and a shared commonality of goals among a team or group [11, 49]. The military promotes an identity that emphasized patriotism, self-sacrifice, unit cohesion, self-respect, physical fitness, and striving to achieve mission objectives [2, 7, 8, 58]. Thus, Team RWB seeks to affect purpose in life and renew a civilian-veteran identity through service and leadership opportunities by working with other organizations through community engagement. Volunteering to help others instills a sense of meaning and purpose, which are associated with increased longevity and life satisfaction and reduced stress, negative affect, and depressive symptoms [81]. Team RWB seeks to promote camaraderie among members so that they share a sense of unity, solidarity, and belonging to something bigger than oneself through a united purpose in service. Team RWB also makes good use of displaying its Eagle logo and wearing its distinct red athletic apparel at community events to not only raise public awareness but to help provide veterans with a renewed sense of identity and belonging with the organization and community.

The Enrichment Funnel

Figure 1 presents the Team RWB Enrichment Funnel that shows how the EEq constructs of health, people, and purpose have overlapping and mutually reinforcing components. Physical activity contributes to health, yet also creates routine opportunities for social interaction, thereby potentially reducing loneliness [33]. Goal-setting related to physical activity may contribute to individual and shared sense of purpose [15, 34]. In addition, "Team" process of RWB promotes a sense of cohesion and trust between team members working together in small

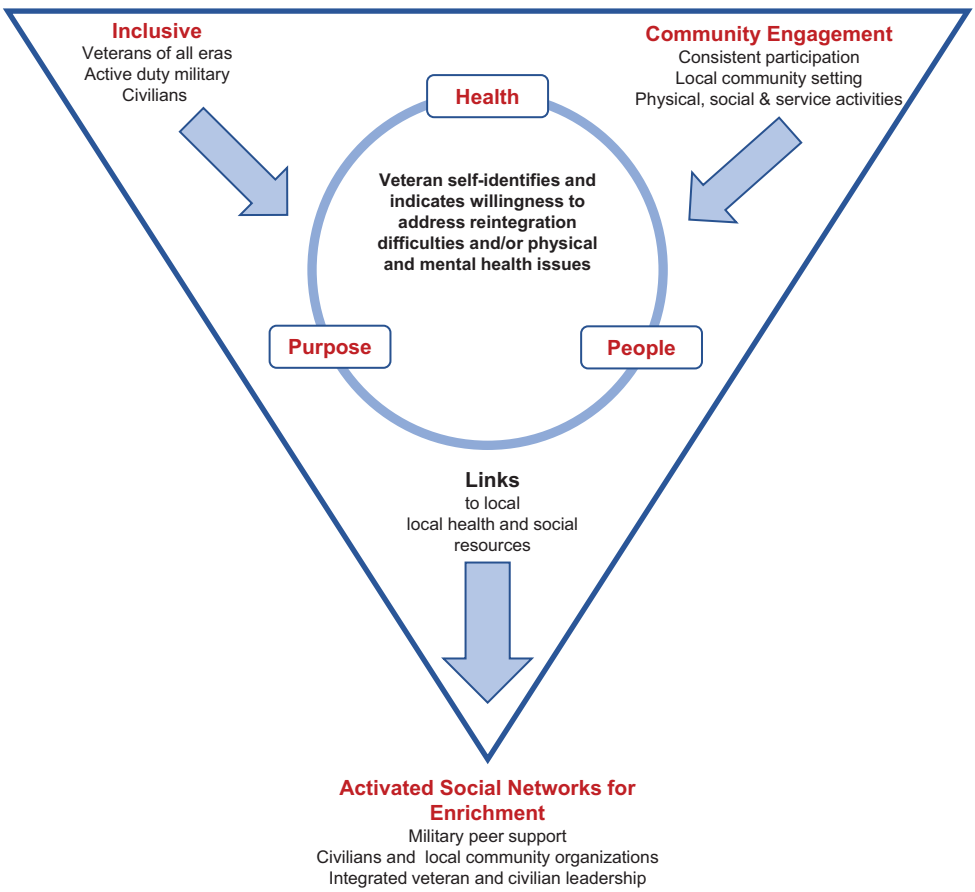

Fig 1 | Team Red, White & Blue (RWB) Engagement Funnel and the Enrichment Equation.

groups toward shared goals, essential in helping veterans address problems. Hence, regular community engagement combined with inclusive membership participation help create an environment for health-promoting social networks developed through peer-to-peer veteran engagement and broad civilian support. These social networks begin supporting health using physical activity as a low cost, low barrier mechanism to maintain these networks. Through Team RWB's networks, veterans become more willing to self-identify and address reintegration. Ultimately, these networks help to achieve Team RWB's long-term goal of preventing future health problems among at-risk veterans by "funneling" or linking veterans to other people and resources before the onset of serious health problems emerge.

TEAM RWB OPERATIONAL COMPONENTS

As a volunteer nonprofit organization, Team RWB has had considerable success in translating theory and mission goals into real-world programming, as outlined in Table 2. Key to this success is the reliance on veterans helping veterans. The military trained service members to work well as decentralized units, and the following programming elements have provided the structure to actuate ideals into action in diverse communities.

Chapter and community program

As of June 2017, the Team RWB community had grown to 217 Chapters. Each Chapter focuses on delivering consistent, local, and inclusive activities to build a "community of communities." Each Chapter is comprised of a *volunteer* leadership team of at least five positions, including a Chapter Captain, who oversee the Chapter's day-to-day functions and four directors who have responsibilities directly relevant to cultivating veteran social networks and running regular physical activity and social activities. Chapter participation is structured around daily-to-weekly exercise activities for individual engagement with other team members and the larger community. Activities include one-to-one engagement, such as grabbing a cup of coffee to talk (referred to as "Eagle Engagements"), to team specific athletic events (i.e., weekly group functional fitness sessions), social events (i.e., weekend family picnic), or volunteer service opportunities. Taking a "bottom up" approach, events are tailored by the local chapter to address specific interests of members of the local team as well as the environmental resources that facilitate promoting certain types of activities over others (e.g., availability of gym for functional training or ocean for surfing). Events vary in attendance from 2 to over 50. Those who sign up in geographic areas without a physical chapter presence are invited to participate in a large online community via social media, with all the benefits of national community partnerships, with updates on local events and activities and as information and resources related to health, training, and reintegration.

Inclusivity

Team RWB is inclusive, allowing membership to veterans, active duty service members, family members, and civilians to cultivate local links and resources for reintegration. This emphasis evolved over time. When founded in 2010, Team RWB's initial goals were to connect struggling "wounded warriors" who self-identified as needing support with fellow veterans and community members who self-identified as *advocates* for them. The team found that veterans who identified as advocates benefitted from support themselves, despite not identifying a need originally. This original model perpetuated the "rank ordering of suffering," whereby the veteran advocates minimized their own challenges to help others perceived to be worse off [82]. By 2011, it became evident that local Chapter leaders could not assume which veterans needed advocacy and care, because many veterans faced psychosocial difficulties related to reintegration.

In 2012, a leading consulting firm interviewed Chapter members around the country and helped Team RWB national leadership identify a key theme—the relationships between team and community members were at the core of Team RWB's purpose and long-term impact. Veteran members sought connection but did not want their issues "pathologized" as those associated with visibly wounded warriors but instead, to offer more opportunities to all veterans to serve their local communities and one another. Veterans who engaged in Team RWB had three types of motivations for participation: (a) *connection seekers*—those who were looking to reconnect with a community post-service; (b) *driven*–those looking for further opportunities to serve; and (c) *family-focused*—those who were focused on reintegrating in a healthy manner to be good parents or spouses (blinded reference). As membership grew from 10,000 members in 2012 to 45,000 in 2014, there was also a misperception by community members that Team RWB was a physical fitness group for veterans who mostly run or do CrossFit® workouts. Accordingly, the mission changed to providing consistent social interaction through a leadership-based community of veterans. Between 2013 and 2014, the organization invested heavily in operationalizing several components to attract veterans and civilians: (i) standardizing the language of enrichment, (ii) investing in chapter leadership, and (iii) investing in leadership training and evaluation capabilities to cultivate a capacity for better meeting the diverse needs of its members.

Table 2 | Operational programming elements of Team Red, White & Blue (RWB)

Intervention component	Operational element	Description
Chapters/communities		Chapters are run by *volunteer*s (veterans, civilians)
Local leadership	Chapter captain	Oversees overall chapter programming, recruits and manages other leaders, manages finances, and communicates with national headquarters
	Veteran outreach director	Increases veteran enrollment and involvement, establishes relationships with veteran referral sources, and collects data on impact
	Community outreach director	Drives community membership and participation, develops relationships with local businesses and organizations, manages chapter's social media, and promotes the chapter in community
	Athletic director	Executes weekly fitness activities, coordinates chapter participation in local events, and communicates with local race/event directors
	Social director	Coordinates social activities, assists Community Outreach Director in building local community partnerships, creates cost-effective activities, creates synergy between physical and social activities, and mobilizes member involvement
Chapter events	Weekly fitness events	Consistent, local opportunities for team members to connect through face-to-face fitness training activities
	Monthly social and service events	Events to promote meaning and purpose through volunteer service and leadership in local community
	Races and athletic competitions	Events promote self-improvement, health, personal accomplishment, and team membership
Social media	Facebook community	Local and regional social media platforms that serve team members without a chapter but who still want to be involved (updates, information, and resources)
Inclusion	Members, leaders	Volunteers including veterans, active duty military, families, and civilians who can be members/leaders
Leadership development	Local, regional, and national trainings	Courses to help make members better leaders for Team RWB and community through personality profiles, analysis, and individualized mentoring
Eagle leader experiences and camps	General	Enable members to learn a new sport or activity from national experts to take back to local chapter
	Regional	1–2 per year for each of 6 regions that feature leadership mentoring Team RWB staff
	National	6–9 camps per year (300 attendees) related to trail running, functional fitness, rock climbing, triathlons, surfing and yoga, paired with leadership skill building
Community and partner engagement	Signature events and collaborative activities	High visibility events with support of sponsors or other veteran serving nonprofits to raise awareness of veteran issues through physical activity events
Branding	Team gear/emblem	Eagle logo and red athletic gear build camaraderie and team identity while helping raising national awareness
Evidence-based and accountable	Eagle Research and Innovation Center	PhD and associated researchers who assess Team RWB effectiveness and areas for improvement

Eagle leadership development program (ELDP)

Team RWB Eagle Leaders were designated the primary facilitators of the organization's activities. Team RWB has continuously sought to train leaders to actively engage new or prospective team members as they join Chapters to achieve three goals: (i) make members better leaders, (ii) improve Team RWB as an organization, and (iii) to strengthen local communities. The core of the Eagle leadership philosophy was defined as building genuine relationships. ELDP was designed to be a 3-year process featuring both online and face-to-face trainings comprised of instructional modules to help leaders develop more active, accurate, and empathetic listening skills to work with members, develop personal self-awareness through personality profile and personalized strength/weakness assessments, and obtain mentoring from other Team RWB Eagle Leaders. Face-to-face trainings are scheduled to coincide with Eagle Leader Experiences and Camps (see below) and occur over 2 days in which Team RWB's national full-time staff facilitates classroom teaching,

readings, videos, and interactive team-building exercises and physical activities. Leaders then return to their local communities, in their respective leadership roles, to implement community-based activities for the broader team membership.

Eagle leader experiences and camps

All Team RWB members, especially leaders, have the chance to apply for and attend Eagle leader experiences and camps to engage in a new activity, and hone their leadership skills, to bring back to a local Chapter in a leadership capacity or as a highly active community member. Camps are held throughout the USA and led by experts in sports, leadership, and storytelling, to cultivate local expertise in health promotion, improving athletic performance, and developing team-building through leadership skill development (LDP). Since 2015, most camps have focused on fitness leader development related to functional fitness, rock climbing, surfing, trail running, triathlons, and yoga. Team RWB regional leaders have typically hosted one to two camps per year with approximately 20 members in attendance, while there have been up to nine national camps per year held across the USA with more than 300 members in total attendance. The camps are viewed as a critical investment in the members and the organization as a whole.

Preliminary program evaluation

As of December 31, 2016, Team RWB was comprised of more than 123,000 intergenerational people, 69% of whom were veterans, 12% active duty military, and 19% civilians, with nearly half (45%) being women [19]. In 2016, Team RWB produced over 43,000 activities, creating over 320,000 interactions. The ELDP has produced over 1,920 leaders (57% veterans, 13% active duty military, and 30% civilians; 51% women). Team RWB is beginning to develop its evidence basis, exploring how the organization affects the health, lives, and reintegration of service members and veterans. In 2016, The Institute for Veterans and Military Families at Syracuse University (IVMF) issued a case study on Team RWB, highlighting Team RWB's leadership as one of the first veteran service organizations to define and measure their outcomes. The case study presented findings from Team RWB's 2015 web-based survey conducted for grant-reporting purposes among a convenience sample of 2,542 veteran Team RWB members [19]. Team RWB designed the survey based on a thorough review of the clinical literature and existing psychometric instruments. These data demonstrated positive trends. Among the most frequently organizationally active veterans surveyed (n = 597), 81% reported that Team RWB increased their life satisfaction, 64% reported that participating in Team RWB helped them maintain a healthier weight, 53% reported it helped them better connect with civilian peers, and 70% reported it helped them build a better network of professional contacts. In bivariate tests, those who most frequently participated in Team RWB (i.e., "very active" members) reported significantly more positive endorsements of the above items than those who were "not at all" or "rarely active" Team RWB members [19]. Although lacking the rigor of a randomized controlled design, this program evaluation provides important insights into Team RWB's reach and preliminary insights into its potential impact on member outcomes [83]. As described below, more rigorous research is planned and underway, which will yield critically important information about impacts of Team RWB.

FUTURE DIRECTIONS

Research

As an evidence-based organization, Team RWB aims to measure and communicate its programmatic impacts. In an increasingly competitive environment among nonprofit organizations, particularly among veteran-serving organizations, Team RWB is accountable to its sponsors as well as to its members to improve veteran outcomes. With only preliminary evidence in support of the Engagement Funnel and EEq, it is a priority to measure the organization's outcomes to improve the quality of members' experience and to refine programming at the local community level. This article serves as an evidence-based rationale for the design of our intervention model and to partner with clinical researchers to employ new statistical methods and evaluation designs to better understand effective components of the RWB model [19]. A randomized controlled trial (RCT) with recently transitioned veterans was conducted between 2014 and 2017 to assess the effects of Team RWB when combined with trained peer mentors, on military-to-civilian reintegration difficulties as well as physical and mental health outcomes (NCT02627612). Another pilot RCT launched in 2017 will investigate the impact of Team RWB plus vigorous physical activity on reintegration outcomes (NCT03152214). Future evaluation efforts will incorporate the RE-AIM framework to systematically measure the public impact of programming [84]. Team RWB and evaluators from the IVMF are in the process of developing and validating the "Enriched Life Scale" to track changes in health, people, and purpose among veteran and civilian populations over time to improve annual membership surveys started in 2015. Ideally, long-term impact will be assessed by longitudinally tracking enrichment, service utilization, and morbidity and mortality rates.

Collaboration

There is growing awareness that promoting social connectedness should be a public health priority in the USA and Team RWB is receptive to partnering

with clinicians and researchers from such fields as behavioral medicine, public health, psychology, and sociology to address this imperative [51, 85]. Through its national network of chapters organized in diverse American communities, Team RWB affords behavioral medicine professionals with the opportunity to support their local chapter's activities by sharing their clinical and/or research expertise which in turn helps to advance the science of behavioral medicine. Operationally, Team RWB maintains a network of national, regional, and community-based care providers (e.g., safeTalk suicide alertness training), critical to the enhancing the community of care for veterans and service members. Similarly, the organization works to develop and maintain strong working relationships with community-based veteran serving resources including, Team Rubicon, The Mission Continues, and AmericaServes [86]. Future efforts will also seek new strategies to educate and engage individuals and organizations in local communities in the RWB mission.

CONCLUSIONS

Team RWB is a partner in the "community of care" for veterans and stakeholders in advancing the translation of evidence-based behavioral medicine interventions into American communities. Veterans who require clinically-based services need to be identified and connected to those resources, as quickly as possible. To that extent, Team RWB's network of over 123,000 veterans and civilians spanning 217 U.S. locations and a vast online community addresses a need while providing a compelling social intervention model for researchers to better understand. Team RWB highlights the importance of engaging veterans with culturally sensitive messages and interventions and by tailoring programming to the unique characteristics of local communities to better help at-risk veterans overcome individual and system-level barriers to addressing health needs. The organization was designed as an adjunct to existing Department of Defense and VA programs and is an "upstream intervention" to the organizations that can address the specific health needs of veterans in transition. The social networks established as veterans' progress through the Engagement Funnel provide an environment to promote enrichment. Moreover, these social networks are a culturally appropriate approach to better identify the unmet health needs of veterans and provide the supportive relationships that can mitigate adverse outcomes while overcoming social barriers (alienation, distrust) to engaging care resources.

We have described Team RWB's translational framework of the Engagement Funnel, which encases Team RWB's EEq. Based on the contributing evidence spanning many disciplines, from health services research to social psychology, and the vast experience of veterans who developed the EEq, we have defined an "enriched life" as being filled with health, people, and purpose. Although not exhaustive in scope to address every veteran need during transition to civilian life, these are three areas that Team RWB can actively intervene upon. The model will benefit from longitudinal tests of effectiveness and formally testing implementation-related factors. Our increasing ability to measure and track outcomes will help Team RWB grow as an evidence-based health promotion program that has the potential to affect daily life of Americans for years to come.

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Compliance with Ethical Standards

Conflict of Interest: The authors declare that they have no conflict of interest.

Ethical Approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

References

1. Elnitsky CA, Blevins CL, Fisher MP, Magruder K. Military service member and veteran reintegration: a critical review and adapted ecological model. *Am J Orthopsychiatry*. 2017;87(2):114–128.
2. Berglass N, Harrell MC. *Well After Service: Veteran Reintegration and American Communities*. Washington, D.C.: Center for a New American Security; 2012.
3. Reistetter TA, Abreu BC. Appraising evidence on community integration following brain injury: a systematic review. *Occup Ther Int*. 2005;12(4):196–217.
4. Ahern J, Worthen M, Masters J, Lippman SA, Ozer EJ, Moos R. The challenges of Afghanistan and Iraq veterans' transition from military to civilian life and approaches to reconnection. *Plos One*. 2015;10(7):e0128599.
5. Orazem RJ, Frazier PA, Schnurr PP, et al. Identity adjustment among Afghanistan and Iraq war veterans with reintegration difficulty. *Psychol Trauma*. 2017;9(suppl 1):4–11.
6. Schuetz A. The homecomer. *Am J Sociol*. 1945;50:369–376.
7. Olenick M, Flowers M, Diaz VJ. US veterans and their unique issues: enhancing health care professional awareness. *Adv Med Educ Pract*. 2015;6:635–639.
8. Hall LK. The importance of understanding military culture. *Soc Work Health Care*. 2011;50(1):4–18.
9. Westwood MJ, Black TJ, McLean HB. A re-entry program for peacekeeping soldiers: prompting personal and career transition. *Can J Couns*. 2002;36(3):221–232.
10. Koenig CJ, Maguen S, Monroy JD, Mayott L, Seal KH. Facilitating culture-centered communication between health care providers and veterans transitioning from military deployment to civilian life. *Patient Educ Couns*. 2014;95(3):414–420.
11. Cacioppo JT, Reis HT, Zautra AJ. Social resilience: the value of social fitness with an application to the military. *Am Psychol*. 2011;66(1):43–51.
12. Danish SJ, Antonides BJ. The challenges of reintegration for service members and their families. *Am J Orthopsychiatry*. 2013;83(4):550–558.
13. Zogas A. *US Military Veterans' Difficult Transitions Back to Civilian Life and the VA's Response*. Providence, RI: Brown University; 2017.
14. National Center for Veterans Analysis and Statistics. *Profile of post-9/11 veterans: 2015*. 2017. Available at https://www.va.gov/vetdata/docs/

SpecialReports/Post_911_Veterans_Profile_2015.pdf. Accessibility verified *November 11, 2017*.
15. Institute of Medicine (IOM). *Returning from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*. Washington, D.C.: National Academies Press; 2013.
16. Geiling J, Rosen JM, Edwards RD. Medical costs of war in 2035: long-term care challenges for veterans of Iraq and Afghanistan. *Mil Med*. 2012;177(11):1235–1244.
17. Johnson BS, Boudiab LD, Freundl M, Anthony M, Gmerek GB, Carter J. Enhancing veteran-centered care: a guide for nurses in non-VA settings. *Am J Nurs*. 2013;113(7):24–39; quiz 54, 40.
18. Defense Manpower Data Center (DMDC). *Active Duty Military Transitioning from Active Duty to Reserve/Guard (FY 13 to FY 15)*. Arlington, VA: U.S. Department of Defense; 2015.
19. Angel C, Armstrong NJ. *Enriching Veterans' Lives Through an Evidence Based Approach: A Case Illustration of Team Red, White & Blue (Measurement and Evaluation Series, Paper 1)*. Syracuse, NY: Institute for Veterans and Military Families, Syracuse University; 2016.
20. Sayer NA, Noorbaloochi S, Frazier P, Carlson K, Gravely A, Murdoch M. Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatr Serv*. 2010;61(6):589–597.
21. Higgins DM, Kerns RD, Brandt CA, et al. Persistent pain and comorbidity among operation enduring freedom/operation Iraqi freedom/operation new dawn veterans. *Pain Med*. 2014;15(5):782–790.
22. Goulet JL, Kerns RD, Bair M, et al. The musculoskeletal diagnosis cohort: examining pain and pain care among veterans. *Pain*. 2016;157(8):1696–1703.
23. Office of Public Health Post-Deployment Health Group, Veterans Health Administration, Department of Veteran Affairs. *Analysis of VA Health Care Utilization Among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans: Cumulative from 1st qtr FY 2002 Through 1st qtr FY 2014*. Washington, D.C.: Office of Public Health Administration; 2014.
24. Ramsey C, Dziura J, Justice AC, et al. Incidence of mental health diagnoses in veterans of operations Iraqi freedom, enduring freedom, and new dawn, 2001-2014. *Am J Public Health*. 2017;107(2):329–335.
25. Gawande A. Casualties of war–military care for the wounded from Iraq and Afghanistan. *N Engl J Med*. 2004;351(24):2471–2475.
26. Institute of Medicine (IOM). *Preventing Psychological Disorders in Service Members and their Families: An Assessment of Programs*. Washington, D.C.: The National Academies Press; 2014.
27. Miller KM, Kabat M, Henius J, Harold C, Van Houtven H. Engaging, supporting, and sustaining the invisible partners in care: young caregivers of veterans from the post-9/11 era. *N C Med J*. 2015;76(5):320–322.
28. Hoerster KD, Lehavot K, Simpson T, McFall M, Reiber G, Nelson KM. Health and health behavior differences: U.S. Military, veteran, and civilian men. *Am J Prev Med*. 2012;43(5):483–489.
29. Lehavot K, Hoerster KD, Nelson KM, Jakupcak M, Simpson TL. Health indicators for military, veteran, and civilian women. *Am J Prev Med*. 2012;42(5):473–480.
30. Littman AJ, Jacobson IG, Boyko EJ, Smith TC. Changes in meeting physical activity guidelines after discharge from the military. *J Phys Act Health*. 2015;12(5):666–674.
31. Widome R, Laska MN, Gulden A, Fu SS, Lust K. Health risk behaviors of Afghanistan and Iraq war veterans attending college. *Am J Health Promot*. 2011;26(2):101–108.
32. Littman AJ, Jacobson IG, Boyko EJ, Powell TM, Smith TC; Millennium Cohort Study Team. Weight change following US military service. *Int J Obes (Lond)*. 2013;37(2):244–253.
33. Maguen S, Madden E, Cohen B, et al. The relationship between body mass index and mental health among Iraq and Afghanistan veterans. *J Gen Intern Med*. 2013;28(suppl 2):S563–S570.
34. Rosenberger PH, Ning Y, Brandt C, Allore H, Haskell S. BMI trajectory groups in veterans of the Iraq and Afghanistan wars. *Prev Med*. 2011;53(3):149–154.
35. Hall KS, Hoerster KD, Yancy WS Jr. Post-traumatic stress disorder, physical activity, and eating behaviors. *Epidemiol Rev*. 2015;37:103–115.
36. Hoerster KD, Jakupcak M, McFall M, Unützer J, Nelson KM. Mental health and somatic symptom severity are associated with reduced physical activity among US Iraq and Afghanistan veterans. *Prev Med*. 2012;55(5):450–452.
37. Bollinger MJ, Schmidt S, Pugh JA, Parsons HM, Copeland LA, Pugh MJ. Erosion of the healthy soldier effect in veterans of US military service in Iraq and Afghanistan. *Popul Health Metr*. 2015;13:8.
38. Fryar CD, Herrick K, Afful J, Ogden CL. Cardiovascular disease risk factors among male veterans, U.S., 2009-2012. *Am J Prev Med*. 2016;50(1):101–105.
39. Epidemiology Group, Post-Deployment Health Group, Office of Patient Care Services, Veterans Health Administration, Department of Veteran Affairs. *Analysis of VA Health Care Utilization Among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans: Cumulative from 1st Qtr FY 2002 Through 3rd Qtr FY 2015 (October 1, 2001–June 30, 2015)*. Washington, D.C.: Department of Veterans Affairs; 2017.
40. Hoerster KD, Malte CA, Imel ZE, Ahmad Z, Hunt SC, Jakupcak M. Association of perceived barriers with prospective use of VA mental health care among Iraq and Afghanistan veterans. *Psychiatr Serv*. 2012;63(4):380–382.
41. Seal KH, Maguen S, Cohen B, et al. VA mental health services utilization in Iraq and Afghanistan veterans in the first year of receiving new mental health diagnoses. *J Trauma Stress*. 2010;23(1):5–16.
42. Vasterling JJ, Proctor SP, Amoroso P, Kane R, Heeren T, White RF. Neuropsychological outcomes of army personnel following deployment to the Iraq war. *Jama*. 2006;296(5):519–529.
43. Vogt D. Mental health-related beliefs as a barrier to service use for military personnel and veterans: a review. *Psychiatr Serv*. 2011;62(2):135–142.
44. Painter JM, Gray K, McGinn MM, Mostoufi S, Hoerster KD. The relationships of posttraumatic stress disorder and depression symptoms with health-related quality of life and the role of social support among Veterans. *Qual Life Res*. 2016;25(10):2657–2667.
45. Sripada RK, Pfeiffer PN, Rauch SA, Bohnert KM. Social support and mental health treatment among persons with PTSD: results of a nationally representative survey. *Psychiatr Serv*. 2015;66(1):65–71.
46. McGinn MM, Hoerster KD, Stryczek KC, Malte CA, Jakupcak M. Relationship satisfaction, PTSD symptom severity, and mental healthcare utilization among OEF/OIF veterans. *J Fam Psychol*. 2017;31(1):111–116.
47. Elnitsky CA, Kilmer RP. Facilitating reintegration for military service personnel, veterans, and their families: an introduction to the special issue. *Am J Orthopsychiatry*. 2017;87(2):109–113.
48. Sripada RK, Bohnert AS, Teo AR, et al. Social networks, mental health problems, and mental health service utilization in OEF/OIF National Guard veterans. *Soc Psychiatry Psychiatr Epidemiol*. 2015;50(9):1367–1378.
49. Peterson C. *A Primer in Positive Psychology*. New York, NY: Oxford University Press; 2006.
50. Meyer T. *Uniform Champions: A Wise Giver's Guide to Excellent Assistance for Veterans*. Washington, D.C.: The Philanthropy Roundtable; 2017.
51. Kobau R, Seligman ME, Peterson C, et al. Mental health promotion in public health: perspectives and strategies from positive psychology. *Am J Public Health*. 2011;101(8):e1–e9.
52. Cohen R, Bavishi C, Rozanski A. Purpose in life and its relationship to all-cause mortality and cardiovascular events: a meta-analysis. *Psychosom Med*. 2016;78(2):122–133.
53. Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. *Plos Med*. 2010;7(7):e1000316.
54. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspect Psychol Sci*. 2015;10(2):227–237.
55. Kokkinos P, Myers J, Kokkinos JP, et al. Exercise capacity and mortality in black and white men. *Circulation*. 2008;117(5):614–622.
56. Kelley GA, Kelley KS. Exercise and sleep: a systematic review of previous meta-analyses. *J Evid Based Med*. 2017;10(1):26–36.
57. U.S. Department of Health and Human Services. *2008 Physical activity guidelines for Americans*. 2008. Available at https://health.gov/paguidelines/pdf/paguide.pdf. Accessibility verified *January 30, 2010*.
58. Goodrich DE, Hall KS. Physical activity among veterans. In: Bopp MJ, ed. *Physical Activity in Diverse Populations: Examining the Evidence and Strategies for Practice*. New York, NY: Taylor & Francis; 2018: 200–225.
59. Whitworth JW, Ciccolo JT. Exercise and post-traumatic stress disorder in military veterans: a systematic review. *Mil Med*. 2016;181(9):953–960.
60. Conn VS. Depressive symptom outcomes of physical activity interventions: meta-analysis findings. *Ann Behav Med*. 2010;39(2):128–138.
61. Edwards MK, Loprinzi PD. The association between sedentary behavior and cognitive function among older adults may be attenuated with adequate physical activity. *J Phys Act Health*. 2017;14(1):52–58.
62. Vallance JK, Eurich DT, Lavallee CM, Johnson ST. Physical activity and health-related quality of life among older men: an examination of current physical activity recommendations. *Prev Med*. 2012;54(3–4):234–236.
63. Linke SE, Ussher M. Exercise-based treatments for substance use disorders: evidence, theory, and practicality. *Am J Drug Alcohol Abuse*. 2015;41(1):7–15.
64. Orth U, Wieland E. Anger, hostility, and posttraumatic stress disorder in trauma-exposed adults: a meta-analysis. *J Consult Clin Psychol*. 2006;74(4):698–706.
65. Vaughan CA, Schell TL, Tanielian T, Jaycox LH, Marshall GN. Prevalence of mental health problems among Iraq and Afghanistan veterans who have and have not received VA services. *Psychiatr Serv*. 2014;65(6):833–835.
66. Dursa EK, Reinhard MJ, Barth SK, Schneiderman AI. Prevalence of a positive screen for PTSD among OEF/OIF and OEF/OIF-era veterans in a large population-based cohort. *J Trauma Stress*. 2014;27(5):542–549.

67. Park N, Peterson C, Seligman ME. Strengths of character and well-being. *J Soc Clin Psychol.* 2004;23(5):603–619.
68. Liao Y, Shonkoff ET, Dunton GF. The acute relationships between affect, physical feeling states, and physical activity in daily life: a review of current evidence. *Front Psychol.* 2015;6:1975.
69. World Health Organization (WHO). *The determinants of health.* 2015. Available at http://www.who.int/hia/evidence/doh/en? Accessibility verified April 24, 2018.
70. Valliant GE. *Triumphs of Experience: The Men of the Harvard Grant Study.* Cambridge, MA: Harvard University Press; 2012.
71. Uchino BN. Social support and health: a review of physiological processes potentially underlying links to disease outcomes. *J Behav Med.* 2006;29(4):377–387.
72. Cacioppo JT, Cacioppo S. Social relationships and health: the toxic effects of perceived social isolation. *Soc Personal Psychol Compass.* 2014;8(2):58–72.
73. Tsai J, Harpaz-Rotem I, Pietrzak RH, Southwick SM. The role of coping, resilience, and social support in mediating the relation between PTSD and social functioning in veterans returning from Iraq and Afghanistan. *Psychiatry.* 2012;75(2):135–149.
74. Granovetter MS. The strength of weak ties. *Am J Sociol.* 1973;78(6):1360–1380.
75. Hinojosa R, Hinojosa MS. Using military friendships to optimize postdeployment reintegration for male operation Iraqi freedom/operation enduring freedom veterans. *J Rehabil Res Dev.* 2011;48(10):1145–1158.
76. Spoont MR, Nelson DB, Murdoch M, et al. Impact of treatment beliefs and social network encouragement on initiation of care by VA service users with PTSD. *Psychiatr Serv.* 2014;65(5):654–662.
77. Pietrzak RH, Russo AR, Ling Q, Southwick SM. Suicidal ideation in treatment-seeking veterans of operations enduring freedom and Iraqi freedom: the role of coping strategies, resilience, and social support. *J Psychiatr Res.* 2011;45(6):720–726.
78. Pietrzak RH, Southwick SM. Psychological resilience in OEF-OIF Veterans: application of a novel classification approach and examination of demographic and psychosocial correlates. *J Affect Disord.* 2011;133(3):560–568.
79. Campbell R, Riggs SA. The role of psychological symptomatology and social support in the academic adjustment of previously deployed student veterans. *J Am Coll Health.* 2015;63(7):473–481.
80. Holt-Lunstad J. Why social relationships are important for physical health: a systems approach to understanding and modifying risk and protection. *Annu Rev Psychol.* 2018;69:437–458.
81. Jenkinson CE, Dickens AP, Jones K, et al. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Public Health.* 2013;13:773.
82. Brown B. *The Gifts of Imperfection: Let Go of Who You Think You Are Supposed to Be and Embrace Who You Are.* Center City, MN: Hazeldon Publishing; 2010.
83. Berk RA, Ross PH. *Thinking About Program Evaluation.* 2nd ed. Thousand Oaks, CA: Sage Publications; 1999.
84. Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *Am J Public Health.* 1999;89(9):1322–1327.
85. Holt-Lunstad J, Robles TF, Sbarra DA. Advancing social connection as a public health priority in the United States. *Am Psychol.* 2017;72(6):517–530.
86. Armstrong NJ, McDonough JD, Savage D. *Driving Community Impact: The Case for Local Evidence-Based Coordination in Veteran and Military Services and the Americaserves Initiative.* Syracuse, NY: Institute for Veterans and Military Families, Syracuse University; 2015.