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# ***AFAP ISSUE UPDATE BOOK***

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**Active Issues**

**September 2011**

## Active Army Family Action Plan (AFAP) Issues Sorted by Subject Area

#	Issue title	Status	Subject area	Entered
671	Military Child Development Program (MCDP) Fee Cap	Active	Child Care	02/11
615	Donation of Leave for Department of Defense (DoD) Civilian Employees	Active	Employment	12/07
634	Death Gratuity for Beneficiaries of Department of the Army (DA) Civilians	Active	Employment	01/09
674	Strong Bonds Program for Deployed Department of Army Civilians (DACs) and Family Members	Active	Employment	02/11
677	"Virtual" Locality Pay for Department of the Army Civilians (DACs) Retiring Outside the Continental United States (OCONUS)	Active	Employment	02/11
626	Traumatic Servicemembers' Group Life Insurance (TSGLI) for Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and Uniplegia	Active	Entitlements	12/07
654	Monthly Stipend to Ill/Injured Soldiers for Non-Medical Caregivers	Active	Entitlements	01/10
657	Reserve Component Inactive Duty for Training Travel and Transportation Allowances	Active	Entitlements	01/10
670	Medically Retired Service Member's Eligibility for Concurrent Receipt of Disability Pay (CRDP)	Active	Entitlements	02/11
515	Application Process for Citizenship/Residency for Soldiers and Families	Active	Family Support	11/02
596	Convicted Sex Offender Registry OCONUS	Active	Family Support	11/06
652	Family Readiness Group External Fundraising Restrictions	Active	Family Support	01/10
663	Eligibility Benefits for the Unremarried Former Spouses of Temporary Early Retirement Authority (TERA) Soldiers	Active	Family Support	02/11
665	Formal Standardized Training for Designated Caregivers of Wounded Warriors	Active	Family Support	02/11
667	Identification (ID) Cards for Surviving Children with Active Duty Sponsor	Active	Family Support	02/11
673	Space-Available (Space-A) Travel for Survivors Registered in Defense Enrollment Eligibility Reporting System (DEERS)	Active	Family Support	02/11
529	Retirement Services Officer Positions at Regional Support Commands	Active	Force Support	11/02
612	Army Career and Alumni Funding	Active	Force Support	11/06
653	Funding Service Dogs for Wounded Warriors	Active	Force Support	01/10
662	Comprehensive and Standardized Structured Weight Control Program	Active	Force Support	02/11
664	Flexible Spending Accounts (FSA) for Service Members	Active	Force Support	02/11
669	Medical Retention Processing 2 (MRP2) Time Restrictions for Reserve Component (RC) Soldiers	Active	Force Support	02/11
618	Health and Wellness Centers (HAWC)	Active	Medical	12/07
629	24/7 Out of Area TRICARE Prime Urgent Care Authorization & Referrals	Active	Medical	01/09
638	Medical Nutrition Therapy (MNT) Benefits for All TRICARE Beneficiaries	Active	Medical	01/09
641	Over Medication Prevention and Alternative Treatment for Military Healthcare System Beneficiaries	Active	Medical	01/09
644	Shortages of Medical Providers in Military Treatment Facilities (MTF)	Active	Medical	01/09
661	TRICARE Allowable Charge Reimbursement of Upgraded/Deluxe Durable Medical Equipment	Active	Medical	01/10
666	Full Time Medical Case Managers for Reserve Component (RC) Soldiers	Active	Medical	02/11
668	In-Vitro Fertilization (IVF) Reimbursement for Active Duty Soldiers and their Dependant Spouse	Active	Medical	02/11
675	TRICARE Medical Coverage for Dependent Parents and Parents-in-Law	Active	Medical	02/11
676	TRICARE Medical Entitlement for Contracted Cadets and Their Dependents	Active	Medical	02/11
614	Comprehensive Behavioral Health Program for Children	Active	Medical/Command	12/07
625	Transitional Compensation (TC) Benefits for Pre-existing Pregnancies of Abused Family	Active	Medical/Command	12/07
648	Behavioral Health Services Shortages	Active	Medical/Command	01/10
650	Exceptional Family Member Program Enrollment Eligibility for RC Soldiers	Active	Medical/Command	01/10
609	Total Army Sponsorship Program	Active	Relocation	11/06
672	Reimbursement for Public School Transportation for Active Component (AC) Army Families	Active	Youth	02/11

## **Issue 515: Application Process for Citizenship/Residency for Soldiers and Families**

**a. Status.** Active

**b. Entered.** AFAP XIX, Nov 02

**c. Final action.** No (Updated: 8 Jul 11)

**d. Subject area.** Family Support

**e. Scope.** Soldiers and Family members encounter problems with the citizenship and residency application process. Under most circumstances, the Immigration and Naturalization Service (INS) will not accept Department of Defense (DOD) physical exams and fingerprinting. The Family member application process is further complicated by language barriers and inaccessibility to INS services and facilities. Lack of effective assistance to Soldiers and their Families causes emotional hardship, additional costs, distraction from mission, and possible deportation of Family members.

### **f. AFAP recommendations.**

(1) Designate and train a liaison at the installation level to assist Family members with the INS process, including review of documentation for accuracy and completeness.

(2) Coordinate with INS for approval of DOD administered fingerprinting and physical examinations.

### **g. Progress.**

(1) Liaison to assist Family members with USCIS process.

a. In 3<sup>rd</sup> Qtr FY03, FMWRC Family Programs (FP) met with USAHRC to develop plan to accomplish recommendation. USAHRC establishes guidance for citizenship issues within the Army.

b. In 4<sup>th</sup> Qtr FY06, FMWRC FP submitted an update to AR 608-1 requiring the addition of USCIS liaison function within the ACS Relocation Readiness Program. The revision was published on 6 Dec 06.

c. ACS Relocation Readiness staffs are the primary liaisons to USCIS at installations and are trained annually at the DoD Joint Services/Agency Relocation Training Conference. Area USCIS employees serve as guest speakers at these training events.

(2) Fingerprinting and physical examinations.

a. A physical examination and electronic fingerprinting at a USCIS approved site is required to obtain an adjustment of status for permanent residency, allowing individuals to receive a USCIS permanent resident card (aka green card).

b. In Apr 06, the Under Secretary of Defense (Personnel and Readiness) sent a letter to the Director, USCIS, requesting acceptance of physical examinations and electronic fingerprints from military installations. In May 06, the Director, USCIS, approved and outlined the process for acceptance of physical examinations and fingerprints for military personnel, but did not agree to all biometric data collection by the military. The USCIS did not approve this request for Family members.

(3) As a result of the 12 Jun 06 AFAP GOSC meeting, the Army G-6 was tasked to coordinate the military services' biometric capabilities with USCIS requirements. The Army G-6 Biometrics Task Force (BTF) reported an established process with USCIS, DoD, and the Federal Bureau of Investigation (FBI) whereby the Soldier/applicant applying for citizenship provides a signed Privacy Act statement to USCIS to allow for use of pre-

viously obtained fingerprints. This process does not exist for Family members of the Soldier.

(4) In Jun 06, USAHRC communication with OUSD (P&R) indicated USCIS was willing to implement the OUSD (P&R) request for acceptance of military examinations, provided that USCIS is provided with the names of military physicians who will perform the physical examinations and the specific locations where the examination will be performed.

(5) In Jun 08, the Department of Homeland Security, USCIS Chief, Field Operations, issued an executive memorandum instructing FODs to initiate contact with military installations in their jurisdictions to assess the immigration needs, including biometric collection, of Soldiers and their Family members and provide services on a regular basis at military installations.

(6) In May 09, FMWRC FP coordinated with the FMWRC PAO to publish the USCIS plan, advising installations to work collaboratively with the USCIS Field Offices, who will provide USCIS services on the installations, including biometric collection, for Soldiers and Families.

(7) In Jul 10, USCIS began developing policy regarding Civil Surgeon designation to include a fee structure for such designation. USCIS determined that physicians employed by the US Armed Forces would be fee exempt. This change took effect on 23 Nov 2010. A decision has not been made whether military employed physicians (civilian or contract) will be required to submit a USCIS Civil Surgeon designation application. The USCIS Director is responsible for making this decision.

(8) In Dec 2010, USCIS indicated they would be willing to accept, as a courtesy, DoD fingerprint cards prepared at domestic military installations, should DoD determine that a service or Family member is not able to obtain fingerprints at a USCIS Application Support Center (ASC) or by a mobile fingerprint unit. Previously, USCIS only accepted fingerprint cards for overseas applicants. However, fingerprints captured at a USCIS ASC or by a mobile fingerprinting unit remain the more advantageous and efficient method for both the applicant and USCIS. This meets the intent of part one of recommendation two. The Army will develop a strategic marketing campaign to advertise the availability of fingerprinting services (biometric collection).

(9) In Jan 11, OACSIM-ISS coordinated with OTSG to complete an updated cost analysis, based on the results of the "IMCOM Operations Order 11-077: Army Community Service Relocation Readiness Data Call – Immigration Services," for Army physicians to conduct physical examinations required for Family members.

(10) In Mar 11, OTSG/MEDCOM leadership will be presented with a decision brief to determine course(s) of action for Army physicians to be designated as civil surgeons to perform physical examinations for Family members.

(11) A strategic marketing campaign regarding the availability of USCIS services, to include fingerprinting services, was released in Mar 11. Recommend this issue be transferred to OTSG for resolution of the physical examination portion of this issue.

(12) On 10 Mar 11, this issue transferred to OTSG/MEDCOM to determine the distribution of Military

Treatment Facilities and physicians to perform physical examinations for Family members. MEDCOM will publish guidance to recommend at least one physician with civil surgeon designation for sites with 600 or less applicants and at least two physicians for sites with over 600 applicants. The civil surgeon duty will be an additional duty performed by these physicians. USCIS must designate the physician as a civil surgeon in order to perform immigration physical examinations.

To register, physicians submit a letter to the local District Director requesting consideration, a copy of a current medical license, a current resume that shows four years of professional experience not including a residency program, proof of US citizenship or lawful status in the US, and two signature cards showing name typed with signature below. To transfer civil surgeon status to a new district, physicians notify the new office of the transfer and submit new signature cards.

(13) Staffing a draft OPOD with implementation instructions to the Regional Medical Commands. We are assessing the costs, manpower and eligibility requirements.

(14) GOSC review.

a. Jun 06. GOSC declared the issue active. The VCSA stated the Army is leading OSD efforts on biometrics and that CIS does not realize the service's capability. G-6 was tasked to inform CIS of our capability so they will accept DOD administered fingerprints.

b. Jan 10. Issue remains active to further pursue USCIS recognition of military fingerprinting and physical exams. The VCSA questioned why the military, despite processing countless security clearances a year, is not considered capable to fingerprint for CIS applications and why doctors, who take care of wounded Soldiers on the battlefield, are not capable of doing physical examinations without CIS certification. The Surgeon General responded that the pilot at Fort Bragg demonstrated that certification is possible and said that with some energy this can be done.

c. Feb 11. The issue remains active. OTSG/MEDCOM leadership will determine course(s) of action for Army physicians to be designated as civil surgeons to perform physical examinations for Family members as required by USCIS.

d. Aug 11. Over the next six months, OTSG/MEDCOM will explore the feasibility of designating and certifying physicians in military treatment facilities as civil surgeons to perform immigration physical examinations for Family members.

**h. Lead agency.** OTSG/MEDCOM

**i. Support agency.** USAHRC, DAIM-ISS, and OUSD (P&R)

### **Issue 529: Retirement Service Officer (RSO) Positions at Regional Support Commands**

**a. Status.** Active

**b. Entered.** AFAP XIX, Nov 02

**c. Final action.** No (Updated: 24 Jun 11)

**d. Subject area.** Entitlements

**e. Scope.** The United States Army Reserve does not have regional Retirement Service Officers to assist individual Soldiers and Families. Two Army Reserve

Personnel Command (AR PERSCOM) representatives provide retirement counseling services as an additional duty. Soldiers may not receive crucial retirement counseling which adversely affects their ability to make timely and accurate decisions regarding their entitlements and benefits.

**f. AFAP recommendation.** Authorize and fund a Retirement Service Officer at each Regional Support Command.

**g. Progress.**

(1) Army Regulation 600-8-7, Retirement Services Program, dated 6 Jun 10 for the first time contains separate chapters for ARNG and USAR retirement services. This was the first step in establishing a holistic cross component standard for delivery of retirement services.

(2) USARC initiated its Pilot RSO Program on 2 December 2010 to gather metrics and develop procedures while supporting the 19 states of the 88<sup>th</sup> Regional Support Command (RSC) under a "holistic approach". The lessons learned and metrics gathered during this pilot program will be used to develop permanent RSO positions at each RSC to provide services equivalent with those received by the Active Duty. The USARC Pilot RSO program will be used to determine an accurate cost for the total number of RSOs required supporting each RSC.

(3) On 14 April 2011, the Army Reserve G1 requested eight Directed Military Overstrength (DMO) positions with placement of two per each RSC as a "bridging strategy" until a permanent solution is obtained. On 13 May 2011, BG Purser, DCAR, approved the eight DMO personnel to support the Army Reserve RSO Pilot initiative. These Soldiers will provide pre/post retirement services. Each RSC will receive two personnel (MAJ & MSG) to fill these DMO positions.

(4) There is an agreement between Army Retirement Services, HRPD, G-1; and G-1, USARC that RSOs must be strategically dispersed to provide support for Army Reserve Soldiers and Families. Efforts are ongoing to document POM requirements and justify added billets at each RSC.

(5) The Active component provided training slots to the Reserves with all three components attending the same certification training. Army G-1 RSO developed and implemented Survivor Benefit Plan (SBP) certification training designed to ensure retirement personnel are trained to counsel all retiring Soldiers on retirement and SBP without regard to component. In 2010 and 2011, 176 ARNG, 82 Active Duty, and 34 USAR personnel completed this holistic training at six combined training conferences. The Reserve Component Retirement personnel are attending training and receiving access to the Soldier Management System (SMS) and DFAS's Defense Retired Annuitant Pay System (DRAS) to allow quick resolution of problems with Reserve Soldier's/Retiree's records. The Reserve components are actively working to improve the transfer of retirement data between the Reserve components, HRC, and DFAS.

(6) The ARNG in partnership with the USAR developed a distance learning module that is designed to provide the individual Soldier comprehensive information to prepare Reserve Soldiers for retirement. The module

provides points of contact for clarification on individual concerns and or questions. The test pilot was completed May 2011. The release of the module is scheduled for July 2011.

(7) Army G-1 RSO developed Reserve pre-retirement guides, briefings, and other retirement information designed to provide retiring or retired Reserve Soldiers up to date retirement information and counseling similar to what is available to retiring active duty Soldiers. This information has been posted in a Reserve Retirement section on the Army G-1 RSO homepage accessible to all retiring or retired Soldiers, their Families and survivors, without regard to component. ARNG and USAR retirement and survivor websites contain links to the retirement and survivor information available on the Army G-1 RSO homepage. ARNG and USAR Soldiers near Army installations attend the installation retirement briefings and/or contact the installation RSO for information or assistance.

(8) The Office of the Secretary of Defense and the US Army developed a Reserve Component Transition Guide, and pre-separation counseling form (DD Form 2648-1) to provide transitional services to Reserve Soldiers as they transition from Active Duty to Troop Program Unit status, or retirement. Although there are still processes to be developed for the full delivery of services, this is a giant step forward in a holistic endeavor to significantly upgrade the entire range of service to our RC Soldiers, and Families.

(9) GOSC review.

a. Feb 11. The GOSC declared the issue active until USARC authorize and fund RSO positions.

b. Aug 11. RSO will submit Concept Plan for full resourcing for DA Civilian and/or contract personnel.

**h. Lead agency.** DAPE-HR-RSO

**i. Support Agency.** USARC, OCAR and HRC

#### **Issue 596: Convicted Sex Offender Registry**

**a. Status.** Active

**b. Entered.** AFAP XXIII, Nov 06

**c. Final action.** No (Updated 22 Jun 11)

**d. Subject area.** Family Support

**e. Scope.** The OCONUS population is not afforded the same information about convicted sex offenders as personnel stationed in CONUS. No OCONUS registry of convicted sex offenders with a Department of Defense Identification/Installation Access Card exists, thereby denying overseas community members the ability to identify a potential risk of harm to the community. Overseas personnel are more vulnerable to potential assaults by convicted sex offenders.

#### **f. AFAP Recommendations.**

(1) Establish a searchable convicted sex offender registry comparable to CONUS registries and make it available to the military community.

(2) Require all convicted sex offenders who reside OCONUS and are authorized a Department of Defense Identification/Installation Access Card to register with the installation Provost Marshal Office and be entered into a registry system

#### **g. Progress.**

(1) G-1 Sexual Assault Prevention and Response Program (SHARP) have increased manning and have

assigned a person to manage actions related to sex offenders. The Army Sex Offender Working Group (ASOWG) meets quarterly to continue to work existing gaps to Army Policy limiting the ability to manage sex offenders. The ASOWG will continue to work the Secretary of the Army approved Sex Offender Action Plan dated 17 Jul 10.

(2) Fifteen Army regulations require revision to close gaps in Army Policy to ensure leaders can identify, track, and manage convicted sex assault offenders.

(a) Highlights of policy revisions already made are: citizens cannot enlist or be commissioned with a qualifying sexual assault conviction; commanders must initiate separation if a court-martial did not impose a punitive discharge; Soldiers may be retained in the Army as a result of this process. Human Resources Command (HRC) is tracking Soldier offenders by coding them with an assignment available code of L8; this limits their assignment eligibility. Quarterly updates of Soldiers with a qualifying sexual assault conviction are provided to HRC by Office of the Deputy Chief of Staff, G-1 (HRPD), Office of the Judge Advocate General, and the Office of the Provost Marshal General.

(b) Future Army regulation revisions will ensure sex offender registration and management of all Soldiers convicted (by court martial) of any sex offense covered, whether or not the Soldier's punishment includes discharge. It will require the Office of the Judge Advocate General (OTJAG) notify HRC (DA 7439) of Soldiers convicted of sex offences to included all sex offences covered in the Uniform Code of Military Justice (UCMJ).

(c) Army regulations will state that all qualified convicted sex offenders who enter, reside, or are employed on Army installations must register at the installation Provost Marshal Office (PMO); a statement will be added to civilian job announcements notifying applicants of the requirement to register as a sex offender if offered employment on a military installation; it will establish policies and procedures for current sex offender employees to meet the registration requirements; and provide Garrison Commanders the authority to revoke authorization to reside in housing for sex offender misconduct or when the best interests of the Army for reasons relating to health, safety, morale, or welfare on the installation.

(3) The new Army In-Processing Personnel Record (DA Form 5123-1) and Installation Clearance Record (DA form 137-2) requires all Soldiers to process through the installation PMO. Installation Management Command (IMCOM) is developing a system to screen these Soldiers against the National Sex Offender Registry. The names of Soldiers, Army employees, and Family members detected through this process will be provided to: the installation provost marshal, the Garrison Commander, senior commander, applicable unit commander, and the installation SHARP proponent. These leaders will ensure this population is properly managed and tracked. The new AR 190-45 will direct installation provost marshals to perform this requirement. Projected publish date is Oct 11.

(4) The Department of Justice presently has a proposal before the Advisory Policy Board of the Federal Bureau of Investigation (FBI)'s Criminal Justice Information System (CJIS)/National Sex Offender

Registry (NSOR) to enable the automatic sharing of information between all relevant federal agencies when a sex offender is detected in the process of departing or entering the country. A decision and implementation of the DOJ Proposal is projected for 4th quarter FY13.

(5) GOSC review.

a. May 07. The issue was declared active.

b. Jan 10. Issue remains active and is refocused to address sex offender registry across the Army, not just OCONUS.

c. Aug 11. DAPE-HR will change AR 190-45 to direct installation provost marshals to screen in/out processing personnel against the National Sex Offender Registry and provide results to Garrison Commanders. Projected publish date of AR 190-45 is Oct 11.

**h. Lead agency.** DAPE-HR

**i. Support agency.** OSD (P&R), SAMR-HR, DAPM-OPS, DAJA-AL, IMWR-FP, AHRC, DAPE-MPO-D, DAPE-MPE, WSO-JTFSAPR, CCE, DAPE-CP, DAPE-MPE-PD, Departments of Justice and State, INTERPOL, U.S. Marshals Service

### **Issue 609: Total Army Sponsorship Program**

**a. Status.** Active

**b. Entered.** AFAP XXIII, Nov 06

**c. Final action.** No (Updated: 21 Jun 11)

**d. Subject area.** Relocation

**e. Scope.** The current sponsorship program is not effectively implemented, utilized, monitored, and inspected Army wide. Soldiers arriving at some gaining installations/units do not benefit from having an assigned sponsor. If assigned, the sponsor may not be adequately trained. A Soldier's critical first impression may be negatively impacted due to inadequate sponsorship.

**f. AFAP Recommendations.**

(1) Standardize and enforce Total Army Sponsorship Program (TASP) throughout the Army through the Command Inspection Program (CIP).

(2) Add the TASP to the CIP using AR 600-8-8 Appendix B checklist.

**g. Progress.**

(1) In Feb 06, the Vice Chief of Staff, Army (VCSA) approved the initial concept to develop the Virtual Installation Movement System (VIM). United States Army Family and Morale, Welfare and Recreation Command (FMWRC) determined implementation of the VIM and adding Army Regulation (AR) 600-8-8, The Total Army Sponsorship Program, Appendix B checklist in the Command Inspection Program would standardize and enforce the TASP Army wide. However, at the Jan 10 AFAP General Officer Steering Committee, FMWRC reported that VIM was not funded, therefore is no longer an option to standardize TASP. FMWRC recommended that TASP be viewed from a holistic perspective that takes into consideration the current Army OPTEMPO.

(2) During the Jan 10, AFAP GOSC, the VCSA stated that fixing TASP will make a huge impact in the lives of Soldiers and directed that AFAP Issue # 609 be placed on fast track and presented again at the Jun 10 GOSC.

3. In Apr 10, OACSIM-ISS forwarded copies of the AFAP 609 Issue Paper, an excerpt from the AFAP GOSC transcript that addresses TASP, a copy of DA Form 7274

(Sponsorship Survey) and the Sponsorship Questionnaire (Appendix B) to Inspector General (IG) Office (FORSCOM) to use to inspect TASP at select FORSCOM commands. In Sept 10, the FORSCOM Inspector General completed TASP inspections at select installations. As a result of the inspection the FORSCOM CG directed commanders to immediately execute TASP and ensure that advance arrival sponsorship is provided to every Soldier when possible.

(3) In May 10, Command Sergeant Major (CSM), ACSIM/IMCOM convened a working group to identify ways to improve TASP. Participants included CSMs from FMWRC and Korea; Sergeant Major, DA G1; Chief, IMHR-M; Chief, OACSIM-ISS; the ACSIM/IMCOM Surgeon, and action officers from OACSIM-ISS, FMWRC and IMCOM. The group concluded that AR600-8-8, TASP is clear, but requires visibility and enforcement Army wide.

(4) In Jun 10, ACSIM/IMCOM CSM briefed the ACSIM on a concept to improve TASP by directing IMCOM G-1 and the installation Directorate of Human Resources (DHR) to designate Sponsorship Integrators to implement TASP. The ACSIM approved the integrator positions concept and the TASP StratComm Plan, however directed CSM to identify services that would not be provided in order to execute the new TASP requirements. In Jul 10, FMWRC-FP submitted a quad chart and an information paper to IMCOM CSM that outlined Relocation Readiness requirements and highlighted that the program is not funded to provide Sponsorship. The Army Community Services (ACS) identified 10 ACS Accreditation Standards assigned to the Relocation Readiness Program; 9 out of 10 standards are congressionally mandated. In addition, IMHR-M provided IMCOM CSM a "One to N" list of tasks executed within installation DHR and concluded the infusion of integrator duties at the level necessary would be challenging without additional resources.

(5) In Jul 10, ACSIM/IMCOM CSM met with DoD Relocation and Family Programs Division point of contact regarding the new DoD eSponsorship Application and Training (eSAT) web application. Findings concluded that eSAT is an effective training tool, but lacks the capability to meet the Army's intended end-state of having a live person to monitor the status of the Sponsorship Program Counseling and Information Sheet (DD Form 5434) and, when necessary engage commands to ensure Soldiers, Civilians, and Family members receive a sponsor when transitioning to gaining commands.

(6) In Oct 10, OACSIM-ISS updated the ACSIM at the AFAP IPR on the status of improving TASP. The ACSIM approved the concept to establish Sponsorship Integrator and Director Positions and placing them at IMCOM-HR to improve TASP.

(7) In Nov 10, Services and Infrastructure Core Enterprise (SICE) began chairing the TASP working group meetings and expanded membership to include stakeholders across the Active, Reserve, and Guard components. The working group finalized the TASP EXORD draft and in Dec 10, the ACSIM approved the draft for official staffing to the ARSTAF.

(8) In Dec 10, The Chief, IMHR-M commenced Phase I of modifying the Mobilization Planning Data Viewer (MPDV) at Fort Hood to enhance Soldier Readiness Processing (SRP). Initial phase II testing was completed in Apr 11. Funding decisions and time resulted in an inability for the unit to accurately assess MPDV using the initial research and testing processes. Through alternative means, IMHR-M determined that MPDV is a viable solution for enhanced Soldier Readiness Processing (SRP) and will assess the cost and requirements of modifying MPDV to accommodate AC business rules, interfaces, and adding Sponsorship functionality.

(9) In Jan 11, OACSIM-ISS officially staffed the TASP EXORD to the ARSTAF. Concurrences were received from the ARSTAF with the exception of Army G-8, who requires IMCOM to complete a concept plan and cost benefit analysis for the Sponsorship Integrator Positions and submit documents to G-3/5/7 for approval. In addition, Army G-8 advised that the EXORD should not be executed until a fully funded and approved concept plan has been authorized in FY 13-17 POM.

(10) In Mar 11, The Chief, IMHR-M reported that the IMCOM TASP OPOD (based on the TASP EXORD (draft)) has been staffed through IMCOM directorates and sent to IMCOM Operations for final processing and signature. The OPOD directs garrisons to establish 75 Installation TASP Integrator positions using existing authorizations until IMCOM identifies workload requirements, finalize the concept plan, and submit the plan to Army G-3/5/7 for approval. The TASP OPOD is on hold pending alternative means to execute integrator functions at no additional cost to the Army.

(11) In Feb and Mar 11, the OACSIM-ISS requested both the IMCOM-IG and the U.S. Army Human Resources Command (HRC) to verify if Sponsorship is included in Pre-CIP and CIP, and being inspected. According to the IMCOM-IG, the CIP has been postponed due to funding shortages. HRC advised Sponsorship Inspection is a HRC requirement; their focus is on training S1/G1's on readiness issues such as reducing nonavailables, casualty documents, and personnel systems. As a result of these inquiries, in Apr 11, OACSIM-ISS requested SICE's assistance to help address TASP compliance and enforcement issues across the Army.

(12) During the Apr 11, AFAP IPR, the ASCIM disapproved funding for the Sponsorship Integrator positions due to current fiscal constraints and directed the issue be tabled until discussed with IMCOM. As a result, during the IMCOM Symposium, Sponsorship Session, the ACSIM SGM and IMCOM CSM briefed the status of the integrator positions and funding constraints; the IMCOM CSM is exploring the feasibility of using non deployable Soldiers to function as Sponsorship Integrators. The ACSIM SGM and IMCOM CSM will provide IMCOM-HR with "The Way Ahead" for executing Sponsorship Integrator responsibilities.

(13) In May 11, OACSIM-ISS and the SICE point of contact met and agreed to reconvene the TASP working group to determine the degree in which commands are using the TASP, Appendix B checklist in their CIP to ensure standardization of the Program Army wide.

(14) On 18 May 11, SICE reconvened the TASP

working group to provide an update and a heads-up on the forthcoming questionnaire designed to solicit feedback on the status of Sponsorship Inspections through CIP.

(15) GOSC review.

(a) Jan 10. The GOSC declared the issue active to fast track an approach to sponsorship that can function in the current operational environment. TRADOC stated the Army holds off giving Soldiers in the training base their final assignment to try to get it right in terms of ARFORGEN. Even if a unit is trying to implement sponsorship, it has less time to do that effectively. FORSCOM noted the VIM module would have tracked Soldiers between installations and ensured they are deployable, getting their medical checks and appropriate out-processing. ACSIM stated that IMCOM has to do a better job with the warm handoff for Soldiers and their Families as they move from point A to B and said that sponsorship is one of the many second and third order effects of not doing this correctly. The VCSA noted that the most dangerous period for suicide is transition: transition to go home for leave, from AIT to first unit, between units, and units to school.

(b) Feb 11. The GOSC declared the issue active.

(c) Aug 11. OACSIM will coordinate with IMCOM on using non-deployable Soldiers as sponsor integrators and the design and functionality of an automated system to help commands improve in/out processing and track sponsorship.

**h. Lead agency.** DAIM-IS

**j. Support agency.** IMHR-M

## **Issue 612: Army Career and Alumni Program (ACAP) Funding**

**a. Status.** Active

**b. Entered.** AFAP XXIII, Nov 06

**c. Final action.** No (Updated: 1 Jun 11)

**d. Subject area.** Force Support

**e. Scope.** Current and future budget cuts seriously threaten the effectiveness of ACAP. The program assists Service Members (SMs) and their Families to be successful in their transition from federal service to civilian life. Approximately 11,000 SMs were retained on active duty in 2005 from briefings provided by ACAP. Loss of ACAP's employment assistance and support for job searches will result in higher unemployment rates, increased unemployment compensation and reimbursement costs paid by the Department of Army.

**f. AFAP Recommendations.**

(1) Eliminate future ACAP budget reduction.

(2) Expand the ACAP operating budget to maintain a viable program to serve SMs and their Families.

(3) Maintain professional staff to provide personalized services currently available.

**g. Issue History.** This was an OCONUS direct submit issue to the Nov 06 GOSC.

**h. Progress.**

(1) In June 2007, the Lean Six Sigma study conducted by ASA(M&RA) recommended improving ACAP by expanding accessibility for Soldiers to ACAP utilizing WEB services. Implemented as ACAP Express, it allows Soldiers to access the menu of available ACAP services and

schedule appointments for themselves from any location via the internet 24/7 and was launched 28 February 2008. Eligible Soldiers utilize tools such as resume writer from the world-wide web in the same manner they would at an ACAP Center. If they begin ACAP early on in the transition process, Soldiers and Family members are more able to utilize individual transition counseling and employment assistance offered by ACAP, and subsequently are more prepared for their transition.

(2) ACAP Express was evaluated in February 2009 and found to be successful. In the first year, over 10,000 Soldiers registered and utilized ACAP Express. For FY 10, 21,675 users utilized ACAP Express, and for the first 2 quarters of FY 11, 14,812 users utilized ACAP Express. Soldier feedback critiques are supportive of ACAP Express, and request additional tools be placed on-line. Although ACAP Express eases the burden on the ACAP staff by allowing some self-service, the mission continues to increase with support to the WTUs and AW2 populations, and supporting the G-1's Continuum of Service concept with additional emphasis on transition to National Guard and Army Reserve, as well as Army Civilian Employment. For example, the Department of Army Civilian Human Resource Agency, AW2 Operations Division and ACAP have developed a process to bypass the resumix system for all AW2 Soldiers. 334 AW2 Soldiers were hired during FY 10. These focused efforts will continue and expand.

(3) Issue was considered by the AFAP GOSC 1 July 2009. Several attendees emphasized the value of ACAP services, in particular to OCONUS Soldiers, demobilizing National Guard and Reserve Soldiers and Wounded Warriors. Other discussion addressed a secondary issue of updating ACAP service delivery and consideration of strategies utilized by online civilian employment services. The VCSA said that ACAP is a viable program that the Army needs to fund and said he would take this issue into budget discussions, and the issue remains active.

(4) A meeting with the Assistant Chief of Staff for Installation Management, Resource Directorate (ACSIM-RD) on 28 July 2009 between the Director ACAP and Deputy Chief, Resource Integration Division subsequently supported AFAP Issue 612 and a commitment was made to restore an additional \$1M if II PEG Total Obligation Authority (TOA) level permits. To date, Army has provided an additional \$800K in FY 11 in support of AFAP Issue 612. An update will be provided to the VCSA during the next AFAP GOSC. This issue went before the II PEG for POM FY 12-17 in an effort to restore an appropriate level of funding, and was favorably received.

(5) In support of AFAP Issue 612, the Army recently increased the ACAP funding by \$1M annually through FYs 12-16; resulting in a funded level of \$5.8M per year.

(6) On 1 April 2010, the VCSA directed a bottoms-up review of ACAP and commissioned the United States Military Academy to independently review and determine whether ACAP meets the needs of the Soldiers of the 21<sup>st</sup> century. The VCSA received the formal report in October, which included 16 Determinative Wins.

(7) Issue was considered by the AFAP GOSC 3 February 2011. The Chief of the Army Reserve said they may be able to assist by deploying full-time personnel into

ACAP to help enhance it. The draft ACAP Regulation is including Reserve Components to assist Army Reserve/National Guard with defined Roles and Responsibilities. It is scheduled to be sent to OCAR and NGB for their input 1<sup>st</sup> quarter FY 12. This will be a tremendous boost to reaching Reserve component Soldiers who often do not reside within commuting distance of an ACAP center and therefore miss out on critical services to assist in their transition.

(8) During AFAP GOSC 3 February 2011, the VCSA, GEN Chiarelli indicated that Commanders should allow their Soldiers the time to utilize ACAP services. He stated that "we owe our Soldiers the opportunity to take advantage of ACAP, because it really gives them a great opportunity to make the transition into civilian life as painless as possible." He followed up with a "VCSA Sends" memo stating "As leaders, it is paramount to ensure every transitioning Soldier visits an ACAP center not later than 12 months prior to their departure from the Army."

(9) ACAP will not be able to maintain its current level of support to Soldiers and their Families, implement all the recommended 16 Determinative Wins, or provide service to the additional 27,000 Soldiers identified to leave the Army under Secretary Gates' proposed Army end strength without additional funding. Any decrement in funding and lack of additional resources will result in a failure to meet the VCSA's intent of caring for Soldiers and Families as a critical leader task.

(10) GOSC Review.

(a) Dec 07. The GOSC requested the issue remain active.

(b) Feb 11. The issue remains active. The Chief, Army Reserve talked about how the Army Reserve can be part of the solution and said they are looking at possibly deploying full-time personnel into ACAP to help enhance it. The VCSA noted that commanders tend to not allow Soldiers to go to ACAP until they are so close to leaving the Service that they can't take full advantage of ACAP services. He told attendees that the message to take back to their posts, camps and stations is that we owe our Soldiers the opportunity to take advantage of ACAP, because it really gives them a great opportunity to make the transition into civilian life as painless as possible. AHRC will continue to monitor the USMA ACAP Study Group and report to the VCSA.

(c) Aug 11. AHRC will Synchronize roles/responsibilities, choice-based options and RC transition in new regulation and policy.

**h. Lead agency.** AHRC-PDP-T

## **Issue 614: Comprehensive Behavioral Health Program for Children**

**a. Status.** Active

**b. Entered.** AFAP XXIV, Dec 07

**c. Final action.** No (Updated: 8 July 11)

**d. Subject area.** Medical/Command

**e. Scope.** Multiple barriers exist in providing timely, convenient and appropriate Behavioral Health Care Services for children of Active Duty Soldiers, Wounded Warriors and Veterans. There is a critical shortage of Behavioral Health Care Child and Adolescent Providers to meet the current demand. Many Behavioral Health

providers are unable to dedicate their entire practice to children's therapy due to occupying administrative positions and performing adult behavioral health care. For example, 504 child psychiatric providers were contacted and only 13% stated they were providing full time child psychiatric services. The difficulty in recruiting and training direct care providers and a lack of a national educational plan to raise awareness in schools and identify treatment needs, further exacerbate the problem. Comprehensive services are not readily available, nor aligned with other ranges of services for military children, thus creating unneeded barriers to quality Behavioral Health Care.

**f. AFAP Recommendations.**

(1) Create and implement a unified, comprehensive source of Children's Behavioral Health Services (Psychiatrists, Psychologists and Social Workers) with dedicated providers and timely access to care, working in concert, for children of all Soldiers.

(2) Increase, integrate and streamline existing Behavioral Health Support Services with other counseling services (Military Family Life Consultant, Morale Welfare and Recreation, Chaplain, Child Youth Services, Military Child Education Coalition) to provide a comprehensive range of Behavioral Health Services for children of all Soldiers.

**g. Progress.**

(1) The Child, Adolescent and Family Behavioral Health Office (CAF-BHO), established in FY10, is located at Fort Lewis WA. The CAF-BHO is an integral part of the Army's force generation and deployment processes through its support and sustainment of comprehensive and integrated behavioral health system of care for Military Children and their Families.

a. Preliminary Needs and Capabilities Assessments have been conducted by the Child, Adolescent and Family Behavioral Health Office (CAF-BHO) at the following installations, to include: Schofield Barracks, Joint Base Lewis McCord, Fort Carson, Fort Wainwright, USAG Bavaria, Fort Bliss, Fort Hood, Fort Campbell, and USAG Landstuhl. Additional sites selected for preliminary assessments include Fort Drum, Fort Bragg, Fort Stewart, Fort Polk and Fort Meade.

b. Criteria for site selection include: (1) Population Size/Deployable Soldiers, (2) Operation Tempo, (3) Projected Growth, (4) BH Needs, (5) Rollout Posture (BH Champion, (6) Local BH Infrastructure, and Facilities).

c. A standardized comprehensive BH Need and Capabilities Assessment Tool is in development by CAF-BHO with support from Public Health Command.

(2) The CAF-BHO continues to focus on 4 key tasks designed to increase access for Military Children and Families to behavioral health services by:

a. Promoting coordination and integration of Child and Family programs at the Army and installation level

b. Developing and providing behavioral health models for schools and civilian communities that promote prevention, early detection and delivery of care.

c. Providing coaching and training programs for primary care clinicians in the evaluation and management of common behavioral health disorders.

d. Centralizing and standardizing data collection for needs identification, outcome measurement and performance improvement.

e. The CAF-BHO has recruited a team of 20 personnel to support the mission in the following divisions: (1) Outreach, (2) Training, (3) Evaluation, (4) Strategic Communication.

(3) The CAF-BHO interface with organizations, universities, and subject matter experts throughout the nation has allowed for increased marketing opportunities to recruit Child/Adolescent behavioral health providers. The CAF-BHO Strategic Communications Division has been created to play a key role in designing marketing strategies for decreasing stigma associated with behavioral health, collaborating in development of an information/education website for Child, Family, Providers, and Commanders, collaborating with military and civilian agencies in developing Communities of Practice and Systems of Care for Children and Families.

(4) The task of the Outreach Section of the CAF-BHP is to assist and support the development of an Integrated Comprehensive BH Delivery System promoting optimal force readiness, wellness, and resilience in Army Children and Families. The CAF-BHO/Outreach Section directly assists installations in determining their needs and capabilities in providing BH care for Families and Children. Through the development and implementation of a standardized Need and Capabilities Assessment Tool, CAF-BHO will improve their ability to recommend improved coordination/integration of Child and Family BH Services. Schofield Barracks has successfully integrated BH clinics to provide care for Soldiers and their Families.

(5) The CAFAC pilot at Joint Base Lewis McCord has successfully integrated Child and Family direct BH services to include the Preventive Intervention Program Licensed Marriage and Family Therapists, Family Assistance for Maintaining Excellence (FAME), the Child Guidance Clinic and the School Behavioral Health Program under one comprehensive integrated system of care. CAFAC is further coordinating efforts with the JBLM Medical Home to improve referral and coordination of care. Fort Carson has recently established a pilot CAFAC and School Behavioral Health Program. The pilot plans to coordinate/integrate care with the Fort Carson Medical Home and Embedded Behavioral Health (eBH) care for Soldiers. The CAFAC facility at Fort Wainwright is under construction and hiring is in progress. Additional sites have been identified for proliferation utilizing standardized criteria. A CAF-BHO standardized CAFAC training workshop is in development and is scheduled for June 2011.

(6) The task of the Training Division of the CAF-BHP is to develop and implement behavioral health curricula and training modules for primary care providers and support staff. Evidence-based modules are being developed to promote prevention, early identification, evaluation, and treatment of common BH concerns in a primary care setting. It is expected these modules will become standardized Army training tools to assist in screening and treating Children and Adolescents in Primary Care. The CAF-BHP is collaborating with national SMEs and organizations (American Academy of Pediatrics, American Academy Child and Adolescent psychiatry and American Psy-

chological Association) in developing these curricula to ensure best practices.

(7) Army Primary Care providers and support personnel will be provided opportunities for behavioral health training by the CAF-BHP to assist in screening common behavioral health concerns, identification of problematic functioning, effective intervention strategies in primary care, and referral guidelines to specialty behavioral health care. Standardized Behavioral Health Pilot Training for Primary Care Managers is scheduled to be provided during 4<sup>th</sup> quarter of FY11 at JBLM.

(8) Army School BH Programs (SBH) currently includes: Tripler, Walter Reed, Bavaria (Grafenwoehr, and Vilsek), Landstuhl (Baumholder), Fort Campbell, Fort Lewis, and Fort Carson. Fort Lewis and Fort Carson have received funding and have begun initial ground work for the new school year. The Fort Lewis MOA has been signed. The Fort Carson MOA remains in progress. Fort Campbell continues to expand.

(9) Army School Behavioral Health Programs are operating successfully at 7 Army installations, in 36 schools. Schofield Barracks, Fort Campbell, Vilseck/Grafenwoehr, Fort Meade, Joint Base Lewis McCord, Baumholder and Fort Carson currently have SBH programs in various stages of development. All programs are reporting positive clinical, process, resource and customer satisfaction outcomes.

(10) A standardized training workshop program at TAMC is provided to all SBH staff across the enterprise. SBH staff from (7) installations and (36) on-post schools with SBH Programs have attended the educational workshop. Plans are in development to transfer the SBH Educational Workshop to JBLM in 2011.

(11) GOSC review.

a. Jun 08. The issue remains active. A representative from the National Military Family Association (NMFA) stated that a research study was presented at the Madigan conference that showed an increase in counseling visits at midpoint of deployment and three months after redeployment. Other attendees noted increase in adolescent incidents on installations. The NMFA has partnered with the Rand Corporation to do a study on deployment and related issues with children. The Surgeon General asked that the study look at the Reserve Component as well as the Active. The VCSA stressed the importance of getting programs and services out to children who need support. He referenced Military One Source and the increased programs and funding in Youth Services.

b. Jan 10. Issue remains active to further develop behavioral health programs in schools and the community. Attendees identified the need to reach children within the RC and Accessions Command and suggested an approach that is not just garrison based. The VCSA commented about the value of online counseling, especially for geographically separated populations.

c. Aug 11. OTSG will increase number of uniformed and civilian child and adolescent providers. Develop Standardized Needs and Capability Assessment tool.

**h. Lead agency.** DASG-HSZ

## **Issue 615: Donation of Leave for Department of Defense (DoD) Civilian Employees**

**a. Status.** Active

**b. Entered.** AFAP XXIV, Dec 07

**c. Final action.** No (Updated: 30 Jun 11)

**d. Subject area.** Employment

**e. Scope.** Voluntary Leave Transfer Program (VLTP)-eligible DoD Civilian employees on leave without pay face avoidable financial hardships. VLTP does not have a common leave bank to which all DoD employees can donate. Additionally, lost annual leave at the end of the year (use or lose) is not automatically deposited into a leave bank. The resultant loss of income only increases the stress and burden already experienced by employees and their Families.

**f. AFAP Recommendation.** Create a DoD-wide leave donation bank within VLTP for DoD Civilian employees funded through both donation and automatic collection of unused use or lose annual leave.

**g. Progress.**

(1) In FY09, in response to HQDA's inquiry concerning the establishment of a DoD-wide Leave Bank, DoD advised there was insufficient need to support a DoD-wide Leave Bank. In 2009, based on command feedback, HQDA determined there was no support to establish an Army-wide Leave Bank either. A follow up query with CPAC Employee Relations Advisors revealed an interest in establishing local Leave Banks. As a result, HQDA drafted an Army Leave Donation Policy in coordination with DFAS, which includes guidance on the VLTP, Leave Banks, and the voluntary donation of annual leave (to include use or lose). The draft was coordinated with the Civilian Human Resources Agency (CHRA) and DFAS. In February 2011, the Office of the Judge Advocate General (OTJAG) recommended changes to the draft policy, which have been incorporated.

(2) HQDA has worked with CHRA, DFAS, and other Federal Agencies on details of local leave banks, to include administration, payroll issues, the creation of an automated database, and levels of control. HQDA worked with DFAS to determine the process for adding and/ or updating the list of organizations/levels that may establish leave banks. The policy is being formally staffed for ASA (M&RA) signature.

(3) Army briefs the topic of leave donations during the annual Defense Employee and Labor Relations Symposium, during training courses for HR Specialists, and continues to provide guidance on improving the existing leave donation methods. At a minimum, reminders are distributed yearly to encourage donations, especially toward the end of the leave year when annual leave might otherwise be subject to forfeiture.

(4) GOSC review.

a. Feb 11. The AFAP GOSC declared the issue active. The Army will monitor DFAS' payroll system change.

b. Aug 11. When policy is released, Issue 615 will be closed as a completed action.

**h. Lead agency.** DAPE-CPZ

**i. Support Agency:** DFAS, CHRA

## **Issue 618: Army Wellness Centers (AWC)**

**a. Status.** Active

**b. Entered.** AFAP XXIV, Dec 07

**c. Final action.** No (Updated 8 Jul 11)

**d. Subject area.** Medical

**e. Scope.** Installations Army wide do not have standardized/consolidated wellness centers that promote preventable health conditions and improve the mental and physical well being of Army Families. According to Army Training Requirements & Resources System from 2003 to 2005, the US Army discharged 2,323 Soldiers due to overweight issues at a direct recruitment and training cost to the US Army of \$61 million which could have been preventable. Due to positive lifestyle changes, Family members utilizing the health and wellness centers have been taken off hypertensive medications. Modeling centers after the United States Army Center for Health Promotion and Preventive Medicine Europe would positively impact the health and welfare of Soldiers and Families throughout the Army.

**f. AFAP Recommendation.** Create an integrated center at each installation (separate from the hospital) modeled after the Europe HAWC.

**g. Progress.**

(1) United States Public Health Command Region-Europe (USAPHCR-E) has completed the setup of 5 Army Wellness Centers. These are located at: Heidelberg - personnel and equipment funded by USAPHCR-E; Stuttgart - personnel and equipment funded by USAPHCR-E; Vicenza - personnel funded by OASD (HA) equipment funded by garrison; Landstuhl - personnel and equipment funded by USAPHCR-E; Grafenwoehr- funded by USPHC(P)'s HPPI program.

(2) USAPHC (P) conducted a survey locating Army Wellness Centers that are currently active. The survey identified staffing and services offered and identified the targeted populations. This provides a starting point for assessing what is currently available and what will be needed to implement the program throughout the Army.

(3) In the 2012-2017 POM USAPHC (P) briefed the Army Wellness Centers as an emerging requirement with an estimated cost of \$44M providing high visibility to the initiative. See above costs.

(4) On 7 January 2010 the Surgeon General was briefed on the USAPHC (P) plans to deliver integrated health promotion thru facilitation of Health Promotion Councils with Health Promotion Coordinators and standardizing Army Wellness Centers throughout Army communities. TSG gave approval of current plans. On 12 January 2010 TSG provided an update to the AFAP GOSC and got further endorsement of the plan from VCSA and CG, IMCOM.

(5) An overarching Memorandum of Agreement between US Army Medical Command, US Army Forces Command, US Army Installation Management Command, US Army Materiel Command, and US Army Training and Doctrine Command regarding the implementation of the USAPHC (P) Health Promotion Initiatives on Army Installations which includes each organizations' responsibilities implementing AWCs on military installations is being forwarded to MEDCOM for staffing after being approved by the CG of USAPHC (P).

(6) On 3 March 2010 CG and members of the USAPHC (P) briefed the following individuals from the organizations as listed at the Pentagon on the USAPHC (P) Health Promotion initiatives that includes AFAP 618, Establishment of Army Wellness Centers. Those in attendance were: Army Suicide Prevention Task Force, MEDCOM Chief of Staff, Deputy of the Well-Being Division, G1, IMCOM Division Surgeon, Comprehensive Soldier Fitness Program and the Office of the Chaplains. The meeting was to inform the other organizations of USAPHC (P) plans and alert them that an MOA regarding the initiative would be coming to them.

(7) USAPHC (P) has begun plans on a Lean Six Sigma Rapid Improvement Event (RIE) to establish current best practices used in AWCs and then will initiate an evaluation of the program using the Public Health Assessment Program in the Directorate of Health Promotion and Wellness.

(8) USAPHC (P) has a representative who regularly participates on the Comprehensive Soldier Fitness (CSF) Program workgroup. USAPHC (P) continues to use that forum to keep the CSF Program informed of progress in establishing the Army Wellness Centers in CONUS. CSF has also been in contact with Heidelberg's Wellness Director in order to get information on the metrics they are using to measure physical fitness for the CSF's Global Assessment Tool (GAT). It incorporates the same metrics developed by USAPHCR-E Heidelberg Wellness Center to measure physical fitness in the Comprehensive Soldier Wellness Program.

(9) USAPHC (P) also has a staff officer working with the Suicide Prevention Task Force (soon to become the Health Promotion and Risk Reduction Task Force) at the Pentagon to provide information to the task force on initiatives that may be relevant to health promotion/suicide reduction initiatives. This representative is no longer serving in this capacity since the Task Force work is now complete, but still provides input when requested by key members of the former Task Force.

(10) During April 2010, USAPHC (P) conducted a RIE to establish best practices used in AWCs throughout the US Army. Thirteen representatives from wellness centers participated in the event. A survey of current wellness center operations indicated 11 CONUS and 5 OCONUS facilities were currently functioning at various capacity. Over 30 wellness programs were identified. OCONUS AWCs reported a core set of programs and processes across an entire region. The RIE produced a core set of programs based on industry best practice as well as recommendations from leading health organizations. A draft Implementation Guide was completed for replication of AWC program. A timeline was established to align current wellness centers into the RIE based AWC model. In addition, new AWCs were projected at FORSCOM installations.

(11) The initial MOA staffing process is with MACOMS. USAPHC (P) is coordinating comments and requests for information, and will resubmit for final review and approval. The current state of progress is:

a. CONUS: FORSCOM – awaiting approval; TRADOC – questions regarding POM; AMC –revising

memo from input; IMCOM – to date all RFIs addressed; MEDCOM - Signed 3 MAY 2010.

b. OCONUS: MEDCOM - TSG signed MOA 6 September 2010. In process of reformatting for IMCOM and USAREUR. IMCOM & USAREUR – awaiting signed memorandum for review/comment/signature.

(12) August to present. USAPHC (P) provided technical support and subject matter expertise for an AWC replication initiative at Fort Bragg, North Carolina. This project required program recommendations, space allocation courses of action, facility design, equipment procurement, and draft marketing plan. Partnerships were established with Womack, XVIII Airborne Corps, and USAPHC (P). The Implementation Plan draft is being written around the developmental experiences of the FT Bragg AWC and lessons learned from previous uncoordinated initiatives. The integration of current community and medical assets provided the personnel and material to establish a new AWC at Fort Bragg by 1 November 2010.

(13) USAPHC(P) will continue to work to get cooperation from other organizations outside of MEDCOM needed to implement the AWC concept. Funding requirements are updated and going into the 2012 – 2017 POM. Initial estimates were underestimated WRT equipment requirements and personnel.

(14) The original resource requirements identified above were submitted to both the Army and Defense Health Program (DHP) Operation and Maintenance 12-17 POM and were not supported. The revised requirements will be re-submitted in the 13-17 PBR.

(15) Program Manager for Army Wellness Centers hired at Army Institute for Public Health (AIPH). MEPEPERS code (FBBW) identified for AWCs meeting standardization requirements. AIPH conducted a thorough program evaluation of AWCs and report is being staffed. Per Army Medical Home Transformation Conference, dated 25-29 April, AWCs will be included in the Patient Center Medical Home model as a key component for assisting patients with initiating lifestyle behavior change. Revision of HPO/AWC MOA updated based on stakeholders comments, presently with ACSIM Surgeon, staffing through ACSIM and approval pending.

(16) On 10 June 2011, quarterly update on AWC presented to LTG Lynch and Mr. Stamilio. LTG Lynch took an aggressive lead to move this issue forward by signing MOA and inviting AIPH DHPW Portfolio Director and AWC Program Manager to present issue at SICE board. On 13 June TSG re-signed MOA and at SICE board LTG Bromberg, FORSCOM Deputy, said he would resign. LTG Lynch took MOA to facilitate signatures from TRADOC, AMC, and FORSCOM. Implementation guide is complete and being staffed through AIPH for final release.

(17) GOSC review.

a. Jun 08. The issue remains active.

b. Jan 10. Issue remains active to proliferate the AWC model across the Army. OTSG and ACSIM addressed the inclusion of Wellness Centers into the Services and Infrastructure Core Enterprise (SICE). Expansion of Wellness Centers is currently focused on active installations, but MEDCOM is willing to partner with

the Reserve Components.

c. Feb 11. The GOSC declared the issue active. The Army Materiel Command (AMC) representative expressed concerns about the inclusion of civilians, but noted that those details are being worked.

d. Aug 11. OTSG will resubmit revised requirements (\$86M) in the 13-17 PBR.

**h. Lead agency.** MHCB-HP

**i. Support agency.** MCHB-TS-H

### **Issue 625: Transitional Compensation (TC) Benefits for Pre-existing Pregnancies of Abused Family Members**

**a. Status.** Active

**b. Entered.** AFAP XXIV, Dec 07

**c. Final action.** No (Updated: 6 Jul 11)

**d. Subject area.** Medical/Command

**e. Scope.** Transitional Compensation (TC) does not account for pre-existing pregnancies when determining TC benefits. The benefit is intended to reduce victim disincentives to reporting abuse by providing transitional compensation to abused Family Members of military personnel who were separated and discharged due to the abuse. Extending TC benefits to unborn children upon birth will increase financial support for abused Families and may encourage reporting of abuse.

**f. AFAP Recommendation.** Extend TC benefits to the unborn children of pre-existing pregnancies upon birth.

**g. Progress.**

(1) In Jan 08, consulted with ASM Research, the contractor that developed the TC database, to determine whether the database tracks pre-existing pregnancies to establish a baseline or scope of the problem. The system does not track this information.

(2) In Feb 08, FMWRC Family Programs (FP) consulted with FMWRC CJA. FMWRC CJA did not recommend supporting the recommendation because it would require a change in the definition of “dependent,” which does not include unborn children.

(3) In Feb 08, FMWRC FP consulted with the US Department of Health and Human Services Children's Bureau, who indicated that services are not made available to unborn children.

(4) In Feb 08, FMWRC FP consulted with OSD (P&R) regarding unborn children and the definition of “dependent.” Changing the definition would require legislation and OUSD (P&R) approval.

(5) In Mar 08, FMWRC FP consulted with the Air Force, Navy, and Marine Corps regarding the extension of TC benefits to unborn children. Navy and Marine Corps do not recognize unborn children as dependents; Air Force did not respond.

(6) In Oct 08, FMWRC CJA stated that a legal definition of “dependent” does not exist that is applicable for all situations. The term “dependent” is outlined in the TC statute.

(7) In Sep 08, at the AFAP IPR it was determined that this issue should be closed as unattainable. However, subsequent to this decision, the Veterans' Benefits Improvement Act of 2008 was passed in Oct 08. This act

extends coverage to an insured member's stillborn child under the Servicemembers' Group Life Insurance (SGLI).

(8) In Sep 09, a VA official informed FMWRC FP that, although the Veteran's Benefit Improvement Act was signed into law, the regulation that provides for the definition of stillborn had not been finalized.

(9) In Sep 09, FMWRC FP consulted with FMWRC CJA regarding the feasibility of VA definition/legislation being applied for TC. FMWRC CJA opined that the VA's decision to include stillborn as an insurable dependent under FSGLI alone does not set a precedent for TC. However, FMWRC CJA indicated that the military justice system has the ability to charge a Soldier for two separate offenses if a Soldier causes injury to a child in utero – one for injury to the mother and one for injury to the unborn child. As a result, FMWRC CJA considered that this recent trend within military justice and the passage of UCMJ articles to cover unborn children in certain circumstances, combined with the VA's recent decision, may be justification to support the request of legislative action to change the TC definition of "dependent."

(10) In Nov 09, regulations implementing section 402 of the Veteran's Improvement Act of 2008 were published in the Federal Register and immediately went into effect. The regulation defines the term "member's stillborn child" and applies to deaths occurring on or after October 10, 2008, the date of enactment of the Veteran's Benefits Improvement Act of 2008.

(11) In Mar 10, OACSIM-ISS consulted with FMWRC CJA to reconfirm support to request a legislative change to the definition of "dependent" in the TC statute. FMWRC CJA supports this change as it is consistent with the intent of the TC Statute.

(12) In Jul 10, OACSIM-ISS submitted a legislative proposal under the FY13A ULB cycle. In Sep 10, OSD sponsored the proposal and it is currently under review.

(13) In Mar 11, the Principal Deputy, Under Secretary of Defense (Personnel and Readiness) approved the ULB. OACSIM-ISS will continue monitoring the progress of this proposal through the omnibus process.

(14) GOSC review.

a. Feb 11. The GOSC declared the issue active. OACSIM will monitor the progress of the FY13A ULB.

b. Aug 11. OACSIM will monitor final language in the FY13 NDAA.

**h. Lead agency.** DAIM-ISS

**i. Support agency.** IMWR-JA

## **Issue 626: Traumatic Servicemembers' Group Life Insurance (TSGLI) for Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and Uniplegia**

**a. Status.** Active

**b. Entered.** AFAP XXIV, Dec 07

**c. Final action.** No (Updated: 8 Jun 11)

**d. Subject area.** Entitlements

**e. Scope.** Servicemembers and Veterans diagnosed with PTSD, TBI (other than leading to coma) as well as Uniplegia receive no immediate Traumatic Servicemembers' Group Life Insurance (TSGLI) payment under current regulatory and compensatory guidelines. These diagnoses, which may or may not stem from physical loss, can and often do lead to financial hardship

for the Servicemembers, Veterans, and Families.

Servicemembers and Veterans who are diagnosed with the conditions cited above may receive monetary compensation from the Physical Disability Evaluation System (PDES) in the future, but receive nothing upon initial diagnoses. Traumatic Servicemembers' Group Life Insurance (TSGLI) already covers TBI when TBI injury results in the inability to carry out at least two of the six activities of daily living and/or coma. Uniplegia (the complete and irreversible paralysis of one limb) by other than amputation is currently not considered in the table of scheduled losses. However, it is being considered for addition. PTSD is not under consideration at this time for payment of TSGLI. Servicemembers and Veterans are forced to make life altering decisions based on the provision of their care, maintaining a viable household, and the potential loss of short and/or long term employment.

**f. AFAP Recommendation.** Add PTSD, TBI, and Uniplegia as a schedule of loss under Traumatic Servicemembers' Group Life Insurance (TSGLI).

**g. Progress.**

(1) The July 2008, TSGLI One Year Review added Uniplegia to the TSGLI Schedule of Losses. Traumatic injury and coma resulting in the inability to perform at least 2 activities of daily living are also covered in the TSGLI Schedule of Losses, when TSGLI standards are met.

(2) The FY 2010 NDAA requires the SECDEF, in consultation with SECVA, to provide a study for on treatment of PTSD to be conducted by institute of Medicine of National Academy of Sciences or other independent study.

(3) Coordinated with the DoD Line of Action 2 Chair, who is tracking this (Sec 726 of the NDAA FY10) requirement. The contract has been awarded and the contract kickoff was held on December 2, 2010. At that time, the contract office representative (COR) and the action officer met with the Institute of Medicine (IOM) project manager. IOM finalized the committee membership and conducted the first meeting from February 28 through March 1, 2011. A new COR was identified on April 21, 2011, and attended the open session at the Institute of Medicine on that day. At this meeting, the committee received briefings from: the National Center for PTSD; Veterans Affairs, Evaluation Division; the Chief Readjustment Counseling Officer, Veterans Health Administration; the Associate Director, VISN 6, Mental Illness Research; the National Military Family Association; and the Director of the Army's RESPECT- Mil program in the Department of Defense. The committee received a presentation from an enlisted Marine with PTSD. Finally, the committee allowed opportunity for public comment. On April 25, 2011, the IOM Program Officer and the new COR conducted a follow-up meeting. The IOM team reported that they will be requesting the assistance of the COR to conduct a site visit to Fort Hood in September, 2011.

(4) GOSC review.

a. Jun 08. The issue remains active.

b. Feb 11. The issue remains active. Army G-1 will monitor the results of the IOM study.

c. Aug 11. The July 2008 TSGLI One Year Review added Uniplegia to the TSGLI Schedule of Losses.

Traumatic injury and coma resulting in the inability to perform at least two activities of daily living (ADLs) are also covered in the TSGLI Schedule of Losses, when TSGLI standards are met. PTSD is still excluded. The FY10 NDAA requires a study on the treatment of PTSD by the Institute of Medicine (IOM) of the National Academy of Sciences or other independent study. Contract was awarded; committee meetings and site visits are occurring.

**h. Lead agency.** DAPE-PRC

**i. Support agency.** VA

### **Issue 629: 24/7 Out of Area TRICARE Prime Urgent Care Authorization and Referrals**

**a. Status.** Active

**b. Entered.** AFAP XXV, Jan 09

**c. Final action.** No (Updated: 8 Jul 11)

**d. Subject area.** Medical

**e. Scope.** TRICARE Prime beneficiaries are unable to obtain 24/7 out of area authorizations and referral assistance for urgent healthcare services. Beneficiaries are required to obtain authorizations from their enrollment sites in order to receive urgent care when traveling outside of their area. TRICARE beneficiaries do not have a streamline one call/one resolution process when urgent care needs are required. Out of area referral/authorization process is confusing, untimely, does not help beneficiaries find needed care and imposes an unnecessary demand while traveling.

**f. Conference Recommendation.** Establish a 24/7 centralized toll free process for TRICARE beneficiaries to request and acquire out of area urgent care authorization and referral assistance.

#### **g. Progress.**

(1) The Army Surgeon General made a personal request to the TMA Deputy Director regarding this issue and requesting the highest attention by TMA. A TMA POC was identified and he was provided the AFAP Issue and supporting documentation on its value added to the MHS and how this effort ties into other MHS business design improvements.

(2) The DoD/MHS Innovation Investment Process (IIP) was already undertaking a study of NAL usage to support TRICARE Prime beneficiaries and the Medical Home model of healthcare delivery.

(3) On 3 Apr 09, TMA released an official tasker to their three TRICARE Regional Offices (TROs) and all three Services, that requested input into implementation alternatives to execute this AFAP issue's recommendation to provide for a 24/7 centralized HOTLINE to support out-of-area urgent healthcare requests and facility/provider locator functions. The MEDCOM coordinated with its sister Services to encourage a unified recommendation to TMA.

(4) On 9 Jun 09, an official memo from TMA informed the Services of TMA's decision regarding the 24/7 centralized, toll-free process tasker. TMA did not accept the AMEDD proposed solution or any of its components. TMA endorsed a different process for single out-of-area encounter authorization by the TRICARE regional contractors. However, o/a 18 Aug 09, the Services were informed in two separate Enterprise Working Groups that

this TMA memo was to be rescinded. Exact reasons for rescinding the memo is unknown; however, the ability of the TRICARE regional contractors to execute without a current contract modification was cited.

(5) On 12 Dec 09, another official TMA tasking to the Services for comments regarding the same issue identified in their 9 Jun 09 tasker. The AMEDD sent forward a 14 Jan 10 DSG Memo informing TMA that the AMEDD was again requesting the re-establishment of Title 32 Code of Federal Regulations requirements for an active Health Care Finder (HCF) program, managed by the regional TRICARE contractors; plus the AMEDD informed TMA of the potential dis-connected efforts to reinstate the HCF under the current TRICARE contracts while at the same time working the IIP effort to provide another contract to support a CONUS-wide HCF functions along with the NAL. As part of our official reply the AMEDD also provided our original 15 May 09 reply after the original recommendations were verified as still appropriate.

(6) On Feb 10, the IIP Board of Directors approved a call for Service representatives to assist in the review the Request for Information (RFI) from industry, and to begin the work of drafting a Request for Proposal (RFP) to solicit a vendor that would provide a CONUS-wide centralized NAL and referral assistance service. Once procured, this new contracted functionality would meet the needs of the AFAP recommendations, but only in CONUS.

(7) Timelines for implementation of IIP NAL cannot be finalized until the Enterprise working group has been officially called together; however, projected timelines based on scope of program is as follows: (1) RFI review by 30 Jun 10; (2) RFP crafting by 31 Oct 10; (3) solicitation and selection by 30 Jan 11; and (4) start of work 30 Jun 11. These timelines are the action officers' best guess determined from past experience of contract movement of this scope and size.

(8) The timelines defined in 5.c above slipped to the right: (1) RFI review completed on 14 Oct 10; (2) RFP 1<sup>st</sup> DRAFT anticipated by 31 Nov 10; (3) solicitation and selection by 30 Jun 11; and (4) start of work 30 Dec 11.

(9) The timelines for "(2)" were provided by OASD(HA) and the timelines for "(3)" and "(4)" were the action officers' best guess determined from past experience of contract movement of this scope and size.

(10) The timelines for completion of key deliverables continues to slip to the right. There has been no change in DoD, TMA, or Service support for the NAL, but crafting of the RFP to completion has slowed to ensure the RFP is accurate and appropriate.

(11) The current projected timelines for the RFP and source selection are now under procurement sensitive realm, thus projected timelines can only be given in quarters: (1) RFP completion by mid 3<sup>rd</sup> quarter FY11; (2) solicitation and selection in 4<sup>th</sup> quarter FY11; and (3) implementation of NAL services by end of 3<sup>rd</sup> quarter FY12.

(12) Based on the Feb 11 HQDA AFAP GOSC's recommendations, MEDCOM requests that this issue remain ACTIVE until the selection of a vendor has been completed. The movement of the Enterprise WG is on target to meet the intent of this AFAP issue and has strong backing of ASD(HA)/TMA and the Services. There is one

caveat to this working NAL proposal; it is a centralized NAL for CONUS only at this time. Discussions within the WG show strong intent to move toward global application once the CONUS contract has been established. Currently our Europe-based beneficiaries have a centralized NAL for at home use, and when all our OCONUS enrollees travel, they have the use of the current TRICARE Overseas Program contractor's 24/7 Hot-Line for urgent/emergent medical assistance.

(13) GOSC review.

a. Feb 11. The GOSC declared the issue active.

b. Aug 11. OTSG will finalize drafting and release of the RFP by the Enterprise NAL Working Group.

h. Lead agency. MCHO-CL-M

i. Support agency. TMA

#### **Issue 634: Death Gratuity for Beneficiaries of Department of the Army (DA) Civilians**

**a. Status.** Active

**b. Entered.** AFAP XXV, Jan 09

**c. Final action.** No (Updated: 30 Jun 11)

**d. Subject area.** Employment

**e. Scope.** The preferred beneficiary of a Department of the Army (DA) Civilian killed in a military contingency operation is not always allowed to receive 100% of the Death Gratuity. The law permits those DA Civilians' eligible survivors (spouse, children, and parents, siblings) to receive up to 100% of the Death Gratuity. Other survivor beneficiaries (foster child, fiancée, grandparent, uncle, etc), are only authorized up to 50% of the Death Gratuity; the remaining amount is paid to an eligible survivor or remains with the government. Soldiers' beneficiaries are authorized to receive 100% of their Death Gratuity regardless of their relationship to the Soldier. By differentiating between DA Civilian beneficiaries, the government fails to fully recognize the significance of all survivors' loss.

**f. Conference Recommendation.** Authorize 100% of the Death Gratuity to be paid to any person(s) designated by the DA Civilian regardless of their relationship.

**g. Progress.**

(1) DAPE-CP researched similar modification of Public Law 110-181 (10 U.S.C. Section 1477) pertaining to Armed Forces Service Members dated 1 July 2008 to designate 100% to any person as the beneficiary of the \$100,000 Death Gratuity benefit.

(2) Change in legislation to modify Public Law 110-181 (5 U.S.C. Section 8102a) to reflect the same law for DA Civilian beneficiaries has been uploaded into the ULB database on 1 March 2010 with submission to OSD and is on track for FY12 ULB Cycle.

(3) Issue has been reviewed and approved by OSD and Other Services to move forward through the Omnibus process on 24 September 2010.

(4) In June 2011, the death gratuity legislative proposal has been included in the House and Senate Armed Services Committee versions of the FY12 NDAA submission.

(5) AG-1 CP is continuing to engage the legislative process to achieve affirmative results in the finalization process of the FY12 NDAA.

(6) GOSC review.

a. Feb 11. The GOSC declared the issue active. The Army will monitor the FY12 ULB legislative proposal to authorize 100% of a DA Civilian employee's death gratuity (\$100,000) to any person designated by the DA Civilian.

b. Aug 11. DAPE-CP will monitor final language and enactment of this legislation into the FY12 NDAA.

**h. Lead agency.** DAPE-CPZ

#### **Issue 638: Medical Nutrition Therapy (MNT) Benefits for All TRICARE Beneficiaries**

**a. Status.** Active

**b. Entered.** AFAP XXV, Jan 09

**c. Final action.** No (Updated: 8 Jul 11)

**d. Subject area.** Medical

**e. Scope.** Medical Nutrition Therapy (MNT) is not a TRICARE benefit. MNT is the assessment and appropriate use of Nutrition therapy for a patient. It is provided at Military Treatment Facilities (MTF) that have dietitians on staff, but is not always available due to deployments, duty station, and appointment availability. Research shows MNT plays a vital role in wellness and disease management. A study done by the Lewin Group, Inc. in 1998, found that cost savings generated from a reduction in both inpatient and outpatient utilization of health care services over time as a direct result of MNT. They estimated \$6.2 M in potential TRICARE cost avoidance savings annually once MNT benefits are achieved. Providing this TRICARE benefit will reduce out of pocket expenses for beneficiaries and reduce overall healthcare costs for TRICARE.

**f. Conference Recommendation.** Establish MNT as a TRICARE Benefit for all TRICARE beneficiaries.

**g. Progress.**

(1) In January 1997, Army and Air Force dietitians briefed the Assistant Secretary of Defense (ASD) for Health Affairs (HA), on the issue of including MNT as a uniform and authorized benefit across TRICARE. The ASD (HA) supported the importance of MNT. He felt that MNT was under-utilized within the Military Health System (MHS), and established HA policy (97-055) to establish MNT as an intrinsic element of clinical practice, through inclusion as part of demand management, disease management (e.g., practice guidelines), and discharge planning.

(2) The Lewin Group, Inc. was awarded an OSD (HA) contract in 1998 to study the cost of covering MNT services under TRICARE. As noted earlier, they estimated a cost savings in excess of \$3M annually. The Army DSG submitted a tri-service proposal for outpatient MNT as a TRICARE benefit in Jul 99. On 10 Jan 01, TMA submitted this proposal for internal review as a potential new benefit; it was not approved due to funding limitations.

(3) In December 2000, Congress passed and President Clinton signed a Medicare Part B, Medical Nutrition Therapy provision as part of Benefits Improvement and Protection Act, P.L. 106-554. This benefit became effective in January 2002, and was limited to patients diagnosed with diabetes and/or renal disease based upon cost projections by the Congressional Budget Office. The benefit was contingent on a referral from a physician, and

services were covered only if performed by a registered licensed dietitian.

(4) In December 2003, the Medicare Prescription Drug Improvement and Modernization Act (H.R. 1) was passed into law. It contained two major new benefits which increased utilization of the Medicare MNT benefit including the Medicare Health Support Program and the Initial Preventive Physical Exam. The Medicare Medical Nutrition Therapy Act of 2005 (H.R. 1582 and S. 604), a bill that gives the authority to expand the MNT benefits to include any disease, disorder, or condition deemed medically reasonable and necessary, was introduced in Congress, however was not passed. In the Medicare Physician Fee Schedule Final Rule for 2005, CMS expanded the list of Medicare tele-health services to include individual MNT.

(5) Medicare has historically set the pace for other third party payers, and this is especially true for MNT services for disease management. Today, many civilian health care plans through Cigna, Aetna, Blue Cross/Blue Shield, and Humana, among others, cover MNT for various diagnosis including hypertension, hyperlipidemia, obesity, cancer, and eating disorders.

(6) In July 2008, the Medicare Improvements for Patients and Providers Act was passed which establishes a procedure by which Medicare may expand coverage of preventive services, including MNT. As evident in research, diet plays an essential role in sustaining human health, maintaining, and enhancing mental performance, and improving physical capabilities. Today, this concept is strongly supported and advocated today by the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) and the Comprehensive Soldier Fitness Program, part of the U.S. Army Posture Statement (2009). Both entities promote and link the five domains of health for Soldiers and their Families, ensuring a fit, ready force.

(7) TRICARE authorizes some inpatient and outpatient nutrition therapies and specifically excludes others, like obesity and weight management. Recently, TRICARE completed a Weight Management Demonstration Project, and based on evidence from this study, may change the coverage for this particular diagnosis.

(8) In Sep 2009, the MEDCOM Judge Advocate General provided a preliminary review of the problem and has determined 2 specific issues that need addressing: (1) is MNT a necessary medical treatment as required by 10 USC 1079, and (2) are registered dietitians an authorized TRICARE provider? A statutory change (10 USC 1079 and 32 CFR, 199.6) will likely be required for both issues. The first one depending on how expansive the MNT coverage will be (disease management and/or prevention and wellness e.g., obesity), and the second issue to add registered dietitians to the approved provider list.

(9) The value of MNT as a TRICARE benefit has many advantages: it resolves the current lack of a uniform benefit for this clinical service; it benefits the patient by improving their quality of life and encourages active participation in managing their medical condition; and it supports the 2007 DoD Task Force on the Future of Military Health Care's recommendations to promote wellness thereby optimize readiness and beneficiary health. The current national debate on health care reform has led health

care providers and payers to develop new approaches to meet the challenges of cost containment and quality care. Dietetics professionals are key members of the health care team and are uniquely qualified to provide medical nutrition therapy as an essential reimbursable component of comprehensive health care services.

(10) In July 2010, a formal request to TMA was prepared and staffed within OTSG for final revision. This memo will ask TMA to consider adding MNT as a TRICARE benefit for all TRICARE beneficiaries, and will ascertain TMA's current position on this issue.

(11) In October 2010, OSTG received a response from the Office of the Assistant Secretary of Defense Health Affairs (OSD (HA)) stating that their Medical Benefits & reimbursement Branch (MB&RB) will conduct an analysis of the requested change and a literature review on MNT to determine if it is a safe and effective medical treatment and what conditions it treats. Once the review is completed, a decision paper will be developed and options for coverage will be considered. If the decision is made to cover MNT under TRICARE, OSD (HA) will pursue the regulatory change necessary to allow registered dietitians to render MNT to TRICARE beneficiaries.

(12) In April 2011, TMA reported an analysis was completed on the issue of TRICARE coverage of MNT for diabetes, renal disease, hypertension, and hyperlipidemia. A decision paper will be submitted to TMA leadership for consideration within the next couple of weeks. This decision paper will provide options for TRICARE coverage of outpatient MNT for the conditions listed above. If approved, coverage of MNT for any, some, or all of these conditions and the required regulatory changes will be initiated. Additionally, the Office of the Chief Medical Officer (OCMO) in Falls Church VA is working the specific issue of TRICARE coverage of the treatment of obesity (including MNT as a treatment for obesity). However, it must be noted that treatment of obesity, when it is the sole or major condition being treated, is currently excluded by statute.

(13) On 9 June 2011, TMA indicated that the decision paper would shortly go into coordination. If approved by the TMA Director, the process of drafting the regulatory language required to implement the benefit would begin soon thereafter. The rule making process averages 18-24 months from drafting the proposed rule to publication of the final rule in the Federal Register.

(14) GOSC review.

a. Feb 11. The GOSC declared the issue active as they await TMA analysis and decision.

b. Aug 11. OTSG will submit decision paper to TMA leadership. Once approved, initiate necessary regulatory changes.

**h. Lead agency.** MCHO-CL-R

**i. Support agency.** TRICARE Management Activity

#### **Issue 641: Over Medication Prevention and Alternative Treatment for Military Healthcare System Beneficiaries**

**a. Status.** Active

**b. Entered.** AFAP XXV, Jan 09

**c. Final action.** No (Updated: 8 Jul 11)

**d. Subject area.** Medical

**e. Scope.** No comprehensive strategy exists for over medication prevention and alternative treatment options for Military Healthcare System beneficiaries. Those suffering from injuries/illnesses are often over medicated because alternative treatment options are not readily available. Patients, Families and providers are not adequately educated about over medication and alternative treatment options. The lack of alternative treatment options and/or rehabilitative resources for all beneficiaries contributes to over medication and adversely impacts function and quality of life.

**f. Conference Recommendation.** Authorize and implement a comprehensive strategy to optimize function and manage pain including but not limited to alternative therapy and patient/provider education for all Military Healthcare System beneficiaries.

**g. Progress.**

(1) In October, 2008 the Proponency Office for Rehabilitation & Reintegration (PR&R) at the Army Office of The Surgeon General (OTSG) established a Pain Management Work Group to assess current state of pain management in Army medicine and to provide a roadmap to immediate, effective, efficient, multi-modal approaches to pain management across Army Medical Command.

a. Group membership included military, Veterans Administration and civilian medicine representatives.

b. Developed and completed task list of "quick wins" to clearly identify group priorities; determine disciplines required for mission success; draft "Army version" of AF Opioid policy for chronic pain; develop brief to TSG to advocate establishing Pain Consultant; and expedite review/revision of DoD/VA CPG for Opioid Therapy.

c. Developed task list of complex objectives/goals for group: creation of MEDCOM Pain Clinic template and begin development of Pain Management OPORD.

d. Developing manpower and other resource requirements necessary to complete evaluation of MEDCOM pain management capabilities and develop comprehensive pain management strategy for the MEDCOM.

(2) In August 2009, the Surgeon General chartered the Pain Management Task Force to focus resources and attention on the issue of pain management in the US Army Medical Command.

a. Assistant Surgeon General for Force Projection (ASG FP) appointed as TF Chairperson.

b. The Army Pain Management Task Force made recommendations for improving clinical, administrative, and research processes involved with the provision of pain management care and services at MEDCOM facilities.

c. Areas for analysis and recommendation included, but not limited to: existing pain management policies, procedures, and resources; best practices for pain management; and ongoing pain management research efforts with emphasis on optimizing delivery of effective pain management, minimizing complications, and maximizing function.

(3) 2010 NDAA mandates that not later than 31 March 2011, the Secretary of Defense shall develop and implement a comprehensive policy on pain management by the military health care system.

(4) May 2010, Pain Management Task Force completed its report. TSG directs MEDCOM to operationalize task force recommendations into Comprehensive Pain Management Campaign Plan.

(5) In September of 2010, the Comprehensive Pain Management CaOTSG will mpaign Plan OPORD was published that directs implementation of Pain TF recommendations to provide for pain management that is holistic, multidisciplinary, and multimodal in its approach, utilizes state of the art/science modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain.

(6) Phased implementation of CPMCP is ongoing across MEDCOM.

(7) GOSC review.

a. Jan 10. The GOSC declared the issue active pending policy development and standardization across the Army.

b. Aug 11. OTSG will conduct phased implementation of CPMCP across MEDCOM.

**h. Lead agency.** DASG-HSZ

**Issue 644: Shortages of Medical Providers in Military Treatment Facilities (MTF)**

**a. Status.** Active

**b. Entered.** AFAP XXV, Jan 09

**c. Final action.** No (Updated: 8 Jul 11)

**d. Subject area.** Medical

**e. Scope.** Demand for healthcare exceeds provider availability in MTFs. The Army's projected growth will further increase this demand. Statutes limit salaries, incentives and contracts which exacerbate recruiting and retaining adequate numbers of medical providers. The lack of providers affects timeliness of medical services, impacts Soldier medical readiness and the health of Family members and Retirees.

**f. Conference Recommendation.**

(1) Expedite staffing of military, civilian, and contracted medical providers to support prioritized needs as identified by the MTF Commander.

(2) Implement new strategies for recruiting and retaining medical providers for MTFs.

**g. Progress.**

(1) The MEDCOM HCDP is a coordinated effort between US Army Human Resources Command (HRC) and MEDCOM to properly distribute military human capital assets across the MEDCOM. All Human Capital resources (Military, Civilian, and Contractor) are taken into account during development of the plan. The HRC managers coordinate and balance the needs of the Army with the Soldier's needs to distribute personnel according to the HCDP. The Fall HCDP Conference is held to develop the HCDP for the upcoming Fiscal Year. During the Spring HCDP Conference, the HCDP approved during the Fall conference is validated and adjusted as needed to ensure the approved plan provides equitable distribution while meeting the Army, MEDCOM, and MTF Commanders' requirements. The HCDP Flag Officer Strategic Session was again held in conjunction with the annual Medical Symposium (May 2010). Topics of discussion were of strategic importance to the Army Medical Department (AMEDD), and the Flag Officers present will

provide strategic manning guidance for the upcoming HCDP cycle (FY12). The HCDP process now includes Veterinary Corps officers and selected Enlisted specialties.

(2) Delegation of the Direct Hire Appointment (DHA) authority for the 24 health-care occupations authorized under the Department of Defense and Full-Year Continuing Appropriations Act of 2011 from Army is imminent. Most importantly, it is expected that DoD will delegate the Expedited Hiring Authority (EHA) granted by the National Defense Authorization Act of 2011 (NDAAFY11), Section 1104, for these same occupations by 30 September 2010. The FY 11 NDAA grants the SECDEF the ability to authorize the use of EHA for healthcare occupations that meet the criteria of "shortage category" or "critical need", removed "highly" from the qualifying criteria, and extended the use of the authority until 31 December 2015. Additionally, the legislation allows the SECDEF to add shortage or critical need occupations which meet the criteria without seeking further Congressional approval.

(3) Despite the best efforts of contractors, contracting offices, and MTFs to provide robust incentives, certain provider positions at remote and other hard-to-fill locations remain unfilled. In order to improve contract administration and reduce the lead time for awarding contracts, the Surgeon General delegated expedited hiring authority on 17 July 2009 for more rapid hiring of contracting professionals. Additionally, the US Army Manpower Analysis Agency (USAMAA) concluded a manpower analysis that identified a shortfall in contracting administration and recommended an increase of 117 additional contracting authorizations to improve all phases of contracting.

(4) The MEDCOM supports the United States Army Recruiting Command (USAREC) Medical Recruiting Brigade (MRB) with military providers to leverage peer-to-peer recruitment. USAREC and MEDCOM will enhance these efforts through the establishment of an enterprise partnership approach with OCAR that aligns regional recruiting efforts for synergy and responsibility. In FY 10, the Brigade achieved 100% of the Regular Army recruiting mission by commissioning 907 AMEDD Officers onto Active Duty, and reached 89% of the Army Reserve mission by commissioning 828 AMEDD Officers into the US Army Reserve (USAR). As of 31 March 2011, USAREC has achieved 44% of its RA mission (440/1003) and 46% of its USAR mission (852/1834). As of 29 April USAREC was on track to achieve 55 of 93 AMEDD specialties, exceeding last year's record of 46 of 93. Health Professional Scholarships (HPSP) continues to be successful. Direct accessions are projected to be the best in over five years. USAREC continues to leverage the Critical War-time Skills Accession Bonus (CWSAB) and the Health Professional Loan Repayment Program (HPLRP) to match that of the regular Army in order to attract and recruit highly skilled medical professionals.

(5) The Military Accessions Vital to the National Interest was established in February 2009. Under this pilot program, the Army recruits legal aliens who are Health Care Professionals in specific areas of concentrations necessary for present and future military operations. As

of 1 April 2011, this program was not approved for accessions in FY 11.

(6) The Officer Accession Pilot Program Option Charlie allows healthcare providers (ages 43-60) to serve in the Army (AC or USAR) with a two year Military Service Obligation (MSO) as opposed to the standard eight year MSO. As of 1 May 2011, 9 officers have boarded for OAPP (three Medical Corps, four Medical Service Corps, and two Army Medical Specialists Corps). Of these 9, three have signed letters of intent to access into the Army. 2 are USAR (1 MS, 1 MC) and 1 is RA (MS).

(7) The Army critical funding level for health professions special pays for the FY10 Program Objectives Memorandum (POM) was \$243.6M, an increase of \$38.2M over FY09. This increase recognizes the expansion of special pays under Section 335 of Title 37, which now includes licensed Clinical Psychologists and Social Work Officers. The actual funded amount in the FY10 budget was \$222M, an increase of \$16.6M.

(8) 459 Physicians and 6 Dentists will transition to the Physicians and Dentists Pay Plan (PDPP) effective 8 May 2011, followed by an additional 87 physicians upon completion of impact and implementation bargaining at Fort Bragg and Fort Stewart. The long awaited Pay Plan for DoD Civilian Physicians and Dentists Covered by the General Schedule is being implemented DoD-wide. The NSPS physicians and dentists (total of 910) will transition to PDPP during the summer; by statute they must transition out by NLT 31 December 2011. The PDPP provides management with needed pay setting flexibilities essential to attract and retain high quality physicians and dentists. It provides the flexibility to set pay by increasing the market pay element to reflect a "competitive market salary" by medical specialty and duty location. The Activity Compensation Panel, made up of peers, assess the individual's qualifications and recommends pay to the Commander, while considering the budget and internal pay equity. Our major challenge in the next 3 to 5 years is to fund pay increases and define the "market salary point" necessary to retain a stable workforce.

(9) Significant progress has been made in developing qualification standards for the 30 healthcare occupations exempted by DoD from NSPS to GS conversion. Under the Civilian-Healthcare Occupations Sustainment Project (C-HOSP), the DoD(HA) Civilian Human Capital Office (CHCO) assembled a tri-service task force last July to develop unique agency qualification standards based on Title 38 Veteran's Affairs (VA) authorities granted to the SECDEF in the NDAA 09. These authorities allow DoD to update antiquated OPM qualification standards and speed up the process to update special salary rate tables as new VA pay schedules are issued. The CHCO is expected to issue semi final drafts for component review, before final review and issuance by the Under Secretary of Defense for Personnel and Readiness this coming September.

(10) The MEDCOM civilian healthcare workforce in 46 key occupations doubled in size from 30 September 2001 through 31 March 2011. Total on-hand civilian strength expanded 204% from 13, 803 to 28,185 employees in less than ten years. The number of Physicians tripled from 372 to 1335 (359% increase); Registered Nurses

more than doubled from 2363 to 6104 (258% growth), Pharmacists grew from 372 to 670 (180% growth), and Dentists increased from 34 to 224 (659%). Our mental health workforce almost tripled; Psychologist and Social Workers grew from 237 to 570 and from 276 to 924, an aggregate growth of 981 or 291% expansion. The expansion of the workforce was achieved through use of the Direct Hire Appointment authority, pay flexibilities inherent in the now abolished NSPS, and the use of Special Salary rates and Recruitment, Relocation, and Retention Incentives.

(11) The Center for Health Care Contracting (CHCC) has 27 active Blanket Purchase Agreements (BPA) to support surge requests such as traveling nurses, locum tenens, and dental support. These BPAs are primarily CONUS based and have an expensive cost associated with hiring temporary clinical providers. The MEDCOM is reviewing the use of Locum Tenen contracts to develop a corporate strategy to maximize their effectiveness.

(12) In FY11 and FY12, CHCC and HCAA's Regional Contracting Offices are beginning to re-compete the follow-on contracts for the Army Direct Care Medical Services (ADCMS) valued at \$967M which will allow MTFs to continue uninterrupted clinical support services as the old contracts expire. The CONUS based contracts and Europe contract are composed of 3 product lines - physicians, ancillary services, and nursing services.

(13) GOSC review.

a. Feb 11. The GOSC declared the issue active as OTSG Examine current requirements and authorizations to distribute FY12 Human Capital resources equitably. Implement a hybrid pay system similar to the NSPS for GS physicians and dentists.

b. Aug 11. OTSG will implement the DoD Physicians and Dentists Pay Plan. Develop a comprehensive strategic direction, review, and prioritization of human capital initiatives.

h. Lead agency. MCHR-C

#### **Issue 648: Behavioral Health Services Shortages**

**a. Status.** Active

**b. Entered.** AFAP XXVI, Jan 10

**c. Final action.** No (Updated: 8 Jul 11)

**d. Subject area.** Medical/Command

**e. Scope.** Soldiers, retirees, Family Members, and previously deployed DA Civilians are not able to access timely behavioral health services needed for their treatment and recovery because of the shortage of behavioral health providers. A 16 November 2009 Office of The Surgeon General (OTSG) Information Paper states from June thru October of 2009, the Army lost 72 Psychiatrists and 50 Psychologists and reports an unmet requirement of 923 behavioral health providers for the Active Component alone. The shortage of behavioral health services impacts the health of Soldiers, retirees, Family Members, previously deployed DA Civilians and ultimately contributes to the rising suicide rates, drugs, and alcohol abuse.

**f. Conference Recommendations.**

(1) Increase the number of readily available behavioral health providers and services for Soldiers, retirees, Family Members, and previously deployed DA Civilians.

(2) Increase the use of alternative methods of delivery; such as tele-medicine.

**g. Progress.**

(1) A total of 4,095 Behavioral Health requirements were determined for the quarter ending 31 March 2011 using the Automated Staffing Assessment Model (ASAM). Through the use of models for functions across the organization, the use of studies for unique functions and concept plans for new missions, the U.S. Army Medical Command quantifies the relationship between workload and manpower resources required to perform the mission. This manpower model is under review to ensure accuracy and is premised on validated workload. The Army G-3/5/7 has also enhanced the review process to ensure model application is accurately documented at the work center level. The Vice Chief of Staff of the Army, General Peter W. Chiarelli was briefed on and approved the use of the ASAM model for use to determine manpower requirements in the MEDCOM.

(2) The unmet BH manpower requirements total 1083 in four BH specialties. They include 57 psychiatrists, 162 military BH specialists (68X), and 864 support civilian and contract psychology and social worker technicians. On-hand strength exceeds requirements in five BH specialties. The on-hand military, civilian and contract personnel for Psychologists, Social Workers, BH Nurse Practitioners and Registered Nurses well exceed requirements in the aggregate by 29% (2327.5 minus 1800 = 527.5). The number of available civilian BH Nurse Assistants (100) exceeds requirements (53) by 47 or 189%. In the aggregate 88% of the total BH manpower requirements for the quarter ending 31 March 2011 were met. Submission into the Total Army Analysis 14-18 process for additional military billets in selected locations will be introduced this Spring.

(3) The AMEDD continues to support and promote incentives to maintain and recruit quality BH professionals. In partnership with Fayetteville State University, MEDCOM developed a Masters of Social Work program which graduated 15 in the first class in 2009 (current capacity is 40 candidates). The next class will graduate in December 2011, and projects 29 graduates. Additionally, the use of the Active Duty Health Professions Loan Repayment Program (HPLRP) was expanded; and offers a \$20K critical skills accessions bonus for Medical and Dental Corps Health Professions Scholarship Program (HPSP) applicants. MEDCOM increased the number of Health Professions Scholarship Allocations dedicated to Clinical Psychology and the number of seats available in the Clinical Psychology Internship Program (CPIP). Since the start of Operation Iraqi Freedom, the Army has significantly increased the annual number of graduate students admitted to its clinical psychology internships. Prior to 2004 the Army historically trained 12 interns per year and has progressively increased that number, admitting 33 interns in 2009. The mission for CPIP for FY11 is set at 30 (12 Civilian Life Gains plus 18 matriculating from the Clinical Psychology HPSP program).

(4) The FY12 HCDP Conference was conducted in December 2010 and provided for the equitable distribution of FY12 behavioral health human capital resources. The Behavioral Health Capability Team briefed the com-

prehensive scope of all behavioral health assets, the current Army behavioral health provider strength and the way ahead to meet the growing needs of the beneficiary population: maintain an adequate provider pipeline, enhance interaction between AC and RC behavioral health providers, focus recruitment efforts, and emphasis on retention.

(5) The hiring of civilian employees remain the primary means of meeting BH requirements. From 30 September 2001 to 31 March 2011 MEDCOM increased its total BH civilian workforce by 1631 employees, from a total of 738 to 2369 civilian employees, a 321% increase. During the same period the number of Psychiatrists increased by a four-fold from 30 to 155, or 517% increase; Psychiatric Registered Nurses increased by more than a three-fold from 52 to 203 or 390% increase. The number of Psychologists and Social Workers continue to increase among our BH civilian workforce; Psychologists increased from 237 to 570 and Social Workers grew from 276 to 924, an aggregate increase of 981 or 191% growth. The BH civilian support staff, Psychology Technicians and Social Work Assistants increased by 300%, from 95 to 286. A total of 234 civilian recruitment actions are currently open, most are for Social Workers (109) and Psychologists (57).

(6) A total of \$27.9M has been utilized in Recruitment, Relocation, and Retention (3Rs) incentives for BH civilian employees from 30 September 2007 through 31 March 2011. In the aggregate Psychiatrists received \$10.56M; Psychologist received \$11.71M, and Social Workers received a total of \$4.37M. As of 31 March 2011, 65% of Psychiatrists (100 of 155); 40% (229 of 570) of Psychologists; 11% (104 of 924) of Social Workers, 29% (8 of 28) of Nurse Practitioners and 12% (25 of 203) of Psychiatric Registered Nurses were receiving an incentive as of 31 March 2011. The average grant for Psychiatrists has steadily increased since 2007 from \$17.8K to the current annual amount of \$35.8K; the average amount for incentives have also increased for Psychologists and Social Workers from \$6.4K to \$10.3K and from \$4.2K to \$6.1K respectively, during this period. As of 31 March 2011, the average annual grant for a Nurse Practitioner is \$22.6K; the average for a Psychiatric Registered Nurse is \$8K.

(7) MEDCOM continues to work with ASA M&RA, Army G-1, USAREC and IMCOM on a Behavioral Health Tiger Team to develop cooperative strategies and approximately 25 strategic initiatives that will provide the Secretary of the Army and other senior leaders' ideas to enhance or implement recruiting and retention of Behavioral Health providers.

(8) MEDCOM continues to increase Behavioral Health contracting by over 7% from a year ago. This increase was achieved through the (1) use of contracting vehicles to speed the award of contracts, (2) contractors utilizing more progressive marketing and recruiting tools to identify potential contractor candidates for BH positions and (3) converting contractor positions to government civilians. Despite the best efforts some of the BH specialties and positions at remote and other hard-to-fill locations remain a challenge to fill. The contracting community has successfully employed the following: (1) in addition to the use of relocation and incentive fees (paid to for filling within a specified timeframe) sign-on and retention bonuses were

also used, (2) speeding the credentialing process for candidates, (3) expanding marketing to all BH communities to access a larger pool of potential candidates, and (4) implementing the Army Direct Care Medical Services (ADCMS) and other Blanket Purchase Agreements (BPAs) as tools to award both sustained and contingency BH requirements.

(9) MEDCOM created the Tele-Health office to focus on the policy and process standardization surrounding the practice of tele-medicine within the Army Medical Command (MEDCOM). Tele-health services are provided via video-conferencing and store-and-forward technology through a network of 91 active sites across five Regional Medical Commands and 19 in Theatre. From January 2010 through December 2010, the Army provided over 34,000 tele-health patient encounters in 50 countries/territories, in 39 specialties, and across 19 time zones. Tele- Behavioral Health services within the MEDCOM include Psychiatry, Psychology, Medical Evaluation Boards, Forensics, Case Reviews, Temporary Disability Retired Lists, Mental Status Evaluations, Neuropsychology, the AKO Tele-consultations Service, and the Virtual Behavioral Health Program (VBH). Tele-health increases access to specialty care in geographically dispersed areas, enables greater continuity of care, and provides surge capacity where needed.

(10) GOSC review.

a. Jun 10. The GOSC declared the issue active. The VCSA recognized the progress that has been made on this issue, but said that he thinks there is a perception that there are not enough behavioral health providers. The VCSA said we should report back at the January 2011 HQDA AFAP conference and let them know everything we've tried to do to fix this.

b. Feb 11. The VCSA stressed that this is a real issue and said he wanted to know what the correct authorization is. Discussion ensued on what services are under the BH umbrella, where those assets are assigned, why staff is leaving the Army Substance Abuse Program and what is our surge capability. Efforts to increase the number of BH specialists by training and recertification were also addressed. OTSG will conduct an analysis to validate behavioral health staffing model. OTSG will then assess impact of increased staffing on ability of beneficiaries to obtain access to care for behavioral health services.

c. OTSG will request additional BH military and civilian billets in the Total Army Analysis (TAA) 14-18 process. Awaiting additional civilian authorizations from TMA through a Resource Management Document. Additional BH assets are needed at selected geographical locations.

**h. Lead Agency:** MCHR-C

### **Issue 650: Exceptional Family Member Program Enrollment Eligibility for Reserve Component Soldiers**

**a. Status.** Active

**b. Entered.** AFAP XXVI, Jan 10

**c. Final action.** No (Updated: 7 Jul 11)

**d. Subject area.** Medical/Command

**e. Scope.** Reserve Component (RC) Soldiers are ineligible for enrollment in the Exceptional Family Member

Program (EFMP). Army Regulation 608-75 dated 22 November 2006, paragraph 1-7a. (2) states mobilized and deployed Soldiers are not eligible for enrollment in EFMP. In order to be eligible for all benefits of the EFMP, you must be enrolled. Enrollment allows EFMP to expedite the process of identifying and providing support to eligible RC Soldiers and Families.

**f. Conference Recommendation.** Authorize RC Soldiers enrollment in the Exceptional Family Member Program (EFMP).

**g. Progress.**

(1) In Feb 10 this issue was reviewed by the EFMP Policy Working Group at the EFMP Summit and ranked as the second highest priority.

(2) In Mar 10, draft language was forwarded to ARNG and USAR EFMP POCs for coordination and review.

(3) In Apr 10 consulted with OTJAG regarding draft language.

(4) In Apr 10 EFMP Policy Working drafted proposed language for regulation and developed a process flow chart for enrollment/tracking of RC EFMs.

(5) In May, June, July and September the EFMP Policy Working Group continued with meetings to define language and process regarding RC Eligibility for the Exceptional Family Member Program. Working Group members have agreed, thus far, that enrollment will be voluntary for mobilized/deployed RC Soldiers/Family members; there are no required changes to DD 2792, and that the DD 2792 may be completed by the Primary Care Physician.

(6) During the Sep 10 EFMP Policy Working Group meeting, it was acknowledged that RC Soldiers and Family member are eligible to receive support services through Army Community Service without being enrolled in the Exceptional Family Member Program. Support services may include educational instruction, support groups or contact with the EFMP Manager.

(7) Oct 10 EFMP Policy Working Group finalized key decision points: Enrollment is voluntary; no need to change DD Form 2792; Primary Care Physician can complete the DD 2792; DD 2792 will be sent to appropriate Regional Medical Command; if eligible for enrollment, non protected information will be sent to the Reserve Component Family Program POC; and the Reserve Component will track/maintain enrollment information.

(8) Mar 11 EFMP Policy Working Group met to review final recommendations and develop strategies to coordinate regulatory change. Members decided that a subset of the policy working group (OACSIM, ARNG, USAR, IMCOM G-9, and HRC) would develop a standardized briefing and each agency would responsible for coordinating and briefing their respective leadership on proposed recommendations. Based upon outcome of leadership briefs, AR 608-75 will be revised to incorporate recommendations.

(9) Mar 11 EFMP Policy Working Group met (ARNG, USAR, HRC and OTSJ) and developed standardized briefing.

(10) Apr 11 EFMP Policy Working Group met to review language and status of briefs to leadership.

11. 9 May 11 ACSIM met with the CAR and Special Assistant to the Director, ARNG to discuss recommendations, resources and way forward.

(11) GOSC review.

a. Jun 10. The GOSC declared the issue active to pursue necessary steps to authorize and track RC enrollment in the EFMP.

b. Aug 11. OACSIM will submit a revision to AR 608-75.

**h. Lead agency.** OACSIM-ISS

**i. Support agency:** IMWR-G9, USAR and ARNG

**Issue 652: Family Readiness Group External Fundraising Restrictions**

**a. Status.** Active

**b. Entered.** AFAP XXVI, Jan 10

**c. Final action.** No (Updated: 7 Jul 11)

**d. Subject area.** Family Support

**e. Scope.** Family Readiness Group (FRG) informal funds can only be obtained through unsolicited donations and fundraising efforts on a military installation or through the Unit membership. Department of Defense 5500.7-R (Joint Ethics Regulation) (JER), Section 2, 3-210a (6) (Fundraising and Membership Drives) and Army Regulation 608-1 (Army Community Service), Appendix J (FRG Operations) restrict external fundraising. Without external fundraising capabilities, the majority of the funds raised come from within the FRG membership. External fundraising will ease the financial burden placed on Soldiers and Family Members.

**f. Conference Recommendation.** Authorize Family Readiness Groups (FRGs) to fundraise in public places external to Reserve Centers, National Guard Armories and military installations.

**g. Progress.**

(1) IMCOM SJA indicated this issue must be worked by OTJAG.

(2) OTJAG concluded that resolving this issue would require change to OPM and/or Federal Ethics Regulation and potentially have legislative impacts. OTJAG suggested FRGs may fundraise on installations; however, Reserve Component FRGs would be limited to AFRCs or Armories. OTJAG indicated that 501-3c (tax-exempt, nonprofit) status and then fundraise externally.

(3) IMCOM G-9 Family Programs reiterated similar recommendations.

(4) Reviewed issue with IMCOM G-9 SJA. IMCOM G-9 SJA will coordinate with OTJAG and provide an opinion on issue resolution and suggested language.

(5) Consulted with IMCOM G-9 SJA to review way ahead. IMCOM G-9 SJA will contact OTJAG to review legal opinion and assist with preparing change to regulation and/or legislation. Requested IMCOM G-9 SJA to opine as to whether legislative change is attainable.

(6) At the Apr 10 AFAP issue review with ACSIM, a recommendation was made to close the issue as Unattainable as this issue will require legislative change. Change to legislation may not be supported by Office of Personnel Management.

(7) Issue was briefed at the June 2010 AFAP GOSC. The VCSA directed a holistic review of FRG funding and

donations to review strategies to fund FRGs without the requirement to fundraise.

(8) OACSIM established a working group to develop strategies to holistically fund FRGs. The recommended course of action was to curtail FRG fundraising and explore options for funding FRGs. Recommendations:

(a) \$500 cap for "Cup and Flower Fund" (not lower than company/battery level)

(b) Commanders have a brigade level mechanism and an SOP to accept donations

(c) Examine option to fund FRGs based on a Dollar to Soldier Ratio

(d) FRGs have the option to establish a 501-3-c, Private Organization, if they desire to fundraise.

(9) Recommendations were coordinated with IMCOM G-9, USAR and ARNG Family Points of Contact.

(10) Explored the option to streamline funding to appropriated fund (APF), non-appropriated funds (NAF) and to establish separate accounting codes within the NAF for fundraising/donations or MWR funds. This option was not viable as funds must be separated for tracking/accounting systems for donations, etc.

(11) ACSIM coordinated a teleconference with, IMCOM G-9 and Reserve Component Family Programs Points of Contact to further review and revise FRG Holistic Funding strategies. Revised recommendations:

(a) Examine option to develop dollar ratio for FRGs (similar to unit MWR funds) to fund non mission essential activities

(b) Recommend a \$1000 cap on Informal Funds

(c) Recommend Informal Funds to be established not lower than the company/battery level

(d) Develop an FRG survey tool/questionnaire to ascertain what FRG tasks are not currently being met via funding options (APF, Informal, and Supplemental

(e) Develop a standard budget template for Commanders for FRG mission essential tasks

(f) Reinforce training for Commanders and FRG members on FRG mission essential tasks.

(12) Recommendations forwarded to OTJAG. In Feb 11 and Mar 11 received no legal objections to recommendations from OTJAG.

(13) Strategic messages will be posted via Army One-Source (AOS) to FRG Leaders and to Commanders regarding guidance for appropriated funding for FRGs. FRG funding guidance provided in the mandatory pre-command course and FRG Leader training currently available in OPREADY Materials.

(14) IMCOM G-9-FP briefed their leadership on the "Dollar to Soldier Ratio" Concept on 30 Mar 11. IMCOM G-9 Leadership non-concurred with concept.

(15) The recommendation to lower the Informal Cap to \$1000 and the recommendation to establish Informal Funds not lower than the company level will be incorporated into the revision to AR 608-1. A Strategic Communication Plan is under development in lieu of an ALARACT regarding guidance of appropriated funding for FRGs.

(16) GOSC review.

a. Jun 10. The GOSC declared the issue active to pursue a holistic review of funding for FRGs.

b. Aug 11. OACSIM will further explore how RC can externally fundraise.

**h. Lead agency.** DAIM-ISS

**i. Support agency.** IMWR G-9, OTJAG, USAR and ARNG

### **Issue 653: Funding Service Dogs for Wounded Warriors**

**a. Status.** Active

**b. Entered.** AFAP XXVI, Jan 10

**c. Final action.** No (Updated: 8 Jul 11)

**d. Subject area.** Force Support

**e. Scope.** The Department of Defense does not offer a formal program that funds service dogs for Wounded Warriors. There is significant anecdotal evidence that animal assistance programs help patients of all types recover and heal from wounds, injuries and illnesses, both physical and psychological. Service dogs may assist Wounded Warriors in attaining a higher level of independence and self-reliance which allows them to function more successfully in their community and jobs.

**f. Conference Recommendation.** Fund a formal program to provide service dogs for Wounded Warriors.

**g. Progress.**

(1) HPS has engaged in several efforts to determine the need, cost, required policies, and potential impact of funding a program that provides service dogs to wounded warriors.

(2) In November 2010 HPS assisted VETCOM with the revision of TB MED-4 Department of Defense Human-Animal Bond Principles and Guidelines. TB MED-4 promotes and supports Human Animal Bond programs by providing guidance on care, maintenance and disease prevention of animals to include dogs.

(3) On 9 November 2010 HPS published MEDCOM Policy Memo 10-077 on the Use of Canines and Other Service Animals in Army Medicine. Policy Memo 10-077 provides guidance on the authorized use, ownership, and accompaniment by service dogs at Military Treatment Facilities (MTF) and WTUs.

(4) On 3 December 2010 HPS held a teleconference with the Walter Reed Army Medical Center subject matter experts (SME) on Animal Assisted Activities. The recommendation from the teleconference was to use components of the Functional Independence Measure (FIM) and Functional Assessment Measure (FAM) that are tools currently used at WRAMC to assist with determining cognitive and physical disabilities of Wounded Warriors and the appropriateness of referral to a non government organization (NGO) that donates service dogs to Service members and Veterans.

(5) On 12 April 2011 HPS held a teleconference with the Rehabilitation and Reintegration Division (R2D) to discuss using the FIM/FAM to identify how many WWs may need or benefit from having a service dog. R2D recommended a general survey as an alternative to the FIM/FAM since these are not tools widely used by Army Occupational Therapists. Other options presented during this meeting included obtaining data for the past three years from Army programs that support Animal Assisted Activities (AAA), the Veterans Administration's funded dog program, and non government organizations (NGO)

that match Service members and Veterans with service dogs.

(6) In May 2011 HPS developed a survey to determine the trend of service dog matching and placements with WWs and Service members over the past three years. HPS sent out this survey to the Veterans Administration (VA), RMCs, and two NGOs who primarily provide service dogs to Army Service members and Veterans. RMC results are expected by the end of May 2011.

(7) Preliminary results indicate the VA does not purchase or obtain dogs for Veterans. At this time the VA only supports benefits for trained service and guide dogs that Veterans obtain for vision, hearing, and mobility disabilities. Per survey results, the VA Guide Dog program received 5 million in congressional funding. Two million is earmarked to support Veterans who have a trained service/guide dog. VA support for Service members who have a service dog includes: (1) provision of equipment (harnesses, leashes etc), (2) veterinarian care, and (3) medications and other supplies/support that are covered under the Veteran's benefits program. The remaining three million is earmarked for research regarding the use of dogs and other animals in animal assisted therapies.

(8) Survey results from America's VetDogs indicate that since 2008 there have been 144 service dogs to include guide dogs placed with active duty Service members and Veterans. In 2008 NEADS Dogs for Deaf and Disabled Americans placed 42 dogs with Veterans and active duty Service members.

(9) Will continue examining surveys to determine the need. Not for Profit Organizations have been providing Service Dogs for Soldiers. There are over 20 active organizations involved with Soldiers needing Service Dogs.

(10) The K-9 Companion Act (H. R. 943) has been introduced in the 112<sup>th</sup> Congress for the Secretaries of Defense and Veterans Affairs to establish a program to be known as the K-9 Companion Program. Through this program Not for Profit Organizations can bid for competitive grants to provide assistance dogs to covered members and veterans.

(11) GOSC review.

a. Jun 10. The GOSC declared the issue active. The issue will be modified to include reference to both service and therapy dogs for wounded, ill and injured Soldiers.

b. Aug 11. OTSG will determine if current program offerings meet the need. If need exceeds current capability, collaborate with the WTC and Resource Management to develop a Concept Plan and submit a funding request.

**h. Lead agency.** DASG-HCZ

**i. Support agency.** DoD Veterinary Service Activity, Veterinary Command, Walter Reed Army Medical Center, U.S. Army Medical Department Center and School

#### **Issue 654: Monthly Stipend to Ill/Injured Soldiers for Non-Medical Caregivers**

**a. Status.** Active

**b. Entered.** AFAP XXVI, Jan 10

**c. Final action.** No (Updated: 8 Jul 11)

**d. Subject area.** Entitlements

**e. Scope.** The Army does not offer a monthly stipend to injured/ill Soldiers who do not qualify for Traumatic Servicemembers' Group Life Insurance (TSGLI) and are certified by a medical provider to be in need of a non-medical caregiver's assistance. Although travel and transportation compensation is provided through the NDAA FY10, there may be additional costs incurred by the non-medical caregiver while caring for the Soldier. Expenses can include child care and the loss of ability to generate income. In the absence of the monthly stipend for non-medical caregivers, the Soldiers that do not qualify for TSGLI could require hospitalization, nursing home care or residential institutional care.

**f. Conference Recommendation.**

(1) Provide a monthly stipend to Soldiers that do not qualify for TSGLI and are certified to be in need of assistance from a non-medical caregiver.

(2) Authorize an annual re-qualification for an additional lump sum payment to offset caregiver expense of SM due to the severity of wounds.

**g. Progress.**

(1) In June 2010, Issue 611 (Traumatic Service Members Group Life Insurance Annual Supplement change to Annual Re-qualification for an Additional Lump Sum Payment to Offset Caregiver Expense) and this issue were combined because of the similarity in scope and recommendations.

(2) TSGLI status should not be a determinate for receipt of a monthly stipend for non-medical caregiver assistance based on recent Congressional action contained in PL 111-84 (NDAA 2010) and PL 111-163 (Caregivers and Veterans Omnibus Health Services Act of 2010) which provide such a stipend based on the care requirements of the Service Member or Veteran without regard to whether TSGLI payouts were made.

(3) PL 111-84. The DoD Office of Wounded Warrior Care and Transition Policy (OWWCTP) continues to develop a USD(P&R) Directive Type Memorandum to implement Section 603 of PL 111-84 to establish a caregiver stipend for catastrophically injured Service Members. Currently, progress remains limited due to a pending decision by DEPSECDEF concerning the population eligible for receipt of the stipend. The issue is whether all catastrophically injured Service Members would qualify or only those wounded or injured in a theater of war or, alternatively, only those who would qualify for Combat-Related Special Compensation. With the impending change of civilian leadership within DoD and the fact that the PL 111-163 program is now getting off the ground may further delay any action on this provision.

(4) PL 111-163. Title I of PL 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010 calls for the Department of Veterans Affairs (VA) to establish a training, support, care, and stipend program for family member primary caregivers of Veterans who require assistance with Activities of Daily Living. Payment will vary by location, nature, and frequency of care provided and payment will be made directly to caregiver. Effective 9 May 2011, Veterans are now able to enroll and receive these benefits and services. Whether the targeted beneficiary population will meet the total need for these services remains to be determined.

(5) GOSC review. The Aug 11 GOSC declared the issue active. OTSG will monitor impact of PL 111-163 and determination on whether the provisions of PL 111-84 Section 603 will be implemented.

**h. Lead Agency:** WTC

**i. Support Agency:** DA G-1, MCWT-STR

#### **Issue 657: Reserve Component Inactive Duty for Training Travel and Transportation Allowances**

**a. Status.** Active

**b. Entered.** AFAP XXVI, Jan 10

**c. Final action.** No (Updated: 28 Jun 11)

**d. Subject area.** Entitlements

**e. Scope.** There is no legal authority for travel and transportation allowances for RC Soldiers conducting Inactive Duty for Training (IDT) when the training duty station, drill site or assigned unit location is over 50 miles from home of record. Soldiers often travel significant distances from home of record to duty locations due to unit relocation, individual assignments and other factors. Traveling these distances imposes safety risks such as accidents caused by sleep deprivation and decreased levels of alertness. Soldiers can incur out-of-pocket expenses that exceed the actual pay received. Providing travel and transportation allowances for RC Soldiers will alleviate financial burdens and mitigate risks associated with traveling to and from the training duty station.

**f. Conference Recommendation.** Authorize travel and transportation allowances for RC Soldiers traveling over 50 miles for IDT.

**g. Progress.**

(1) Section 631 of the NDAA for FY08 amended title 37 United States Code to provide authority for reimbursement of travel expenses of up to \$300 per round trip for certain RC Soldiers who are:

(a) qualified in a skill designated as critical

(b) assigned to a unit or in a reserve pay grade with a critical manpower shortage

(c) assigned to a unit or position that is disestablished or relocated due to defense base closure or realignment or other force structure reallocation and the member is required to commute outside the local commuting distance.

(d) ALARACT 249/2008 further defined the normal commuting distance to be within 150 miles.

(2) DoD Manual 4165.63-M "DoD Housing Management (Sep 93) authorizes "Reserve Component personnel to occupy transient Unaccompanied Personnel Housing (UPH) during periods of scheduled inactive duty training at an installation.

(3) Army Regulation (AR) 21-50, Installation Housing Management (1 Sep 97) states that Reserve component members performing BAT/IDT at installations away from home station are authorized to occupy Visiting Officer Quarters (VOQ)/Visiting Enlisted Quarters (VEQ) on a space available basis at the individual's expense. It further stated that scheduled BAT/IDT personnel are authorized to occupy VOQ/VEQ on an equal basis with active TDY personnel.

(4) If transient government housing is unavailable, the individual service may provide "lodging in kind" during the performance of duties.

(5) Public Law 108-121, the Military Family Tax Relief Act of 2003 contains provisions that allow National Guard and Reserve members, to deduct the round trip costs to travel between their principal residence/place of employment and the BAT/IDT duty location, if that location is in excess of 50 miles or the Soldier is required to stay overnight. These tax provisions are applicable provided the Soldier is not provided free Government transportation or Government furnished lodging.

(6) Issue was taken to the PDTATAC and other Service representatives and they advised that there was no merit to compensate any Service member or DOD employees for travel expenses to and from their duty location.

(7) ALARACT 249/2008 provides implementation guidance and limits the program to Soldiers who travel more than 150 miles (one-way) to their unit. This authority expires on 31 Dec 11. OSD has proposed legislation for implementation of a reduction in the minimum local commuting distance to less than 150 miles (one-way) in circumstances where travel by means other than automobile are not practicable and to extend the authority to 31 Dec 12.

(8) The Army Reserve will utilize this program to help maximize its ability to support units based on their status in the Army Force Generation (ARFORGEN) cycle. Army Reserve G-1 conducted a quick turnaround analysis to look at the projected eligible population based on the ARFORGEN cycle (53,000 Soldiers) that would benefit from this program. Based on the raw data of eligible Soldiers, the projected cost is \$194M per FY. The Army Reserve is drafting a memorandum for the Chief, Army Reserve, requesting authority from the Assistant Secretary of the Army (Manpower and Reserve Affairs) to implement this program with a proposed effective date of 1 Oct 11. The execution of the program will be subject to available resources.

(9) Both the House and Senate versions of the FY12 NDAA authorize the reimbursement of travel expenses for IDT outside of the normal commuting distance, but do not include funding authorizations.

(10) GOSC Review.

a. Feb 11. The GOSC declared the issue as originally written unattainable because the other Services do not support changing the JFTR to provide a general "residence to duty to residence" compensation entitlement for RC IDT travel. Issue will be recrafted by the Army Reserve.

b. Aug 11. USAR will monitor final language in the FY12 NDAA.

**h. Lead agency.** USAR

#### **Issue 661: TRICARE Allowable Charge Reimbursement of Upgraded/Deluxe Durable Medical Equipment**

**a. Status.** Active

**b. Entered.** AFAP XXVI, Jan 10

**c. Final action.** No (Updated: 8 Jul 11)

**d. Subject area.** Medical

**e. Scope.** When the TRICARE beneficiary chooses an upgraded/deluxe DME, the beneficiary must pay full cost out-of-pocket with no reimbursement for the TRICARE

allowable charge. DME providers are limited to accepting the TRICARE allowable charge as payment in full for the medically necessary standard DME. Purchasing the upgraded/deluxe DME could improve patient compliance, quality of life, comfort, or function. Reimbursement of the TRICARE allowable charge offsets the increased cost of the upgraded/deluxe DME incurred by the TRICARE beneficiary.

**f. Conference Recommendation.** Authorize reimbursement of the TRICARE allowable charge for the standard DME when a patient chooses an upgraded/deluxe DME.

**g. Progress.**

(1) DME is purchased or rented medical equipment used for the treatment of an injury or illness which is also medically necessary. DME may include wheelchairs, hospital beds/attachments, oxygen equipment, respirators, and other non-expendable items.

(2) TRICARE covers DME when prescribed by a physician and if the DME:

a. Improves, restores, or maintains the function of a malformed, diseased, or injured body part, or can otherwise minimize or prevent the deterioration of the patient's function or condition.

b. Maximizes the patient's function consistent with the patient's physiological or medical needs.

c. Provides the medically appropriate level of performance and quality for the medical condition present

d. Is not otherwise excluded by the regulation and policy.

(3) Active Duty Family Members (ADFM) enrolled in TRICARE Prime and TRICARE for Life (TFL) users do not have co-payments under TRICARE. Under TFL, Medicare is first payer (for DME, 80%) and TRICARE, as second payer, reimburses the 20% Medicare DME co-payment. Retiree DME co-payments are: TRICARE Prime and Extra, 20% of negotiated fees and Standard, 25% of the allowable charge. ADFM DME/ co-payments are: TRICARE Extra, 15% of negotiated fees and Standard, 20% of the allowable charge. Beneficiaries needing DME are given authorizations for specialty referrals, except for DME costing less than \$500, which does not require an authorization. There is no co-pay for MTF issued DME, which, if available, is issued on loan with a hand receipt.

(4) TRICARE in general uses the reimbursement rates established by the Centers for Medicare and Medicaid Services (CMS) for certain items of DME, Prosthetics, Orthotics, and Supplies. CMS updates these rates twice a year in January and July. Inclusion or exclusion of a reimbursement rate does not imply TRICARE coverage.

(5) TRICARE cannot pay when a preferred DME item is unproven or deemed experimental. TRICARE also does not cover unauthorized DME which may be excessive in features which increases the cost when compared to a more similar item without the extra features. There is no reimbursement when the beneficiary who chooses a same class enhanced DME that will provide convenience, size, or function.

(6) OTSG coordinated with TMA to see if beneficiaries can be authorized reimbursement of the TRICARE allowable charge for the standard DME when a patient

chooses an upgraded/deluxe DME at their own expense. OTSG sent a formal request, asking TMA to assess the feasibility of this option to meet the intent of this AFAP recommendation. In their response, TMA agreed having such an option would offset the cost and would improve patient quality of life, comfort and function. TMA stated they would support our submission of a Unified Legislation and Budgeting proposal to modify Title 10. TMA is preparing a cost estimates and we expect this during 4<sup>th</sup> QTR FY11. Submission of ULB will follow receipt of cost estimate.

(7) GOSC review. The Aug 11 GOSC declared the issue active. OTSG will prepare cost estimate (TMA). Submit ULB proposal after receiving cost estimate.

**h. Lead agency.** DASG-HSZ

**i. Support agency.** TMA

**Issue 662: Comprehensive and Standardized Structured Weight Control Program**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 30 Aug 11)

**d. Subject area.** Force Support

**e. Scope.** Army Regulation (AR) 600-9, The Army Weight Control Program, requires Soldiers who are entered into the program be referred for nutritional counseling, but they are not required to complete any type of comprehensive and standardized medical or nutritional program. The Weight Control Program outlines the administrative requirements and details the Commander's responsibility with regard to the Army Weight Control Program. A Service Member's inability to lose weight under the current regulatory program causes the Service Member to face disciplinary action and possible separation. The value of having a comprehensive and standardized weight control program will increase a Service Member's long-term physical and emotional health.

**f. Conference Recommendation.** Require Soldiers in the Army Weight Control Program to complete a comprehensive and standardized structured weight control program which includes periodic nutritional education and fitness training and leaders to monitor their progression throughout the program.

**g. Progress.**

(1) U.S Army Medical Command (MEDCOM) and U.S. Army Public Health Command (USAPHC) have determined that the Army MOVE! Program, introduced in 2009, meets the intent of a comprehensive weight loss program. The program's current design incorporates the combination of diet, physical activity guidance, behavior therapy, and follow up as needed.

(2) The Army MOVE! Program is available either online or face-to-face. The online program, managed and voluntarily instructed by USAR dietitians, is available to anyone with AKO access (excluding Contractors). The face-to-face version of the Army MOVE! Program is available at Army medical treatment facilities (MTF) that have a dietitian on staff. It was previously identified that the Army MOVE! Program is inconsistently implemented across MTFs due to a lack of resources and staffing. Currently, USAPHC is conducting a process evaluation of both program platforms to identify best practices and im-

prove program design and implementation to standardize offerings across like installations. This assessment should be complete 2<sup>nd</sup> quarter of FY12.

(3) The requirements set forth in AR 600-9 apply to Soldiers in all Components. Component 2 and 3 Soldiers would only be eligible for the online version of the program as they are not entitled to care through an MTF unless on orders.

(4) A policy update working group for AR 600-9 was established to assess policy requirements for the subsequent revision. Gaps in policy guidance are identified in areas of standardized nutrition education, exercise program requirements, and the standardization of commander involvement with weigh-ins and counseling. It is the consensus of the working group that AR 600-9 requires a major revision to include specific actions leading to possible separation proceedings, however participation in the working group has been challenging to date. To facilitate and expedite the process, the Sergeant Major of the Army (SMA) in coordination with the DCS, G-1 SGM has identified the rewrite of AR 600-9 as critical as it related to the Chief of Staff of the Army's Initiative on the Army Brand. An EXORD was published 12 Aug 11 directing a working group with support of key stakeholders. The first formal working group meeting is scheduled for 8 Sept 2011, with updates to the SMA as requested. An entire review of AR 600-9 will be undertaken and clarification of counseling requirements and program participation prior to initiating separation proceeding will be reviewed.

(5) Weight standards are a condition of employment within the Army, and are considered a readiness issue. The guidelines are clearly articulated in AR 40-501, Medical Retention Standards and AR 600-9, The Army Weight Control Program. While having the appropriate tools available to assist Soldiers with meeting the weight and/or body fat standard is appropriate, it has been demonstrated that motivation to lose weight is a key factor to success. Mandating a degree of participation in Soldiers who lack the desire to succeed in weight loss will be cost intensive and not guarantee success. Additionally, if participation in a comprehensive program is a requirement, how to meet this requirement will need to be addressed for all Components, not just the Active Component.

**h. Lead agency.** DAPE-HR

### **Issue 663: Eligibility Benefits for the Unremarried Former Spouses of Temporary Early Retirement Authority (TERA) Soldiers**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 7 Sep 11)

**d. Subject area.** Family Support

**e. Scope.** The unremarried former spouses of Soldiers who retired under Temporary Early Retirement Authority (TERA) are not entitled to benefits under the 1982 Uniformed Services Former Spouses' Protection Act (USFSPA). The TERA allowed Servicemembers (SM) to receive retirement benefits at fewer than 20 years however it did not protect unremarried former spouses. Minimum eligibility requirements for full benefits currently include 20 years of marriage, 20 years of credible service and 20 years of overlap. The minimum eligibility re-

quirements under the USFSPA were not updated to reflect the TERA. For example, a SM and spouse who were married for 18 years while SM served 18 years of credible service and the SM retired with full benefits at 18 years. When they divorced, the SM retains full benefits but the spouse does not. Unremarried former spouses of a SM who retired under TERA deserve full retention of benefits.

**f. Conference Recommendation.** Authorize unremarried former spouses of SMs who retire under TERA to receive benefits.

**g. Progress.**

(1) These benefits are NOT related to what is called the Uniformed Services Former Spouses' Protection Act (USFSPA), which enables state court to divide military retired pay as a matter of property settlement.

(2) Public Law 102-484 granted temporary authority for the military services to offer early retirements to members with more than 15 but less than 20 years of service.

(3) Military benefits such as exchange, commissary, and medical care—commonly referred to as, "20/20/20" benefits are codified in Federal law. The law affords these benefits to an un-remarried former spouse who was married to a member or former member for at least 20 years of credible service (10 U.S.C. Section 1072(2) (F) (i) (2010)). Accordingly, a former spouse must satisfy three elements in order to qualify for benefits: (1) 20 years of marriage, (2) the member or former member must have 20 years of creditable service, and (3) 20 years of marriage that overlaps with the member's service—the "20/20/20" rule.

(4) Consequently, you could have a situation where a former spouse could have been married to the member for 20 years and the member serve 20 years but the overlap falls short by one month. Under the bright line definition of the statute, the former spouse would not be entitled to continued benefits.

(5) No legal authority exists to authorize such benefits. Given our current fiscal constraint environment, we should not pursue this AFAP issue. Moreover, there is no inherent benefit to the Army.

**h. Lead agency.** DAPE-PRC

### **Issue 664: Flexible Spending Accounts (FSA) for Service Members**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 7 Sep 11)

**d. Subject area.** Force Support

**e. Scope.** The Department of Defense does not offer FSA options for Service Members. The Internal Revenue Code allows employers to offer FSAs to employees to cover out-of-pocket expenses such as medical and/or dependent care. FSAs allow employees to make voluntary, pre-tax contributions up to the dollar limit allowable in the Internal Revenue Code. A FSA would allow Service Members to pay authorized expenses with pre-tax dollars, thus reducing the impact of medical and/or dependent care costs.

**f. Conference Recommendation.** Establish Flexible Spending Accounts for Service Members.

**g. Progress.**

(1) Congress gave the Secretary of Defense the authority to establish Flexible Spending Accounts in the FY2010 NDAA.

(2) TRICARE Management Activity (TMA) conducted a web-based survey in April 2010 of active duty military personnel about their interest in an FSA if one were offered by DOD. Nineteen percent (19%) of the respondents indicated that they would participate in both HCFSAs and DCFSA if DOD offered the plans.

(3) DOD has historically chosen not to pursue FSAs and has remained generally neutral or oppose to their implementation although ASD (HA) has express support for HCFSAs. Actual saving depends on many factors and differs according to an individual situation. In general, service members at the higher end of the scale and/or in two income family situations may find the tax advantages of an HCFSAs/DCFSA attractive.

(4) Bills S. 387 and H.R.791 were referred to the Committee on Armed Services on 17 February 2011 to amend title 37, United States Code, to provide flexible spending arrangements for members of the uniformed services, and for other purposes. The proposed language is as follows:

“(a) Flexible Spending Arrangements for the Uniformed Services - (1) not later than 180 days after enactment of this section, each Secretary concern shall establish procedures to implement flexible spending arrangements...”

**h. Lead agency.** DAPE-PRC

#### **Issue 665: Formal Standardized Training for Designated Caregivers of Wounded Warriors**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 30 Sep 11)

**d. Subject area.** Family Support

**e. Scope.** There is no formal standardized training for Designated Caregivers of Wounded Warriors on self-care, stress reduction, burnout and prevention of abuse/neglect. A November 2010 study *Caregivers of Veterans- Serving on the Homefront* showed, “Providing care to a veteran (under the age of 65) with a service-related condition has widespread impacts on the caregiver’s health.” This study also reported increased stress or anxiety (88%) or sleep-deprivation (77%) among Caregivers. The Department of Veteran Affairs recognizes this issue and is developing training for Family Caregivers of Wounded Warrior Veterans. Designated Caregivers with no formal training experience stress, anxiety, and burnout, which may lead to Wounded Warriors abuse/neglect.

**f. Conference Recommendation.** Implement formal standardized, face-to-face training for Designated Caregivers of Wounded Warriors on self-care, stress reduction, burnout and prevention of abuse/neglect.

**g. Progress.**

(1) Standardized, evidence-based training on self-care, prevention of burnout, and/or abuse/neglect awareness and prevention would be appropriate for Family caregivers of moderate to severe Wounded, Ill or Injured (WII) patients. Providing this standardized training to Family Caregivers would help them understand that caring for themselves is as important as caring for WII Family

members. MEDCOM has conducted initial coordination with the VA to develop an Army version of the Veterans Administration (VA) training for Caregivers with an acute care focus. If and when the WII transitions to care from the Veterans Health Administration (VHA), VHA staff could provide this training again to the Family Caregiver. The VHA training would then build on the previous training and focus on long-term care aspects.

(2) Legacy Health’s “Powerful Tools for Caregiving” Program was identified as the best evidence-based training model for Family Caregivers. The tenets of this program and the MEDCOM Care Provider Support Program will be used to establish an Army program for Army trainers (assigned WTU Staff).

(3) A policy is required directing that this standardized training be offered to Family Caregivers within the WII’s first 45 days of admission by designated WTU staff, nurses and medical social workers, trained to educate Family Caregivers about self-care, prevention of burnout, and/or abuse/neglect awareness and prevention.

(4) The VA has implemented training for Family Caregivers that incorporates the topics of burnout, self-care, and prevention and awareness of abuse/neglect. The VA is exploring the possibility of a memorandum of understanding with DoD to use the VA-specific training for designated caregivers. If and when the MOU is completed the VA-specific training will most likely replace the training prepared for this AFAP Action as this training is required for VA Designated Caregivers to receive special compensation.

**h. Lead agency.** MCCC-FCD

#### **Issue 666: Full Time Medical Case Managers for Reserve Component (RC) Soldiers**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 3 Oct 11)

**d. Subject area.** Medical

**e. Scope.** The number of full time Reserve Component (RC) medical case managers is not adequate to monitor and track RC Soldiers’ medical, dental, and behavioral health needs. At any given time, there are between 35,000 and 45,000 Army National Guard (ARNG) and US Army Reserve Soldiers who have been categorized as medically non-deployable during the pre-deployment period and are eligible for a case manager. The case managers assess, plan, coordinate, monitor, and evaluate options and services to meet the health care needs of the non-deployable population. According to the Army National Guard Office of the Chief Surgeon, the average workload for the ARNG is 109 cases per medical case manager, and a formal case management system does not yet exist in the Army Reserve. ARNG research has determined that the targeted ratio is 80 cases per medical case manager. In order to maintain an operational force, it is essential to increase the number of medical case managers to improve RC Soldier readiness by addressing medical, dental and behavioral health needs.

**f. Conference Recommendation.** Increase the number of full time medical case managers for RC Soldiers.

**g. Progress.**

(1) ARNG

a. As budget constrictions have affected every facet of the DoD, the current contract was not able to procure additional funding to reach the target staffing ratios. Work persists on justification of further funding.

b. ARNG research determined that the targeted CM ratio for ARNG Personnel is 80 Soldiers per case manager, and a CM and Administrative Care Coordinator (ACC) ratio of 1:4. The current average workload for the ARNG is 157 cases per medical case manager. In late May 2011, e-Case came online, and work continues to filter through the raw data dump into the system, as well as starting new cases. Additionally, the system is expanding to incorporate the USAR CM's into the eCase system. As they are considered "new" to the system, there is no historical data that needs to be sifted through. Our expectation is to meet the current milestone of 1<sup>st</sup> Quarter FY 2012.

## (2) USAR

a. As of 7 Sept 2011, there were 11,745 USAR Soldiers that potentially require administrative or medical board determinations who have been categorized as medically non-deployable due to unresolved health conditions. The MCMs assess, plan, coordinate, monitor, and evaluate options and services to meet the health care needs of the non-deployable population. Estimated workload per DoDI 1300.24 is 40 cases per case manager. There are currently 3,609 annual referrals. Lack of case management for our wounded, ill and injured RC members is negatively impacting our ability to ensure continuum of care and resolution of health care issues.

b. The OCAR Surgeon's Office prepared and submitted projected AR MCM funding requirements into the 12-17 POM in Dec 2009, which was validated Feb 2010.

c. The National Defense Authorization Act (NDAA) 2008 requires the development and implementation of a comprehensive policy on improvements to the care, management, and transition of Recovering Service Members and their families. Implementation of NDAA Care Coordination Requirements includes the creation of the Recovery Coordination Program (RCP) for Recovering Service Members (RSM) and their families; Developing uniform program for assignment, training, placement, supervision of Recovery Care Coordinators (RCCs), Non Medical Care Managers (NMCs); Developing content and uniform standards for the Comprehensive Recovery Plan (CRP) including uniform policies, procedures, and criteria for referrals; and, Developing uniform guidelines to provide support for family members of RSMs.

d. Title 10, U.S.C., Section 1074a established that all AR Soldiers serving on active duty for a period of 30 days or less, inactive-duty training (IDT); or while serving on funeral honors duty under section 12503 of this title or section 115 of title 32 are entitled to the medical and dental care appropriate for the treatment of the injury, illness, or disease of that person until the resulting disability cannot be materially improved by further hospitalization or treatment.

e. AR 40-501, paragraph 8-20.b.4.a Part 3 of the Periodic Health Assessment (PHA) process requires the physician, nurse practitioner or physician assistant to review the Soldier's statement of health, completed tests and reports, PULHES, and readiness screening informa-

tion and make referrals as indicated. Paragraph 8-20.b.4.e requires referrals to be submitted and orders entered for any required preventative or readiness related medical services not immediately available during the PHA process.

f. AR 40-501, paragraph 8-20.c – Follow up. Soldiers of the USAR who are not on active duty will be scheduled for follow-up appointment and consultations at Government expense when authorized. Treatment or correction of conditions or remediable defects as a result of examination will be scheduled if authorized. If individuals are not authorized treatment, they will be advised to consult a private physician of their own choice at their own expense.

g. The OCAR Surgeon's Office had previously prepared and submitted a similar Concept Plan, for behavioral health case managers. The document will be modified to create a separate AR MCM Concept Plan, as the funding for the behavioral health case managers is only to be allocated for that program. The AR MCM Concept Plan will be ready for internal staffing no later than 4th Quarter FY11.

h. Twelve nurses were mobilized in the 3<sup>rd</sup> Qtr FY 11 to support a bridging strategy.

i. Projected start date for contracted case managers is 2<sup>nd</sup> QTR FY 12.

j. Placement of Case Managers: Case Managers will initially be located at the Medical Management Activity in Pinellas Park, Florida, and at the four Regional Support Commands; 99<sup>th</sup> RSC, Fort Dix, NJ; 88<sup>th</sup> RSC, Fort McCoy, WI; 63<sup>rd</sup> RSC, Moffitt Field, CA, and 81<sup>st</sup> RSC, Fort Jackson MI.

(3) ARNG and USAR met in May and June 2011 to assist in formal development of USAR case management program. The USAR shelved the initial COA, and they are currently activating their Nurse Corps officers to fill in as CM's while they work on a national contract. The USAR plan for full implementation is 1 October 2011.

**h. Lead agency.** ARNG and USAR

## **Issue 667: Identification (ID) Cards for Surviving Children with Active Duty Sponsor**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 6 Sep 11)

**d. Subject area.** Family Support

**e. Scope.** There is no way to annotate dependent survivor status (DB, DEC) and active duty status (AD) on a survivor children dependent ID cards. As a result, surviving dependents must present their active duty dependent ID and additional documentation to be given Army Family Covenant (AFC) survivor-specific services. Without a visible dual identifier, surviving active duty status Families are caused undue emotional stress when they must justify their survivor status.

**f. Conference Recommendation.** Annotate both dependent survivor status and AD status on survivor children dependent ID cards.

**g. Progress.**

(1) There is no annotation of survivor dependent children status DoD Beneficiary (DB), Deceased, (DEC) and active duty status (AD) on dependent ID card for surviving

children. To receive Army Family Covenant (AFC) survivor-specific services, survivor dependent children of deceased service members who have become the step-children of another serving Army member (by the current member's marriage to the deceased service members widow or widower) must present an active duty status ID card and the Report of Casualty which contains graphic detail of how their loved one perished.

(2) A child may possess only one dependent ID card at a time; the benefits afforded the dependent child through DEERS via a dependent ID Card are identical whether they are carrying an ID card as the child of the deceased service member or as the child of the active duty stepparent; and based on information provided, the "valuable" benefits being lost are services of higher priorities being afforded these children as the dependent of a deceased service member and fee reduction or elimination; and finally a Command Memorandum was proposed to be issued for these children in lieu of presenting "casualty documents" or modifying DoD ID Cards.

(3) Army DEERS RAPIDS Project Officer presented the request verbally to the Joint Uniformed Services Personnel Advisory Committee (JUSPAC) representatives, and to the OSD (PR) Identification Card proponent. Response was that there is no loss of benefits, that they do not see a valid requirement, and that there is an unfunded cost to modify DEERS RAPIDS programs.

(4) Army DEERS RAPIDS Project Office prepared a Memorandum for The Adjutant General to the Director, Defense Human Resources Activity for consideration of DoD Policy change which was signed 13 April and sent on 18 April 2011.

(5) DHRA responded with a memorandum dated 23 May 2011 authorizing a "DUAL- STATUS" over-stamp for ID Cards of surviving dependent child population.

(6) Currently working with DMDC to pull data to see how many Families the approved over-stamp will effect.

**h. Lead agency.** AHRC

### **Issue 668: In-Vitro Fertilization (IVF) Reimbursement for Active Duty Soldiers and their Dependant Spouse**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 30 Sep 11)

**d. Subject area.** Medical

**e. Scope.** TRICARE covers minimal infertility testing and treatment for Active Duty Soldiers and their dependant spouse, but does not cover the procedure(s) which may result in conception, i.e. IVF. While costs vary, a typical IVF cycle in a Military Treatment Facility costs the Soldier's Family approximately \$6,500. The majority of couples require two IVF cycles to achieve successful conception. A reimbursement program currently exists for adoption in accordance with DODI 1341.09, DoD Adoption Reimbursement Policy, paragraph 4.1, "a Service member who adopts a child under 18 years of age may be reimbursed reasonable and necessary adoption expenses, up to \$2,000 per adoptive child, but no more than \$5,000 per calendar year." A similar reimbursement program to assist with the costs of IVF for Active Duty Soldiers and their dependant spouse will help ease a significant financial burden.

**f. Conference Recommendation.** Create a reimbursement program for Active Duty Soldiers and their dependant spouse to assist with the medical costs of up to \$2,000 per In-Vitro Fertilization Cycle performed at Military Treatment Facilities, but no more than \$5,000 per calendar year.

**g. Progress.**

(1) TRICARE's exclusion of artificial insemination follows common practices of health insurance companies across the board. The vast majority of health insurance companies do not offer any artificial insemination coverage as part of the benefits. Only a few states have legislation mandating the coverage of artificial insemination to be offered as part of the covered benefits.

(2) In Vitro fertilization services are currently available at a shared cost from a limited number of MHS facilities with adequate resources to perform the procedures. TRICARE does cover a wide range of infertility treatments and services, including, but not limited to: hormonal treatments, Human Chorionic Gonadotropin (HCG) administration, corrective surgery, antibiotics and radiation therapy. Seven (7) Military Treatment Facilities (MTFs), Tripler, Madigan, Walter Reed and Womack, Army Medical Centers provide In-vitro fertilization Services and train providers as well. Other facilities providing IVF services are the San Antonio Military Medical Center (SAMMC), as well as Portsmouth and San Diego, Navy Medical Centers.

(3) In 3<sup>rd</sup> QTR FY11, we wrote a Deputy Surgeon General (DSG) memorandum for the Deputy Director of the TMA requesting assistance in bringing issue before Congress. The statute to allow for the adoption reimbursement would fall under Title 10 USC, chapter 53 § 1052.

(4) On 11 June 2011, TMA replied to the DSG request. They do not support the recommendation of adding a partial reimbursement for in-vitro fertilization. TMA believes existing MTF IVF training programs offer affordable access to these uncovered reproductive services at a significant cost-savings when compared with those offered in the civilian community. TMA would not support a Unified Legislative and Budget Proposal that would provide partial reimbursement of these services as a medical benefit using Defense Health Program (DHP) funding.

**h. Lead agency.** DASG-HSZ

**g. Support Agency.** TMA

### **Issue 669: Medical Retention Processing 2 (MRP2) Time Restrictions for Reserve Component (RC) Soldiers**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 6 Sep 11)

**d. Subject area.** Force Support

**e. Scope.** RC Soldiers can only apply for MRP2 within six months from their date of release from active duty (REFRAD). Warrior Transition Unit Consolidated Guidance (WTUCG 20 March 2009) states the MRP2 program is designed to return Soldiers back to active duty for the purpose of evaluation, treatment, and/or physical disability evaluation system (PDES) processing. Examples of conditions that might not manifest within six months include Post Traumatic Stress Disorder (PTSD), Traumatic

Brain Injury (TBI), and recurring orthopedic injuries. Extending the MRP2 time restriction to five years would allow RC Soldiers to receive proper medical treatment in order to identify and resolve contingency related medical and behavioral health conditions.

**f. Conference Recommendation.** Extend the MRP2 time restriction for RC Soldiers from six months to five years of REFRAD date.

**g. Progress.**

(1) DCS, G1 Medical Policy is currently developing recommendation to remove 6 month MRP2 administratively exception to policy from requirement. The 6-month Army policy was an ASA (M&RA) initiative and does not require DoD involvement to change.

(2) DCS, G-1 is formally staffing a Continuum of Care policy, which is a revision to the current MRP2 process. Current process for RC Soldiers requesting to return to active duty is submitted directly to the Medical Review Board (MRB). Revised process will ensure facilitation and follow-up through the Soldier's chain of command. The policy will have a revised time restriction: Soldier may apply within 6 months of a completed LOD.

(3) Policy change will be reflected into a new Army Regulation (AR 600-XX), Policy, Procedures and Management of Wounded, Ill and Injured. Publication date no later than 2<sup>nd</sup> quarter, fiscal year 2012.

(4) DCS, G-1 implemented a blanket approval for all requiring an administrative exception to policy based on the 6 month rule. Until the completion of the formal staffing and publication of the AR, the implemented blanket approval memo will remain in effect. Any Soldier/Soldier's commander who feels the Soldier's medical treatment plan requires return to active duty for medical management is authorized to apply for MRP2, regardless of time between injury and MRP2 request.

**h. Lead agency.** DAPE-MP

**Issue 670: Medically Retired Service Member's Eligibility for Concurrent Receipt of Disability Pay (CRDP)**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 30 Aug 11)

**d. Subject area.** Entitlements

**e. Scope.** Medically retired service members (SM), with less than 20 years of active service, are not eligible for CRDP. In order to qualify for CRDP, the Soldier must meet the required service time and a 50% or higher Veterans Affairs (VA) disability rating. CRDP eliminates the offset between retirement pay and VA disability compensation. As of June 2010, there were more than 10,000 medically retired Soldiers (statistics were unavailable for all other military branches) with a VA disability rating of 50% or higher who are currently ineligible for CRDP. Removal of the 20 year restriction for CRDP would restore the full retirement pay and VA entitlements to the medically retired SMs.

**f. Conference Recommendation.** Eliminate the time in service requirement for medically retired SMs to be eligible for CRDP.

**g. Progress.**

(1) Legislative proposals H.R. 333, 186, 1979, and S. 344 have been introduced in the 112<sup>th</sup> Congress. This

legislation, if enacted, would provide the relief requested. However, all proposals include additional provisions not related to the scope of this AFAP proposal and would cost \$23.6 billion over the next 10 years (FY 2012-FY 2021), of which \$10.1 billion is the cost to the Army.

(2) On 11 August 2011, Mr. Gary McGee, Assistant Director Military Compensation, Office of the Deputy Undersecretary of Defense for Military Personnel Policy, stated that for the previous two years, DoD supported extending CRDP to medical retirees with less than 20 years active service at the direction of the White House. However, this year the White House did not direct DoD to support this initiative, and DoD did not address it with Congress. At this time, DoD is seeking neither the further expansion of the CRDP program nor the repeal of the VA offset.

**h. Lead agency.** DAPE-PRC

**Issue 671: Military Child Development Program (MCDP) Fee Cap**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No

**d. Subject area.** Child Care

**e. Scope.** Some Military Families utilizing Military Child Development Programs pay greater than 25% of their monthly income for childcare. For example estimated gross monthly income (not including living expenses or taxes as of January 2011): E-5 Single Parent, 3 children under 5 years old, Pay w/allowances \$3,575 Cat 3, MCDP Fees (3 children) \$1,060 = 29%. 2LT with spouse w/minimum wage job 3 children under 5 years old, pay w/allowances \$3,856, wife's pay \$1,075, total combined income \$4,931 Cat 5, MCDP Fee (3 children) \$1,300 = 26%. Military Child Development Program fees are based on Total Family Income (TFI). Establishing a MCDP cap of 25% of TFI will minimize financial hardship caused by the disparity of the gross income to childcare cost ratio.

**f. Conference Recommendation.** Cap Military Child Development Program Fees at 25% of the Military Family's TFI.

**g. Progress.**

(1) The School Year 11-12 Army Child & Youth Fee Policy is being staffed for coordination. Projected date of implementation is 1 Nov 2011.

(2) IMCOM G-9 is preparing updated marketing materials and guidance for Parent Central Services to inform parents whose child care fees exceed 25% of their total family income to apply for financial hardship.

**h. Lead agency.** DAIM-ISS

**i. Support agency.** IMCOM G9, Child, Youth & School Services

**Issue 672: Reimbursement for Public School Transportation for Active Component (AC) Army Families**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 8 Sep 11)

**d. Subject area.** Youth

**e. Scope.** AC Army Families residing in some public school districts are charged for transportation to and from school. According to *The American School Bus Council*, 13 states allow local school districts to charge transportation fees. The average annual fee per child for school transportation in Southern California is \$500, Hawaii is \$360, and Massachusetts is \$520. More and more public school districts nationwide are charging parents for school transportation due to the state of the economy. Without reimbursement, school districts charging fees for school transportation may cause undue financial hardship for AC Army Families.

**f. Conference Recommendation.** Authorize reimbursement to AC Army Families for the cost of public school transportation.

**g. Progress.**

(1) To more fully understand the impact, IMCOM G9 will conduct a data call for bus transportation fees. Estimated cost is \$20M per year.

(2) OACSIM will determine if the Army has authority to reimburse bus fees and who has policy oversight, ramifications of providing reimbursement for bus fees and level of support for this initiative.

**h. Lead agency.** DAIM-ISS

**Issue 673: Space-Available (Space-A) Travel for Survivors Registered in Defense Enrollment Eligibility Reporting System (DEERS)**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 17 Aug 11)

**d. Subject area.** Family Support

**e. Scope.** Survivors are not authorized to travel Space-A on Air Mobility Command (AMC) aircraft after the loss of their sponsor. The Space-A Program was established to support Uniformed Servicemembers as an avenue of respite from rigors of duty. Recent changes allow Family members in certain categories to travel Space-A without being accompanied by their sponsor. Extending Space-A travel to Survivors registered in DEERS maintains the travel benefit they were privileged to while their sponsor was alive.

**f. Conference Recommendation.** Authorize Space-A travel for Survivors registered in DEERS.

**g. Progress.**

(1) Army G-4 submitted this item for consideration and concurrence to ADUSD-TP in Feb 2011 and to the Services and AMC in Apr 2011. ADUSD-TP, Services and AMC non-concurred with a change to DoD 4515.13-R to allow Survivors Registered in DEERS the privilege to travel Space-A, citing that in the current resource-constrained environment an increase in eligibility would impact DoD's ability to effectively accomplish the airlift mission and negatively affect support to active duty Space-A travelers.

(2) The pool of individuals covered under the Survivors Registered in DEERS category is quite large (approximately 594,537). Once accepted for movement, a Space-A traveler may not be "bumped" by another Space-A passenger regardless of category.

(3) Expansion of the eligibility pool to additional personnel will reduce availability of Space-A travel to active duty members, retirees and their families. DoD has consistently non-concurred with similar requests from other categories such as Disabled Veterans and Gray-Area retirees.

**h. Lead agency.** DALO-FPD

**Issue 674: Strong Bonds Program for Deployed Department of Army Civilians (DACs) and Family Members**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 19 Aug 11)

**d. Subject area.** Employment

**e. Scope.** Department of Army Civilians (DACs) are not authorized to utilize the Strong Bonds program. DACs are being deployed into Overseas Contingency Operations (OCO) and combat zones. As a result, deployed DACs and their Families undergo many of the same stresses and have similar relationship issues related to long-term separations and difficult experiences as Soldiers and their Families. Permitting the use of the Strong Bonds program will allow deployed civilians and their Families the benefits of creating strong support groups, building resilient relationships, and promoting healthy Families.

**f. Conference Recommendation.** Authorize deployed DACs and their Families use of the Strong Bonds program during pre-deployment, deployment and/or reintegration.

**g. Progress.**

(1) OTJAG advised action must go through the Unified Legislative and Budgetary (ULB) process to propose a change to Title 10, Section 1789, since this restricts utilization of appropriated funding to military personnel and Family members. To strengthen the case ASA(M&RA)/G-1 Congressional Affairs recommends broadening the legislative proposal to also include other services. Proposal will specify current or future programs that are similar to the Army's Strong Bonds training that are chaplain-led relationship building events to strengthen personal relationships, marriage and Family bonds for deploying Civilians and their immediate Family members prior to and following deployment. Once the legislative change is authorized the Service Chiefs will have final authority to approve use of funding for this purpose.

(2) 18 August 2011. Participation by deployed DACs and immediate Family members would be streamlined into existing Strong Bonds events based upon local commander guidance. It was determined that no CBA is required since no additional funding is requested, simply addition of more participants. Coordinated with ASA (M&RA)/G-1 Congressional Affairs; ASA (M&RA) & DCS, G-1 Legislative Affairs; and Army Family Action Plan, Office of the Assistant Chief of Staff for Installation Management & Family Readiness Division.

(3) An ULB (Nonbudgetary – B Cycle) proposal to be submitted to ASA(M&RA)/G-1 Congressional Affairs February 2012.

**h. Lead agency.** OCCH

**Issue 675: TRICARE Medical Coverage for Dependent Parents and Parents-in-Law**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 30 Sep 11)

**d. Subject area.** Medical

**e. Scope.** Dependent Parents and Parents-in-Law are not entitled to purchase TRICARE medical coverage. Soldiers and their primary dependents are authorized TRICARE benefits, including TRICARE Prime, Standard, Extra, TRICARE Young Adult and TRICARE for Life. Dependent Parents and Parents-in-Law are only authorized care on a space available basis and pharmaceuticals from Military Treatment Facilities (MTF). As a result, Dependent Parents and Parents-in-Law either purchase expensive outside medical insurance, pay out of pocket without reimbursement or neglect their health.

**f. Conference Recommendation.** Authorize Dependent Parents and Parents-in-Law the option to purchase TRICARE medical coverage.

**g. Progress.**

(1) Legislative statutes, Federal regulations, and policies determine dependency and dependent eligibility for any Department of Defense (DoD) sponsored medical entitlement, i.e. TRICARE benefits. The referenced statutes, Federal regulation, and policies are: Title 10, United States Code (USC) Sections 1072, 1079, and 1086; Title 32 of the Code of Federal Regulations (CFR), Parts 199.17 and 199.3; Department of Defense Instruction (DoDI) 1000.13, subject, Identification (ID) cards for Members of the Uniformed Services, Their Dependents, and Other Eligible Individuals, and the DFAS Military Pay Secondary Dependency Guide.

(2) The Defense Enrollment Eligibility Reporting System (DEERS) maintains key data elements on active duty service member (ADSM), active duty family member (ADFM), and military retirees, to identify eligibility status as well as elective enrollments status for many authorized medical entitlements. All authorized entitlement changes to DEERS, including medical, must be done according to the DoDI 1000.13 and executed at a DEERS/RAPIDS ID Card issuance facility.

(3) Title 10 USC status authorizes medical entitlements that are reflected in DEERS based on the beneficiary's eligibility. According to the Military Pay Secondary Dependency Guide, a secondary dependent may include parents or parents-in-law, step-parents, unmarried illegitimate children under age 21, which are verified by the finance or personnel office. Dependent parents or parents-in-law are currently not entitled to TRICARE benefits, including TRICARE Prime, Standard, Extra and TRICARE for Life. Secondary dependents are only authorized medical care on a space available basis in military treatment facilities (MTFs), or TRICARE Plus, as well as the receipt of pharmaceuticals from the MTFs. On turning 65 the dependent parents/parents-in-law can utilize the TRICARE Pharmacy benefit as long as they have enrolled in Medicare B.

(4) Lessons Learned from previous statutory TRICARE plans for purchase. MEDCOM/OTSG was an active participant in the requirements building and implementation strategies for TYA. This AFAP issue's recommendation

to offer a purchased (premium-based) option of TRICARE coverage will be similar to the TYA design. The dependency criteria of the TYA applicant, which is linked to their sponsor, can also be accomplished for the parent/parent-in-law as their dependency status is already outlined in law, Federal regulations and DoD entitlement manuals. Further discovery with sister Services and TMA will be required to determine if authorizing the purchase of TRICARE Standard is the most feasible verses the more complex process of also offering the purchase of TRICARE Prime. Another current program that can be compared for similarity is the TRR plan. Both TYA and TRR have premiums designed to cover the full cost of the purchased plan.

(5) Initial Data. The US Army Medical Command (MEDCOM) requested a data pull from the Defense Eligibility Enrollment Reporting System (DEERS) that outlined the target population by Service and by COMPO.

(6) Follow-on Data. The MEDCOM requested a follow-on data pull from the DEERS that outlined the target population by Service and by COMPO, and then further filtered by only those dependent parents/parents-in-law that are over 65 years old and by age alone eligible for Medicare. The results are portrayed in the table below (see next page). The delta between the initial data pull and the follow-on is the eligible population for dependent parents/parents-in-law, <65 years of age.

a. The program complexity seen in implementing TYA to account for changes in a sponsor's status from Reserve Component to Active Duty (AD), then return, and from AD to retired, leads the action offer to recommend limiting the dependent parent healthcare coverage purchase to those dependent parents/parents-in-law of active duty sponsors only. With this consideration the estimated targeted population decreases to 7,380, with the possibility to max out at 8,462 if every RC with a dependent parent/parent-in-law was activated to AD and enrolled their secondary dependent.

b. The Army Exceptional Family Member Program (EFMP) reports that in the Army alone there are approximately 1,000 dependent parents/parents-in-law that are listed as EFMP members. This awareness of potential complex medical needs by this already small population may have an adverse affect on the premium costs.

c. A formal request to TMA for either their support or non-support is on hold till the final implementation issues surrounding TYA are resolved. The issues surrounding the TYA implementation will determine the most logical approach for success of this AFAP recommendation.

(7) MEDCOM/OTSG requests that this issue remain ACTIVE until discussions with sister Services and TMA can be properly performed to ascertain viability of a premium-based option.

**h. Lead agency.** MCHO-CL-M

**g. Support agency.** TMA

**Issue 676: TRICARE Medical Entitlement for Contracted Cadets and Their Dependents**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 30 Sep 11)

**d. Subject area.** Medical

**e. Scope.** Contracted Cadets and their dependents are not eligible for TRICARE medical entitlements. Cadets are only entitled to DoD funded line of duty medical care during training status. Since they are not covered full time, Cadets are required to obtain medical insurance, often from their university. University insurance policies could cost as much as \$435 per month for a Cadet with authorized dependents. Not all university insurance policies offer dependents coverage. "TRICARE Reserve Select (TRS) is a premium-based health plan available worldwide to Selected Reserve members of the Ready Reserve (and their families) who are not eligible for or enrolled in the Federal Employee Health Benefits (FEHB) program (as defined in Chapter 89 of Title 5 U.S.C) or currently covered under FEHB, either under their own eligibility or through a family member." A contracted cadet and their dependents have many of the same health challenges as a Selected Reserve and their dependents. A medical health care entitlement, similar to TRS, for contracted Cadets and their dependents will help to ease a financial burden.

**f. Conference Recommendation.** Authorize contracted Cadets and their dependents enrollment in an entitlement similar to TRICARE Reserve Select.

**g. Progress.**

(1) Request was made to Army Cadet Command to obtain accurate numbers relating to the current contracted cadet population. Army cadet population numbers requested include the total population, number of contracted cadets, cadet ages, and number of contracted cadets with family members. Yearly commissioning mission numbers and the total percentage of mission accomplishment over the past couple of years was also requested, as well as any other pertinent information that would support this request for medical benefits to the contracted Army cadet population. Rough numbers were received and forwarded in TMA's request for feasibility assessment.

(2) No current ULBs or legislative actions with similar titles were found in the system.

(3) Telephone conversation with Army Cadet Command Surgeon's office provided overview of medical issues with the current contracted cadet ROTC population. Discussion included the generalized breakdown of medical terminations from the program by category of reasons they drop and why they are retained. From 2009-2010, approximately 1379 cadets were considered for possible medical termination drops. Of those 1379, 1098 cadets (80%) were considered for retention and 281 were medically released. Of those 281 medically released, orthopedic issues were the primary reason. Mental Health issues accounted for approximately 1/3 of the releases and comprised of issues not eligible for a medical waiver. These medical terminations are relevant when discussing how many cadets are possibly affected by medical issues during their college studies and must be dropped from the ROTC rolls, which may affect the ROTC commissioning mission.

(4) Per Army Cadet Command, accession was 1-2% short of mission last year (50-100 officers) and OCS picked up the rest of the mission to make 100% of the accession requirement. For at least the last 10 years, the

ROTC commission mission was met based on the additional fill-the-gap OCS commissions.

(5) IAW AR 40-400, all ROTC members are covered under Office of Workers' Compensation Program for injuries sustained provided the condition necessitating treatment was incurred in the line of duty traveling to or from military training, camp, or exercise, or while attending conditions of military training, camp or exercise.

(6) Insurance is about protection and even healthy people need to use medical services. Individuals and their Families need to have access to care and be able to afford the required medical treatments or preventative services. Cadets currently have several ways they can obtain medical coverage for themselves and their families. Under the Affordable Care Act, passed in March 2010 and begun in September 2010, one benefit is that if individuals under the age of 26 years are eligible to be covered under their parent's healthcare policy, they can remain on that policy, no matter what the living situation. Although, until 2014, "grandfathered" group plans do not have to offer dependent coverage up to age 26 if a young adult is eligible for group coverage outside their parents' plan. This plan may prove beneficial for younger ROTC cadets who are able to continue on their parent's insurance plan. Many students obtain medical insurance for an out of pocket cost directly from their school insurance policies made available during their enrollment to the school. Another way for students to obtain healthcare insurance is to purchase it through their own or a spouse's employer.

(7) Request sent to TRICARE Management Activity (TMA) on 21 July 2011 in order to determine the feasibility of providing contracted ROTC cadets and their dependents with a program enabling enrollment in a medical entitlement similar to TRICARE Reserve Select. Response received from TMA, dated 23 September 2011, states that due to the austere funding for the Military Health System, they do not support the creation of a new TRICARE entitlement for cadets and their dependents. In addition, there is no statutory authority to provide any TRICARE coverage to contracted cadets or their dependents until they are commissioned in the Armed Forces.

**h. Lead agency.** OTSG-HR

**g. Support Agency.** OASD-HA, TMA

**Issue 677: "Virtual" Locality Pay for Department of the Army Civilians (DACs) Retiring Outside the Continental United States (OCONUS)**

**a. Status.** Active

**b. Entered.** AFAP XXVII, Feb 11

**c. Final action.** No (Updated: 11 Aug 11)

**d. Subject area.** Employment

**e. Scope.** Because DACs retiring OCONUS do not receive locality pay, their retirement annuity is less than the annuity of a DAC of comparable grade who retires from a CONUS location. When calculating "annuity pay" for a DAC employee located in CONUS, base pay plus the locality pay is used. When calculating "annuity pay" for a DAC employee located OCONUS, only base pay is used. The purpose of "Virtual" Locality Pay is to achieve equity of retirement pay of CONUS and OCONUS employees at the end of the employees' career. "Virtual" Locality Pay

would enable overseas employees to have their annuity benefits calculated as if they received CONUS based locality pay in the computation for their “high three years” of average salary.

**f. Conference Recommendation.** Authorize “Virtual” Locality Pay to DACs for computing retirement annuities when retiring OCONUS.

**g. Progress.**

(a) Researched similar VLP legislative proposals since 2005. Each proposal was rejected by OMB as too costly. In addition, DACs have the option of returning CONUS to increase their average salary for retirement purposes per DoD’s current 5-year OCONUS rotation policy. This policy is predicated on the view that an overseas assignment is one step in the career management process.

(b) Based on analysis of data obtained from FY 2009 Legislative Initiative ULB Proposal (Unified Legislation and Budgeting), Cost Analysis does not support this action due to the current economic climate and cost.

(c) On 1 July 2011, DAPE-CP submitted informal request to OSD with Cost Analysis data to further justify the recommendation for final solution.

(d) On 11 August 2011 DAPE-CP received OSD’s non concurrence due to the current fiscal climate.

**h. Lead agency.** DAPE-CP