AFAP ISSUE UPDATE BOOK

Active Issues

February 2015

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

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688	Resilience Training for Army Children	Active	Child & Youth	Apr-14
679	Creditable Civil Service Career Tenure Requirements for Federally Employed Spouses of Service Members and Federal Employees	Active	Employment	Feb-12
689	Sexual Assault Restricted Reporting Option for Department of Army Civilians	Active	Employment	Apr-14
625	Transitional Compensation Benefits for Pre-existing Pregnancies of Abused Family	Active	Family Support	Dec-07
650	Exceptional Family Member Program Enrollment Eligibility for RC Soldiers	Active	Family Support	Jan-10
684	Survivor Investment of Military Death Gratuity and Service Members' Group Life Insurance (SGLI)	Active	Family Support	Feb-12
614	Comprehensive Behavioral Health Program for Children	Active	Military Health System	Dec-07
641	Over Medication Prevention and Alternative Treatment for Military Healthcare System Beneficiaries	Active	Military Health System	Jan-09
665	Formal Standardized Training for Designated Caregivers of Wounded Warriors	Active	Military Health System	Feb-11
596	Convicted Sex Offender Registry OCONUS	Active	Soldier Support	Nov-06
609	Total Army Sponsorship Program	Active	Soldier Support	Nov-06
669	Return to Active Duty Reserve Component Medical Care Time Restrictions for Reserve Component Soldiers	Active	Soldier Support	Feb-11

Issue 596: Convicted Sex Offender Registry
a. Status. Active
b. Entered. HQDA AFAP Conference, 17 Nov 06
c. Final action. No (Updated: 10 Feb 15)
d. 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.
e. 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
f. Progress.
(1) On 2 Sep 12, AGC and OTJAG did not support publishing the names of Army sex offenders on installation web pages - opining "significant policy concerns". The intent for an Army hosted RSO website is realized by the DoD Law Enforcement (LE) initiative to match the FBI NSOR against the DEERS effectively identifying any RSOs in DEERS (Service members, military dependents, federal employees, contractors).
(2) OUSD (P&R) LE staffed draft DoD DTM 104–XX RSO Identification, Notification, and Monitoring to establish policy for management of information received via the DEERS/FBI NSOR cross-check. Once the system is activated, the DoD LE will forward the OPMG with applicable information for matches encountered. This information will be forwarded to the appropriate installation PMG office for appropriate management.
(3) HRC is tracking Soldier-registered sex offenders by coding them with an eligibility limiting assignment code (L8), which limits their assignment eligibility. Quarterly updates of these Soldiers with a qualifying sexual assault conviction are provided to HRC by the DCS, G-1 (HRPD), OTJAG, and OPMG. Soldiers who are convicted sex offenders are notified of the requirement to in-process with the PMO. Additionally, installation PMOs are required to communicate convicted sex offender information between gaining and losing PMOs.
(4) SecArmy Directive 2013-21, Initiating Separation Proceedings and Prohibiting Overseas Assignments for Soldiers Convicted of Sex Offenses, was signed on 7 Nov 13. The Directive requires commanders to initiate administrative separation of any Soldier convicted of a sex offense. If the separation authority ultimately approves retention, he or she will initiate an action for the exercise of Secretarial plenary separation authority. If a Soldier has already been the subject of an administrative separation action for that conviction and has been retained as a result of that proceeding, the separation authority will initiate a separation action under Secretarial plenary authority. In addition, the directive requires commanders to ensure that Soldiers convicted of a sex offense are not assigned or deployed on a temporary duty assignment, temporary change of station, or permanent change of station status to non-permitted duty stations OCONUS. The only permitted OCONUS locations are Hawaii, Alaska, the Commonwealth of Puerto Rico, or Territories or possessions of the United States. Soldiers currently serving in any non-permitted OCONUS location are ineligible for continued duty at those locations. Accordingly, overseas commanders are required to identify such Soldiers in their commands and coordinate for reassignment to CONUS or permitted OCONUS locations.
(5) SecArmy Directive 2013-06, Providing Specified Law Enforcement Information to Commanders of Newly Assigned Soldiers, authorizes brigade level commanders to receive newly assigned Soldier's criminal history reports. The Army Law Enforcement Report will contain a sex offense reported to Army law enforcement.
(6) AR 614-200, Enlisted Assignments and Utilization Management, and AR 270-10, Military Justice, require Soldiers who are convicted sex offenders to register with the installation PMO. Further, AR 270-10 requires Soldiers convicted of a sex offense in a trial by Special or General Court-Martial (that requires sex offender registration and not confinement) be notified of the sex offender registration requirement by using DA Form 7439, Acknowledgement of Sex Offender Registration Requirements. A copy of that form is required to be sent to the OTJAG who will notify HRC (using the DA 7439 and other relevant materials) of Soldiers convicted of these non-confining sex offenses.
(7) Army in- and out-processing forms (DA Form 137-1 Unit Clearance Record; DA Form 137-2, Installation Clearance Record; DA 5123-1, In-Processing Personnel Record) revised in 3rd QTR FY10 require Soldiers to process through the installation PMO. Installation PMOs can conduct screening of Soldiers for registered sex offender status.
(8) In accordance with AR 420-1, Army Facilities Management, Soldiers, Family members, DoD civilians, or other civilians who are required to register as a sex offender, who intend on occupancy of/or overnight visitation to a Family housing dwelling unit, are required to provide proof of registration at the PMO prior to occupancy or visitation. Failure to do so will result in the host sponsor being evicted from housing.
(9) Publication of the next version of AR 190-45 will require all qualified convicted sex offenders (Family members, civilians, and contractors) who reside or are employed on Army installations to register at the installation PMO.
(10) DoD DTM Draft 104-XX, RSO Identification, Notification, and Monitoring in DoD, is in formal staffing. The DTM provides for the use of National Crime Information Center (NCIC) information retrieved through the Identity Management Capability Enterprise Services Application (IMESA) for DoD identification, notification, and monitoring of RSOs that live or work on DoD installations. The IMESA will identify affiliated personnel through DEERS, the installation local population database, delayed entry population file and the enlisted referral file and match them against the NCIC NSOR file. OSD will share NSOR

information with appropriate defense criminal investigative organizations. Operational capability is anticipated in 3rd QTR FY15.

(10) Draft DoDI 1315.18, Procedures for Military Personnel Assignments, is in final staffing. The DoDI will prohibit command sponsorship for service member dependents who are registered sex offenders. Command sponsorship is to be revoked for a dependent who becomes a registered sex offender while accompanying his or her sponsor during an overseas assignment and the dependent will be processed for early return of dependents.

(11) Publication of AR 614-30, Overseas Service, command sponsorship will not be granted to a dependent who is a registered sex offender. Soldiers will be required to declare RSO dependents during reassignment processing with the order issuing authority.

g. GOSC review.

(1) May 07. The issue was declared active.

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

(3) 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.

(4) Feb 12. GOSC discussion focused on the absence of an OCONUS sex offender registry, mandatory registration of contractors, applicability on joint bases, and military Family access to a PMO/garrison sex offender database. Both the VCSA and SMA addressed the inability to search a garrison registry. The DASD(MC&FP) validated that this is a service-wide problem. The VCSA directed G-1 to look at this across the board. Find out what the other services are doing; see if we can achieve the standards we want to achieve. G-1 will revise AR 190-45; revisit searchable registry and work with OSD and other services on common objectives and means to reach the objectives.

(5) Aug 12. VCSA directed G-1 to work on the specific issue of requirement to notify the community. The SMA's spouse questioned if on post residents are alerted if a pedophile moves into their neighborhood. The G-1 action officer commented that they protect the privacy rights of the sex offender until OGC authorizes release of that information on websites or a broader based alert system in the community. The ACSIM countered that it is a personal choice to live on an installation so if someone does not want that information released, they should live off post.

(6) Jun 13. VCSA directed G-1 to develop milestones for way ahead.

(7) Feb 14. The VCSA directed G-1 to continue working the dependent and Army Civilian side of the issue with OSD and the Joint Staff. OPMG stated brigade commanders have access not only to the sexual offender type information but also everything in the Army general crime database. This information provides the commander with a complete background on the Soldier. The criminal history sharing will evolve into the commander's risk reduction dashboard. The PMG illustrated that at Fort Bragg hundreds of felons are being prevented access due to the deployment of Army Installation Entry which, unlike proprietary systems such as Mobilisa and Rapid Gate, vets against authoritative databases. Installations are steadily becoming more secure. The SMA expressed concern that sex offender dependents are not self-registering with the proper authorities. As a result, the Army has no mechanism to track a dependent sex offender. The ACSIM recommended pulling in language from draft AR 190-45 (Law Enforcement Reporting) into AR 420-1 to assist in identifying sex offender dependents. The ACSIM further requested the Army clearly articulate the criterion which states a person is not permitted to operate or live on the installation. The G-1 representative confirmed there is no DoD policy that clarifies either criterion.

(8) Feb 15. The VCSA declared the issue active pending publication of regulatory guidance.

h. Lead agency. DAPE-ARD

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. HQDA AFAP Conference, 17 Nov 06

c. Final action. No (Updated: 10 Feb 15)

d. 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.

e. 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.

f. Progress.

(1) In May 10, a working group was established to identify ways to improve TASP. The group concluded that the guidance in AR 600-8-8 is clear, but requires visibility and enforcement Army wide.

(2) In Jul 10, 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 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 (DA Form 5434) and, when necessary, engage commands to ensure Soldiers, civilians, and Family members receive a sponsor when transitioning to gaining commands.

(3) In Mar 11, OACSIM-ISS requested both the IMCOM IG and 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 not a HRC requirement; their focus is on training S1/G1's on readiness issues such as reducing non-availables, casualty documents, and personnel systems. In response, in Apr 11, OACSIM-ISS requested Services Infrastructure Core Enterprise (SICE) Board's assistance to help address TASP compliance and enforcement issues across the Army.

(4) In Nov 11, the HQDA EXORD 018-12 and DA Form 5434 (revised) were published, including guidance to ensure standardization and sustainability of program operations, inspections through CIP and a requirement for commands to forward an annual assessment to OACSIM.

(5) In Dec 11, transferred lead agency for AFAP Issue #609 TASP to IMCOM to move forward with new guidance for executing TASP, to flow sponsorship process from receipt of assignment instructions to arrival at new unit of assignment, establish roles and responsibilities for integrators, linking sponsorship and in and out processing, ensuring a warm hand off of Soldier and Family members between losing and gaining commands.

(6) In Aug 12, TRADOC's Learning Integration Team analyzed the sponsorship process flow and requirements with the planned effort to align the ACT system with the mission and goals of the TASP. ACT sponsorship will allow the management of the sponsor-to-Soldier(s) relationship; facilitates the updating of DA Form 5434 by the Soldier and sponsor; build reports that allow program managers the ability to report on the program metrics; allows the creation, management, and storage of an online survey to facilitate collection of program metrics; and provides system-generated email notification to transitioning Soldiers and installation sponsorship coordinators.

(7) In Mar 14, IMCOM initiated the ACT sponsorship 90 day pilot to test standardized sponsorship procedures and requirements that enhance the ability to sponsor, receive, and integrate newly arrived Soldiers and their Families into the commands using an automated system. The sponsorship performance metrics were tracked for permanent party Soldiers placed on assignment instructions to designated pilot sites in Europe, Korea, Fort Hood, Fort Stewart, and Joint Base Lewis-McChord (JBLM) and initial military training graduates on assignment instructions to Hawaii, Fort Hood, Fort Stewart, and JBLM.

(8) In Sep 14, Formal staffing of the ACT Sponsorship Phased Implementation ALARACT will direct the usage of the ACT system to enforce standardized sponsorship procedures.

(9) On 9 Oct 14, ACT sponsorship training was successfully integrated into the Army Learning Management System (ALMS). This will enable commanders to track their pool of trained sponsors and make informed sponsor assignment in accordance with AR 600-8-8 and HQDA EXORD 018-12.

(10) OACSIM Installation Services, OACSIM Information Technology, DCS G1, IMCOM G1, IMCOM-SICE Infrastructure/Logistics Team, USAR, NGB, FORSCOM, and TRADOC continue to meet weekly with focus on the Army-wide deployment of a sponsorship automated system, publication of AR 600-8-8 revision and DA Pam 600-8-8 that will include standardized sponsorship procedures and the requirement to enforce TASP through the CIP using the ACT system.

g. GOSC review.

(1) 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.

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

(3) 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.

(4) Feb 12. VCSA expressed concern that deployments and frequent moves have frayed the Sponsorship Program. Including Sponsorship as an inspection item on the CIP is a good move. IMCOM will implement the TASP STRATCOM, expand in and out processing to include welcoming new Soldiers and Family Members to commands; and designate personnel to execute sponsorship liaison functions.

(5) Aug 12. The IG commented that Army Sponsorship is among one of the reoccurring issues/concerns across the field. The IG supports IMCOM's work but also notes that Sponsorship is a Commander and a leader responsibility for enforcement. The IG highlighted whether rear detachment commanders are sponsoring new arrivals to a unit. The ACSIM stated that IMCOM is creating the architecture that enables Commanders to execute in conjunction with the Garrison Commander. The IMCOM CSM highlighted the successful sponsorship program in USAREUR and their Sponsorship OPORD. The DAS expressed concern that most AIT Soldiers do not have a pin-point assignment prior to PCS and whether a sponsor will be available once that pin-point is determined. The IMCOM CSM concurred that is the goal in utilizing the Army Career Tracker. The ATEC Commander mentioned the complimentary issue with the Department of the Army Civilian (DAC) workforce. The ACSIM confirmed that IMCOM is building a Continuity of Operation Plan specifically for DAC sponsorship.

(6) Jun 13. Command Sergeants Major have to own this process. The VCSA encouraged IMCOM to incorporate texting into the pilot as the prime way to communicate with Soldiers as most Soldiers do not use AKO or enterprise email. The IMCOM CSM validated that at Fort Drum they went from 200 Soldiers without a sponsor every month to less than 20 Soldiers.

(7) Feb 14. The VCSA directed IMCOM to ensure they are incorporating the best practices of sponsorship developed at installations such as Fort Drum. The DASD(MC&FP) commented that the DoD has created the eSponsorship Application and Training website, called eSAT, to bring standardized sponsorship training to all appointed unit sponsors regardless of service. She extended an invitation for IMCOM to walk through what has been implemented to inform the Army's efforts and perhaps prevent any possible redundancies in the sponsorship program. VCSA expressed concern that DoD and the Army were competing against each other. The IMCOM G-1 clarified they have adopted the eSAT training that is incorporated on Military OneSource. It is the training tool used for every Soldier before they out-process at a duty location.

(8) Feb 15. The VCSA directed an IMCOM-led meeting with FORCSCOM, TRADOC, and the RC within 45 days to refine ACT and its role in sponsorship.

h. Lead agency. IMHR-M

i. Support agency. DAIM-ISS

Issue 614: Comprehensive Behavioral Health Program for Children

a. Status. Active

b. Entered. HQDA AFAP Conference, 4 Dec 07

c. Final action. No (Updated: 10 Feb 15)

d. 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.

e. 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.

f. Progress.

(1) OPORD 14-44, published 13 Mar 14, directs implementation of the CAFBHS. The CAFBHS model consists of three interrelated components that work in tandem to deliver BH care to Army children and Families:

(a) MTF Department of BH CAFBHS which provides BH consultation to the PCMH and time-limited, evidence-based BH treatment in collaboration with the PCMs. SBH provided in locations with on-post schools. Community Outreach provided at large installations to collaborate with on-post and community services.

(b) Tele-Behavioral Health (TBH) resources to provide regional tele-consultation support for PCMs and BH providers.

(c) Standardized education, training and coaching of PCMs and BH providers in evidence-based/informed practices to effectively deliver high quality BH care. CAFBHS is one of 11 BH clinical programs currently being standardized across the MEDCOM and is a recognized effort under the Ready and Resilient Campaign (R2C).

(2) Medical literature supports maximizing the role of the PCM in addressing common BH disorders and demonstrates that children and Families are satisfied with being treated for BH needs within primary care settings. The shift from a traditional, stove-piped, specialty-driven BH care model to an integrated, consultative, collaborative care model that maximizes the role of the PCM has been promoted by many professional organizations (American Academy of Pediatrics, American Academy of Family Physicians, American Academy of Child and Adolescent Psychiatry, and the American Psychological Association).

(3) Training for PCMs has been conducted for Pediatrics and Family Practice providers at Joint Base Lewis McChord (JBLM), Puyallup PCMH, Tripler Army Medical Center (TAMC), Schofield Barracks, Fort Bliss, and Fort Campbell. The Resource for Advancing Children's Health (REACH) Institute in collaboration with Mayo Clinic conducted training at Fort Drum in Apr 13. A train-the-trainer program for PCMs is being conducted at Regional Medical Commands (RMC).

(4) Training for BH care providers in evidence-based psychosocial practices has occurred for SBH providers at JBLM, Bavaria MEDDAC, Tripler Army Medical Center, Fort Bliss, Fort Campbell, Fort Carson, and Fort Meade. A train-the trainer program to expand training of BH providers in evidence-based psychosocial practices will be conducted.

(5) Integrating and coordinating BH services for children and Families within the MTF and local Army community, supporting the principles of a public health model of care, was successfully implemented at JBLM and Fort Campbell through the establishment of a Process Action Team (PAT). The PAT is comprised of leaders from Army Community Service; Child, Youth, and School Services; School Liaison Officer; Chaplain; SBH; Community Health Promotion Council; Garrison's Directorate of Human Resources; Military Family Life Consultants; Military OneSource; Family Advocacy Program; Family Readiness; and other Army and civilian community resources. CAFBHS coordination and services will be conducted in accordance with OPORD 14-44. MEDCOM also coordinated with the Military Child Education Coalition and determined that there is minimal overlap in their efforts and

ours since this agency focuses on the education of military youth and not BH care.

(6) Outcome Metrics are being developed. Standardized BH Service Line metrics, such as provider productivity and patient recapture rates within the MTF (access to care) will be collected in evaluating CAFBHS performance.

g. GOSC review.

(1) 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.

(2) 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.

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

(4) Feb 12. The Secretary of the Army (SA) asked what impact CFACs and SBH programs will have on the Army's requirements for BH providers. The Sergeant Major of the Army (SMA) asked if the objective was to expand SBH programs to all Army garrisons and specifically questioned how that would work with local school districts who have schools on military installations. The VCSA directed OTSG to define the objective and identify the resource requirement to achieve that objective. OTSG will train Primary Care Managers and BH providers; continue to establish and expand CFACs and SBHs to more installations and standardize metrics and data collection.

(5) Aug 12. The SMA expressed concern that efforts were targeted at deployment platform installations and needed to be expanded to TRADOC installations. The SMA also questioned whether children with behavioral health concerns are included in the EFMP assignment screening criteria. The G-1 could not confirm whether this was being done.

(6) Jun 13. Assistant Secretary of the Army for Manpower and Reserve Affairs cautioned about the Army's ability to sustain resourcing BH. OTSG countered that they will mitigate costs by training primary care providers and patient-centered homes to provide initial intake and then use telemedicine for consultation. VCSA directed OTSG to incorporate this initiative into the R2C.

(7) Feb 14. The VCSA directed OTSG to confirm the Army is not competing with the Military Child Education Coalition for similar resources. The SMA expressed concern in how to maintain funding for this initiative. The OTSG representative clarified that it is no longer a budget add-in and is now built into the POM through at least FY15-19. It is funded by Defense Health Program. OTSG is also setting up child psychologists, child behavioral health at a centralized location for them to dial in and be accessible for immediate access if a situation arises on an installation. The VCSA directed this issue be tied into the overall Ready and Resilient Campaign structure for visibility and continuity at the senior level. OTSG confirmed this is already in place. The ACSIM recommended that OTSG engage Family Advocacy, Army Community Service, behavioral health, and other Centers of Excellence activities at installations with the drills done with FORSCOM, TRADOC, AMC, USAR, and USARPAC. OTSG noted JBLM's installation Process Action Team, which meets twice a month, combines all of the counseling capabilities on post, including IMCOM, MEDCOM, and the DoDDS school system resources. The team also invites the community BH providers to participate. The Defense Health Agency (DHA) representative offered to work with OTSG on information technology directive with available monies for telemedicine.

(8) The VCSA directed OTSG to lay out their child BH integration efforts with community partners particularly at some larger Army installations. The VCSA expressed interested specifically with the nonprofit organization "Give an Hour."

h. Lead agency. DASG-HSZ

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

a. Status. Active

b. Entered. HQDA AFAP Conference, 4 Dec 07

c. Final action. No (Updated: 10 Feb 15)

d. 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.

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

f. Progress.

(1) In Jan 08, IMCOM G-9 Family Programs 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, IMCOM G-9 FP consulted with IMCOM CJA. IMCOM 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, IMCOM G-9 FP consulted with the Department of Health and Human Services Children's Bureau, who indicated that services are not made available to unborn children.

(4) In Feb 08, IMCOM G-9 FP consulted with OUSD(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, IMCOM G-9 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, IMCOM 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 In Progress Review 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 SGLI.

(8) In Sep 09, a VA official informed IMCOM G-9 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, IMCOM G-9 FP consulted with IMCOM CJA regarding the feasibility of VA definition/legislation being applied for TC. IMCOM 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, IMCOM 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, IMCOM 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 10 Oct 08, the date of enactment of the Veteran's Benefits Improvement Act.

(11) In Mar 10, OACSIM-ISS consulted with IMCOM CJA to reconfirm support to request a legislative change to the definition of "dependent" in the TC statute. IMCOM 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, Office of the Secretary of Defense (OSD) sponsored the proposal.

(13) In Mar 11, the Principal Deputy OUSD (P&R) approved the TC proposal.

(14) In Nov 11, TC proposal became an Omnibus 2013 proposal and was sent to Office of Management Budget (OMB) for review and interagency coordination.

(15) In Mar 12, TC proposal was approved by OMB awaited final approval in the FY13 NDAA.

(16) In May 12, OACSIM-ISS learned TC proposal is included in both the Senate and the House versions of the FY13 NDAA.

(17) In May 12, OACSIM-ISS sent OSD draft language for inclusion in a DoD Policy Memo. If FY13 NDAA includes TC proposal, DoD Policy Memo will be required to ensure TC applicants can benefit as expeditiously as possible from this change.

(18) In Jan 13, the FY13 NDAA was approved by the President. The Services are awaiting formal OSD guidance which will allow the Services the authority to implement the changes as set forth in the FY13 NDAA.

g. GOSC review.

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

(2) Aug 11. OACSIM will monitor final language in the FY13 NDAA.

(3) Feb 12. OACSIM will monitor final language in the FY13 NDAA.

(4) Aug 12. The Chief, Legislative Liaison cautioned that while the proposal was included in the House version of the NDAA, the proposal has not been passed by the Senate floor or gone to conference to be included in the mark. VCSA asked Chief, Legislative Liaison to provide a heads up if it looks like the proposal will run into difficulty.

(5) Jun 13. The VCSA directed the issue remain active.

(6) Feb 14. The ACSIM Installation Services (IS) Director requested DASD(MC&FP)'s support to push the formal OSD guidance which will allow the Services the authority to implement the changes. The DASD(MC&FP) confirmed the DoD Financial Management Regulation should have the changes on in utero dependents published in Apr 2014.

(7) Feb 15. The VCSA declared the issue active pending Army-wide guidance on updated OSD policy.

h. Lead agency. DAIM-ISS

i. Support agency. IMCOM G9

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

a. Status. Active

b. Entered. HQDA AFAP Conference, 30 Jan 09

c. Final action. No (Updated: 10 Feb 15)

d. 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.

e. 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.

f. Progress.

(1) In Aug 09, TSG chartered the Pain Management TF to focus resources and attention on the issue of pain management.

(2) The FY10 NDAA mandates that no later than 31 Mar 11, the Secretary of Defense shall develop and implement a comprehensive policy on pain management.

(3) In May 10, Pain Management TF completed its report. The Health Executive Council (HEC) directed the establishment of the DoD-VA Pain Management Work Group in order to provide a platform for continued inter-Service and Veterans Health Administration (VHA) collaboration to implement pain management policy. Tri-Service Charter was signed in May 14.

(4) The Comprehensive Pain Management Campaign Plan directed implementation of the Pain Management Task Force with recommendations for holistic, multidisciplinary, and multimodal pain management in Sep 10.

(a) MEDCOM directed to establish Regional Medical Command Interdisciplinary Pain Management Centers (IPMC) at: FY11 (start) Eisenhower Army Medical Center, Fort Gordon; Madigan Army Medical Center, Joint Base Lewis-McChord; Tripler Army Medical Center, Hawaii; Landstuhl Army Medical Center, Germany. FY12 (start): Brooke Army Medical Center, Fort Sam Houston; Womack Army Medical Center, Fort Bragg; Darnall Army Medical Center, Fort Hood; Beaumont Army Medical Center, Fort Bliss. IPMCs represent identification/branding of the highest tier of pain management clinics, in effort to standardize personnel, equipment, and services offered. Services offered include acupuncture, bio-feedback, (yoga), and massage therapy to decrease over-reliance on medication-only treatment of pain.

(b) Use of Project ECHO ensures MEDCOM synchronization and inclusion of remote medical treatment facilities. Project ECHO is a nationally recognized best practice using video teleconferencing education to service remote/underserved locations.

(5) In Oct 13, IMCOM, OPMG, and MEDCOM collaborated with the Drug Enforcement Agency on the National Prescription Medication Take Back Day, in an effort to eliminate the improper use, storage, and disposal of prescription medications.

(6) In FY13, Services and VHA synchronized implementation of Pain TF Recommendations.

(7) FY13 hiring freeze significantly slowed continued development of IPMCs. 7/8 IPMCs are at Initial Operating Capability. The FY15 MEDCOM objective is to ensure at least 75% of IPMCs are at full operating capability.

(8) Army clinicians are participating with the Air Force, Navy, and VHA in a $5.4M Joint Incentive Fund Project to field a standardized basic acupuncture training and sustainment model across DoD and VHA medical facilities. Training teams have started traveling to Army, Navy, Air Force, and VHA medical facilities to deliver this training.

(9) MEDCOM continues to address the potential overuse and abuse of opioids through a comprehensive strategy that integrates several other initiatives including Polypharmacy, Substance Abuse, Army Medical Homes and Behavioral Health.

(10) Integrative medicine (massage therapy, acupuncture, biofeedback) is not an existing TRICARE benefit, although it may become one. IPMCs/IPMC (Lights) offer integrative medicine modalities on a space-available basis to non-AD beneficiaries.

(11) Addiction services at IPMCs are not expected to exceed current cost estimates as they leverage current Operating Company Model and maintain the Addictionologist at less than 1.0 FTE.

(12) Standardized drug testing is currently being addressed in the HEC pain work group.

(13) MEDCOM met the intent of the issue, established an enduring strategy and recommends that the issue be completed. Proposed MOEs to track final implementation include Pain Assessment Screening Tool and Outcomes Registry (PASTOR), a National Institutes of Health collaborative data collection platform that tracks progress of patients with pain. Evaluation will be reported via the Strategic Management System.

g. GOSC review.

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

(2) Aug 11. OTSG will conduct phased implementation of CPMCP across MEDCOM.

(3) Feb 12. The SA stressed the importance of working in concert with DoD on the legislative requirement. The IG representative noted that they will be looking at pain management as one of the subsets of a WTU inspection. The SMA asked how we incorporate Guard and Reserve Soldiers in Community Based Warrior Transition Units. Both the IG representative and the Chief, Army Reserve said they would look into it. The VCSA directed OTSG to follow up on DoD interface; refine objectives; address pain management for RC Soldiers from a holistic perspective. OTSG will establish Regional Medical Command Interdisciplinary Pain Management Centers and embed WTU/MTF pain augmentation teams.

(4) Aug 12. Issue remained active.

(5) Jun 13. Issue remained active.

(6) Feb 14. The VCSA directed G-1 for an update on the risk reduction task force pilot at Fort Bragg. The Military District of Washington Commander requested that OTSG include in their review how extra medicine leads to Soldier disciplinary problems. The ACSIM requested the IPMCs integrate efforts with the Army Substance Abuse Program (ASAP). OTSG confirmed polypharmacy will be added to the commander's risk reduction task force.

(7) The VCSA directed OTSG to look at the transparency of information exchange with civilian healthcare providers to ensure the military healthcare system knows what is being prescribed by civilian providers.

h. Lead agency. DASG-HSZ

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

a. Status. Active
b. Entered. HQDA AFAP Conference, 15 Jan 10
c. Final action. No (Updated: 10 Feb 15)
d. Scope. Reserve Component (RC) Soldiers are ineligible for enrollment in the 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.
e. Conference Recommendation. Authorize RC Soldiers enrollment in the EFMP.
f. Progress.

(1) Feb 10, EFMP Policy Working Group reviewed this issue at the EFMP Summit and ranked it the second highest priority.

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

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

(4) Apr-Sep 10, the EFMP Policy Working Group met to define language and process regarding RC Eligibility for the EFMP. Working Group members agreed, that enrollment will be voluntary for mobilized/ deployed RC Soldiers/ Family members. No changes to EFMP Enrollment Form, DD 2792 are required. The DD 2792 Form may be completed by the Primary Care Physician.

(5) Sep 10, EFMP Policy Working Group acknowledged that RC Soldiers and Family members are eligible to receive support services through Army Community Service without being enrolled in the EFMP. Support services may include educational instruction, support groups, or contact with the EFMP Manager.

(6) Oct 10, EFMP Policy Working Group finalized recommendations:

(a) Enrollment is voluntary.

(b) There is no need to change DD Form 2792.

(c) The Primary Care Physician can complete the DD 2792 Form.

(d) The DD 2792 Form will be sent to appropriate Regional Medical Command.

(e) If eligible for enrollment, non-protected information will be sent to the RC Family Program POC.

(f) The RC will track/maintain enrollment information.

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

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

(9) Aug 11, AFAP GOSC convened. ARNG and USAR leadership concurred with recommendations and way forward.

(10) Dec 11, OACSIM-ISS coordinated a Secretary of the Army Directive to authorize policy change. The changes stipulated in the Secretary of the Army Directive will be incorporated into the next revision of AR 608-75.

(11) Jun-Jul 12, OACSIM prepared Secretary of the Army Directive to authorize policy change. Directive is in final stages of informal coordination after receiving comments from both the ARNG and USAR. Effective date for policy change was Oct 12.

(12) Aug-Nov 12, Secretary of the Army Directive was formally staffed with key stakeholders and forwarded to OGC for review. OACSIM-ISS needed final review by OGC prior to forwarding directive for Secretary of the Army signature. Effective date for implementing this policy change may require adjustment due to OGC review and Secretary of the Army approval of policy change.

(13) Dec 12, OACSIM met with OGC to review concerns regarding the proposed policy change. OGC voiced concerns regarding financial implications with proposed change in policy. OGC indicated the SA Directive must state there will be no OMA funds associated with this change in policy and RC will be the "bill payer." Additionally, OACSIM-ISS would need confirmation from RC leadership stating the desire to continue with policy change and are willing to be the "bill payer" for all associated costs.

(14) Dec 12, OACSIM drafted a note to RC Family Programs points of contact reviewing OGC concerns and requirements.

(15) Feb 13, OACSIM received confirmation from USAR confirming desire to pursue policy change. USAR confirmed they will be the bill payer for EFMP respite care only and no other associated costs.

(16) April 13-Jul 13, in lieu of SA Directive authorizing policy change, OACSIM revised AR 608-75 to authorize voluntary enrollment for RC Soldiers into the EFMP.

(17) Sep 13, OACSIM submitted draft regulation to APD for review. APD provided recommended corrective actions to ensure compliance with regulatory guidance, and style manuals. OACSIM reviewed corrective action guidance from APD and is finalizing corrections for resubmission to APD.

(18) Nov 13-Dec 13, OACSIM-ISS worked with IMCOM G-9 to finalize changes to the EFMP respite care section of the regulation.

(19) Jan 14, OACSIM held a bridging strategy meeting with OTSG and the ARNG.

(20) Feb-May 14, OASCIM coordinated interim guidance among key stakeholders (OACSIM, OTSG, RC, and IMCOM) to ensure synchronization between Army policy (AR 608-75) and operational procedures and guidance. Interim guidance has been included in AR 608-75. Interim guidance has been informally coordinated and is currently with OAA for informal review prior to formal staffing. Anticipate formal staffing to begin 1 Jun 14.

(21) Feb-May 14, OASCIM coordinated finalization of regulatory language among key stakeholders to ensure synchronization between Army policy (AR 608-75) and operational procedures and guidance. OACSIM finalized corrective actions from initial review by APD. Regulation resubmitted to APD.

(22) Sep 14, OTJAG conducted legal review and provided recommended regulatory changes prior to publication. In addition to administrative comments, OTJAG recommended EFMP Respite Care specific regulation changes that require resolution before publication.

(23) Oct-Dec 14, OACSIM will reconcile OTJAG comments and recommendations with key stakeholders.

(24) Jan-Mar 15, OACSIM will resubmit regulation to APD for publication.

g. GOSC review.

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

(2) Aug 11. OACSIM will submit a revision to AR 608-75.

(3) Feb 12. The DASD(MC&FP) questioned whether we should pre-qualify all RC Soldiers who have an EFM. The Chief, Army Reserve clarified that the intent is to link voluntary EFMP pre-qualification to the ARFORGEN cycle, i.e., when RC Soldiers are in the "available" window. OACSIM will publish DA Policy Memo and revise AR 608-75 to authorize RC Soldiers enrollment in EFMP.

(4) Aug 12. The National Guard representative supported this initiative. The US Army Reserve representative remarked that they are working through EFMP being a centralized program and the mechanics of identifying and enrolling Families.

(5) Jun 13. In Apr 13, OACSIM revised AR 608-75 to authorize RC Soldier voluntary enrollment in EFMP. The regulation was formally staffed and its anticipated release date is 4th Qtr FY13.

(6) Feb 14. The ARNG expressed concern that the directive would not provide the proper authority. USAR concurred with publishing a directive. The DASD(MC&FP) commented that RC Families would receive support whether they were registered or not. The SMA questioned when EFMP would be standardized across the services. The DASD(MC&FP) confirmed the standardization is underway. The forms are complete with an assist from Office of Management and Budget. The IT piece is also going to be standardized across services as well. An information paper is available that outlines the EFMP standardization process.

(7) Feb 15. VCSA declared the issue active pending OGC's decision if OMA dollars are authorized for respite care.

h. Lead agency. DAIM-ISS

i. Support agency: OTSG, ARNG, USAR and IMCOM G9

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

a. Status. Active

b. Entered. HQDA AFAP Conference, 4 Feb 11

c. Final action. No (Updated: 10 Feb 15)

d. 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.

e. 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.

f. Progress.

(1) NCMs receive Care for the Caregiver training at the AMEDD Center and School (C&S) NCM Course. The training was based upon the VA's Care for the Caregiver Program. The course provides an overview of the concepts and was instructed in a "train-the-trainer" structure during a two-hour block of instruction. AMEDD C&S has provided this training to a total of 433 NCMs.

(2) In FY14, the WTC elevated the needs of caregivers through an analysis of external audit agency reports and several caregiver focus groups. The findings supported that the current program was outstanding but did not meet the acute needs of Families as they begin their care-giving journey. In response, the WTC developed a Care for the Caregiver Training Program focused on assisting Families as they start providing care for Soldiers and serves as a precursor to the VA's Care for the Caregiver Programs. It incorporates new Army initiatives such as the Performance Triad and the Ready and Resiliency Campaign.

(3) In order to determine the effectiveness of this training, the WTC will conduct Caregiver satisfaction surveys. To facilitate the survey, the WTC requested an update to the MODS that will enable the WTC to identify those Caregivers that have received the training. Once identified, the WTC will send a mail survey to the Caregiver requesting input on satisfaction. As of 15 Sep 14, the MODS updates were completed. Over 100 training episodes are documented in the MODS database. Participant survey release is pending. The survey will ask caregivers what the value of training was based on their experience before and after the training.

(4) External to the formalized training the WTU NCMs receive, Caregiver training within the WTUs is robust and continues to evolve. The interdisciplinary team facilitates discussions in self care, stress reduction, and burnout. Social workers, experts at identifying Family stress and burnout, are embedded in the WTU Table of Distribution and Allowances (TDAs) to help Soldiers and Families during times of crisis. Additional assets such as Soldier and Family Assistance Centers are specially designed to assist Families through numerous services, such as financial counseling, life skills development, and childcare.

(5) The WTC is also participating in the OSD Warrior Care Policy Peer to Peer Support Initiative. The initiative will use Military Family Life Counselors, located on military installations across DoD, to conduct the peer-to-peer support forums at designated installations. The initiative will roll out in five phases. As of 10 Oct 14, the installations in Phase 1 rollout are: Fort Belvoir, Walter Reed Medical Center, Fort Meade, Fort Carson, Joint Base San Antonio, Fort Hood, and Joint Base Lewis McChord. The program will begin at the following sites in 1st QTR FY15: Fort Riley, Fort Gordon, Fort Campbell, and Fort Stewart. Comments from Caregivers about the program are posi-

tive. Caregivers also reported satisfaction with the WTUs and the level of support they receive.

(6) Efforts to implement formal, standardized, face-to-face training for Designated Caregivers of Wounded Warriors also support the Soldier for Life program. This program has a healthcare component that seeks to ensure wounded warriors receive the best healthcare and training available. In addition, Soldiers will better understand how to access VA healthcare benefits and will ease their transition and reintegration into civilian society.

(7) Success will be defined as Families that support our Wounded, Ill, or Injured Soldiers are satisfied with support.

g. GOSC review.

(1) Feb 12. In response to the VCSA questioning whether we are distributing the handbook, the OTSG briefer requested the issue remain active to ensure implementation. OTSG will direct MTFs to provide the VA/Easter Seals caregiver handbook to designated caregivers within 60-days of admission and continue coordination with the OSD Wounded Warrior Care and Transition Policy Office to determine when/if face-to-face and computer based training will be made available by the VA.

(2) Aug 12. Issue remains active.

(3) Jun 13. VCSA directed to establish clear tasks and milestones for way ahead. Thus far, 242 individuals are trained and NCMs are receiving training to train the secondary non-medical caregiver. There are 107 non-medical attendants in the WTC. Need to develop a better database that identifies, in advance, the needs of this population. Also need to improve the transition of care to the role of the VA and the civilian healthcare system.

(4) Feb 14. The DASD (MC&FP) introduced the military caregiver concentration area OSD implemented in the Military Families Learning Network, which is a high-quality research, evidence-based information and training program for service providers and caregivers. The training program is webinar based and each webinar is archived and off the shelf so a caregiver can use it as time and schedules permit. The inaugural webinar was 10 Oct 13 and included about 100 participants. The OSD program is a parallel but not redundant effort to the Army's as the caregiver needs and requirements are as wide and unique as the caregivers themselves, dependent on a variety of personal factors. A feedback loop is also built into the program as well as the opportunity for Continuing Education Unit credit. OTSG expressed an interest in linking those webinars to the Warrior Transition Command training module.

(5) Feb 15. The VCSA directed ACSIM to share existing military life and readiness training such as Army Family Team Building with WTC and the RC.

h. Lead agency. Warrior Transition Command

i. Support Agency. AMEDD Center and School

Issue 669: Return to Active Duty Reserve Component Medical Care (RCMC) Time Restrictions for Reserve Component (RC) Soldiers

a. Status. Active

b. Entered. HQDA AFAP Conference, 4 Feb 11

c. Final action. No (Updated: 10 Feb 15)

d. Scope. RC Soldiers can only apply for RCMC within six months from their date of release from Active Duty (REFRAD). Warrior Transition Unit Consolidated Guidance (WTUCG 20 Mar 09) states the RCMC programs are designed to return Soldiers 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 return to Active Duty time restriction to five years would allow RC Soldiers time to receive proper medical treatment in order to identify and resolve duty-related medical and behavioral health conditions.

e. Conference Recommendation. Extend the RCMC return to Active Duty time restriction for RC Soldiers from six months to five years of REFRAD date.

f. Progress.

(1) The issue involves authorization requests and changes to the existing medical care program. The main issue is to extend the time limit to recall RC Soldiers to Active Duty after REFRAD (mobilization) and approve the evaluation and treatment of the injury received in the line of duty (LOD) from six months to five years.

(2) When the issue first came to light, Soldier medical support processes either did not exist or were in a development phase. Lessons learned from over 12 years of war have allowed timely access to medical care for Wounded, Injured, and Ill RC Soldiers.

(3) The many important medical initiatives implemented at the demobilization sites to improve access to medical care for Soldiers and to ensure medical needs are met include:

(a) EXORD 034-14, Mobilization Command Support Relationships and Requirements Based Demobilization Process, 14 Mar 14.

1. Soldiers are given opportunities to present medical issues/concerns while in demobilization (DEMOB), have .medical retention processing-extension initiated to have medical issues evaluated, and to determine the best plan of care via their Warrior Transition Battalion (WTB) on MRP2 orders.

2. Soldiers are allowed the opportunity to complete LOD process prior to leaving the DEMOB station. In accordance with AR 600-8-4, Line of Duty Policy, Procedures, and Investigations, Table 3-1 and 3-2, all USAR and ARNG Soldiers who incurred or aggravated an injury, illness, or disease while mobilized are required to have a LOD electronically initiated in LOD Medical Electronic Data for Care History And Readiness Tracking (MEDCHART) before REFRAD.

3. Periodic Health Assessment (PHA) is conducted at the demobilization site in conjunction with the Post-Deployment Health Assessment (PDHA).

4. Behavioral health and TBI screening for all Soldiers are conducted during MOB and DEMOB.

5. The Army is partnering with the Department of Veterans Affairs (VA) and Defense Health Agency (DHA) to update Soldiers' benefits.

6. Soldiers are counseled and provided information on VA programs. Soldiers who refuse or decline care must sign a declination of care counseling statement.

(b) Medical programs were established to assist and support Soldiers with medical issues:

1. MRP2 was established to address situations after contingency operations.

2. Active Duty Medical Extension (ADME) was established to address situations after non-contingency operation orders.

3. MRP2- Mobilization/Training is approved for Army National Guard (ARNG) Soldiers whom incur low risk/low acuity injuries that can be resolved in 179 days or less.

4. Development of a streamlined MRP2 request process in the MEDCHART application, the Active Duty Ordering Processing system (ADOP). The ARNG has completed the development and has approval to utilize the ADOP electronic system.

5. WTUs provide critical support to Soldiers who are expected to require six months of rehabilitative care and complex medical management. The key to WTU success is its Triad of Care, comprised of a primary care manager (usually a physician), nurse case manger, and squad leader who create the familiar environment of a military unit and surround the Soldier and Family with comprehensive care and support, all focused on the Soldier's mission which is to heal and transition.

(4) Deputy Chief of Staff, G-1, Director of Military Personnel Management (DMPM), is not pursuing a change to the six-month restriction, but authorizing a waiver. Commanders must submit written justification asking for an exception to policy if additional time is required. The change is incorporated in the new AR 600-XX, Administrative Guidelines for the Wounded, Ill and Injured, chapter 4-2. Maintaining the six-month timeline will ensure Soldiers actively pursue assistance for care, prevent potentially aggravating injuries, and avoid complicating the LOD process.

(5) AR 600-XX is on the Director of the Army Staff's Top 50 Regulation List with a publication suspense of 31 Mar 15.

g. GOSC review.

(1) Feb 12. G-1 stated that they will publish Army Regulation and DA Pam to reflect revised time standard.

(2) Aug 12. Issue remains active.

(3) Jun 13. VCSA directed the issue remain active.

(4) Feb 14. The VCSA directed G-1 to ensure they are communicating to the Reserve Component (RC) that a waiver is available to request RCMC. The VCSA also directed G-1 to pursue issuing a Directive-Type Memorandum or other guidance as an interim policy until the regulation is published.

(5) Feb 15. The VCSA declared the issue active pending the publication of AR 600-XX.

h. Lead agency. G1, DMPM

i. Support Agency. OASA(M&RA), OTSG/MEDCOM, USAPDA, WTC, NGB, and OCAR

Issue 679: Creditable Civil Service Career Tenure Requirements for Federally Employed Spouses of Service Members and Federal Employees

a. Status. Active

b. Entered. HQDA AFAP Conference, 2 Mar 12

c. Final action. No (Updated: 10 Feb 15)

d. Scope. Federally employed spouses of Service Members and Federal employees may have difficulties reaching creditable Civil Service career tenure requirements due to relocation assignments. The 5 Code of Federal Regulations (CFR) Chapter 315.201 states a Continental United States (CONUS) Career Conditional employee can only have a 30-day calendar break in continuous creditable service to remain eligible for career employee tenure. A policy change should include Federal employees that must resign and relocate with their Federal sponsor and would make the policy equitable across all Federal agencies. Increasing the 30-day calendar break will reduce the stress of the potential loss of creditable civil service career tenure placed on federally employed spouses of Service Members and Federal employees due to relocation.

e. Conference Recommendation. Increase the 30-day creditable civil service career tenure requirement break for all federally employed spouses of Service Members and Federal employees to 180 days after resignation in conjunction with the relocation of their military or Federal sponsor.

f. Progress.

(1) Deputy Assistant Director at OPM met with his staff and agreed, at a minimum, to increase the time limit for the creditable civil service career tenure requirement break to 180 days. OPM staff has investigated and vetted with other federal agencies the proposal to amend the regulations on creditable service for career tenure by removing the requirement for creditable service to be substantially continuous.

(2) OPM is also proposing to revise the regulation regarding Career Tenure in relation to military spouses. Tenure is important for the purposes of reinstatement eligibility and retention standing in a reduction in force (RIF). Currently, a federally employed spouse may have to resign his/her appointment to accompany a military "sponsor" (in this context, meaning a spouse who is serving in the military) when the sponsor must relocate under PCS orders. Many spouses are unable to obtain another federal job within the 30-day break period. The 30-day break requirement leaves these spouses at a disadvantage in attaining career tenure. When reemployed, they have to re-start the three-year period, basically resulting in a perpetual career-conditional tenure status due to the constant PCS movement of their spouses.

(3) It is anticipated that the appropriate public notice will be posted in the Federal Register by 2nd QTR FY15, followed by changes to the CFR. The comments and recommended changes from the initial posting in the Mar 14 Federal Register are being reviewed by OPM's Office of General Counsel.

(4) As an interim measure, DCS G-1 CP will issue a reminder that "Family members with status will be granted a minimum 90 calendar days LWOP when they relocate with the sponsor to a new assignment location. Extensions of this initial grant of 90 days are encouraged for employees who have been unable to find employment." Army Regulation 690-990-2, Hours of Duty, Pay, and

Leave, Annotated, Book 630, Subchapter S12, states that normally, an initial grant of LWOP will not exceed one year, and if an extension (rare cases) would cause an absence beyond two years, the employee should be separated and reemployed at the time they become available for duty.

(5) Employee impacts when on extended periods of LWOP:

(a) Employee remains on losing command's rolls using an unencumbered full–time equivalent (FTE).

(b) Probationary Period: Only the first 22 workdays in a nonpay status are creditable.

(c) Within Grade Increases: For steps 2, 3, and 4, an aggregate of no more than work two weeks in a nonpay status per waiting period is creditable. For steps 5, 6, and 7, an aggregate of no more than four workweeks per waiting period is creditable. For steps 8, 9, and 10, an aggregate of no more than work six weeks in a nonpay status per waiting period is creditable.

(d) Service Computation Date: Only an aggregate of six months of nonpay status in a calendar year is creditable; therefore, this can directly impact RIF standing and creditable service for severance pay.

(4) The CFR change to resolve the issue is estimated to take one year.

g. GOSC review.

(1) Aug 12. Issue remains active.

(2) Jun 13. VCSA directed to pursue Army authorization as a bridging mechanism until OPM guidance is revised. People moving to and from OCONUS are already authorized this benefit. The Office of the Judge Advocate General (OTJAG) pointed out that in the interim, the Army has the authority to authorize leave without pay for PCSing Family members for up to 180 days so they can maintain that career conditional status.

(3) Feb 14. The VCSA expressed his appreciation to Army Civilians for their patience and continued commitment to the Army through the recent sequestration.

(4) Feb 15. The VCSA directed G-1 to find a bridging strategy until the OPM guidance is realized. The VCSA also asked G-1 to track how many people have been granted LWOP across the Army. Lastly, the VCSA requested G-1 to investigate the worker's compensation role while on the spouse is on LWOP.

h. Lead agency. DAPE-CPP

i. Support agency. ASA (M&RA)

Issue 684: Survivor Investment of Military Death Gratuity and Service Members' Group Life Insurance (SGLI)

a. Status. Active

b. Entered. HQDA AFAP Conference, 2 Mar 12

c. Final action. No (Updated: 10 Feb 15)

d. Scope. A Survivor receiving the Military Death Gratuity and SGLI has only 12 months to place up to the full amount received into a Roth Individual Retirement Account (IRA) or Coverdell Education Savings Account (ESA). Independent grief studies conducted by the University of Maryland and University of California Santa Cruz recommend that life altering decisions not be made within the first year after loss. One year is not sufficient time for Survivors to make an informed decision on making a contribution, resulting in the loss of a valuable investment option.

e. Conference Recommendation. Extend the time period for Survivors to invest Military Death Gratuity and SGLI in Roth IRA and/or Coverdell ESA from 12 months to 36 months.

f. Progress.

(1) On 24 May 12, Senator Richard Blumenthal (D-CT) introduced a bill (S.3234) to amend the Internal Revenue Code of 1986 to extend the time period from one to three years for contributing Military Death Gratuity and SGLI in Roth IRA and/or Coverdell ESA.

(2) On 28 Oct 13, OCLL confirmed through Senator Blumenthal's office that the issue has tax implications and cannot be introduced to the House Ways and Means Committee until they lift a moratorium on introducing all tax-related legislation.

(3) On 1 May 14, OCLL notified DCS G-1 that Representative Aaron Shock (R-IL) introduced H.R. 4559 that would resolve the issue. The legislation has three co-sponsors –Representatives Earl Blumenauer (D-OR); Niki Tsongas (D-MA); and Kristi Noem (R-SD) along with support from the Military Coalition. The legislation was referred to the House Ways and Means Committee.

(4) On 15 Oct 14, in coordination with OCLL, DCS G-1 confirmed that the proposed legislation was not adopted during the 113th Congress. Representatives will have to reintroduce the legislation at the 114th Congress if they can garner support for the issue.

(5) The Assistant Secretary of the Army (Manpower and Reserve Affairs) reviewed the issue and concurs with DCS G-1 that the issue is unattainable at this time.

g. GOSC Review.

(1) Aug 12. The SMA's spouse confirmed the need for extending the period to invest from 12 months to 36 month based on discussions with survivors during installation visits.

(2) Jun 13. VCSA directed the issue remain active.

(3) Feb 14. The VCSA directed G-1 to draft talking points for senior leaders throughout the Army to use when engaging members of Congress. The VCSA also directed we continue to educate our survivors regarding the one year time limit. The Chief Legislative Liaison confirmed Representative McMorris Rodgers is also interested in championing the legislation in the House. He also stated this population is so small that the tax implications are minor to the federal government. The SMA stressed this issue is an important issue for survivors. The ACSIM suggested engaging Representative Bishop who co-chairs the Military Family Caucus. The ACSIM confirmed Survivor Outreach Services works with units and the garrison command to ensure survivors are aware of the time limit as the one year anniversary approaches.

(4) Feb 15. The VCSA declared the issue active pending a legislative proposal to extend the time period for survivors to invest Military Death Gratuity and SGLI funds in a Roth IRA and/or Coverdell ESA from 12 months to 36 months.

h. Lead Agency. DAPE-PRC

i. Support Agency. OCLL

Issue 688: Resilience Training for Teen Dependents
a. Status. Active
b. Entered. Command Focus Group, 21 Apr 14
c. Final action. No (Updated: 10 Feb 15)
d. Scope. The Army provides Resilience Training for Soldiers, Department of the Army Civilians (DACs) and their adult Family Members, but not Army teen dependents. Army teen dependents face significant challenges growing up in the Army Family lifestyle, facing permanent change in station (PCS) moves, Soldiers' and DACs multiple deployments, and potential mental and physical injuries to their parent(s). Resilience Training could help Army teen dependents to cope with adversity, perform better in stressful situations, and thrive in the Army lifestyle.
e. Conference Recommendation. Implement Resilience Training for Army teen dependents.
f. Progress.

(1) The SECARMY Directive dated 26 Mar 13 provides greater focus on building resilience in Soldiers, Families, and units. As such, the CSF2 Teen Curriculum was developed to meet the SECARMY Directive by taking the resilience curriculum that currently trains Soldiers and spouses, and translating it into an adolescent, age-appropriate curriculum. The training provides a common language within the Army Family for Soldiers, spouses, and Army teens.

(2) CSF2-TC pilots were conducted during the 2013-2014 academic school year, in coordination with program evaluation efforts supported by WRAIR. Seven hundred and thirty 7th-12th grade adolescents participated in CSF2-TC pilots at Fort Bliss (20 middle and high school students), Fort Knox (230 9th and 10th Graders), Fort Riley [300 Junior Reserve Officers' Training Corps (JROTC) Cadets], Fort Polk (120 high school students), and Schofield Barracks (60 middle/high school students). Three thousand six hundred 7th-12th grade adolescents will participate in pilots during the 2014-2015 academic school year (3,000 National Guard adolescents; 100 9th graders Fort Campbell; 100 9th graders Fort Knox; 300 Fort Riley; 65 Schofield Barracks; 40 Fort Bragg).

(3) CSF2 has formally staffed a CSF2-TC MOI with IMCOM, FORSCOM, TRADOC, OTJAG, and WRAIR on the Controlled Release of Version 1.0, which will incorporate AAR from pilot instructors, further refining the Teen Curriculum. The Teen Curriculum will be provided as a two hour workshop intended to provide an introduction to three resilience skills as well as a full curriculum that trains the same 14 resilience skills taught to adults in the Master Resiliency Training Course (MRT-C).

(a) Senior Commanders will establish priority and coordinate delivery of the Teen Curriculum Version 1.0 (Controlled Release) at the installation level, including MRT instructor selection. The Community Health Promotion Council (CHPC) provides an ideal coordinating function for this initiative. Key stakeholders include, CSF2 Program Managers, and local DoDEA schools.

(b) To ensure child safety in accordance with Army Directive 2014-23 (Conduct of Screening & Background Checks), instructors must have background checks, above and beyond security clearances, prior to curriculum delivery. The LOI provides a mandatory checklist for CSF2-TC instructors to complete, which assists in meeting AR 608-10, Child Development Services, requirements.

(4) WRAIR has completed final data collection to support the CSF2-TC pilot program evaluation from Fort Knox and reported significant results in reductions in depression and anxiety for females, and increases in positive to negative coping strategies and problem solving for males. Results from the program evaluation have further informed CSF2-TC Curriculum Release 1.0 for delivery to additional adolescents during the 2014-2015 academic school year. WRAIR will complete additional program evaluations at Fort Knox, Fort Campbell, and Fort Riley during the 2014-2015 academic year.

(5) 2014-2015 academic school year will focus on deliveries at Fort Knox, Fort Campbell, Fort Riley, Schofield Barracks, Fort Bragg, and the NG (19 states served by 37 trained MRTs); estimated 3,800 Army teens.

(6) Current CSF2 Teen Curriculum instructors can be MRTs who have experience engaging teens. As such, this training is, in many cases, a natural fit within existing role responsibilities to support Army adolescents.
g. GOSC Review. Feb 15. The VCSA directed commanders to ensure proper background checks are conducted for those involved with teen training.
h. Lead agency. DAPE-ARR-CF
i. Support Agency. OACSIM CYSS, IMCOM CYSS, IMCOM FP, WRAIR

Issue 689: Sexual Assault Restricted Reporting Option for Department of Army Civilians (DACs)
a. Status. Active
b. Entered. Command Focus Group, 21 Apr 14
c. Final action. No (Updated: 10 Feb 15)
d. Scope. DACs are not included in Army Regulation (AR) 600-20 "Army Command Policy" and Department of Defense (DoD) Directive 6495.01 "Sexual Assault Prevention and Response (SAPR) Program" for restricted reporting of sexual assault. Restricted reporting allows the sexual assault victim to obtain counseling, medical care, and victim advocacy without launching a formal investigation. Authorizing restricted reporting of sexual assault empowers DAC victims to decide how they want to report their case, utilize advocacy services, and receive treatment.
e. Conference Recommendation. Authorize restricted reporting of sexual assault for DACs.
f. Progress.

(1) Deputy Chief of Staff (DCS) G-1 conducted meetings and has ongoing communication with DoD OGC, Army Equal Employment Opportunity Commission, Criminal Investigation Command, and OTJAG to re-address this recommendation. OGC and OTJAG Labor Law reiterated their prior legal opinion against this recommendation and if pursued would require changes to legislation.

(2) The issue of extending restricted reporting to DACs was initially addressed as a request for exception to policy from U.S. Army Europe in Sep 09. The DoD and Army approved a one year pilot test allowing DACs to file restricted reports of sexual assault. During the pilot, the

DoD and Army OGC researched potential implications associated with implementation of extending the program to DoD civilians. The OGC concern was implications related to Title VIII of the Civil Rights Act and federal employee's equal opportunity laws and policies.

(3) DoD OGC opined that offering restricted reporting to federal civilian employees creates a liability for the government by not fulfilling obligations under Title VII Civil Rights Act.

(4) On 28 Mar 13, DoD published DoD Instruction 6495.02, SAPR Program Procedures. This Directive states that civilian employees are eligible only to bring unrestricted reports.

(5) The Army is responsible for compliance with Title VII of the Civil Rights Act and Equal Employment Opportunity laws that are not applicable to service members. The Army is required to exercise reasonable care to correct and prevent sexual harassment (including sexual assault). Restricted reporting is in direct conflict with these obligations because it would impede management's efforts to take all necessary steps to correct harassment and prevent future harassment of the victim and of other employees.

(6) Whether DACs make any report to Army, their ability to obtain confidential medical and/or counseling services, whether through their health benefit plans, or in DoD military treatment facilities where eligible, is not impacted. DoD civilian employees and their adult Family dependents have access to the SAPR services of a Sexual Assault Response Coordinator (SARC) and a SAPR Victim Advocate (VA) while undergoing emergency care OCONUS. Additionally DACs have access to anonymous resources from organizations such as chaplains, the National Sexual Assault Safe Helpline, and community-based rape crisis centers.

(7) Future efforts will now concentrate on dialogue/coordination with appropriate DoD and HQDA agencies to explore/pursue possibility of legislative proposals.

g. GOSC Review. Feb 15. The VCSA directed G-1 to draft a legislative proposal, as he sees a double standard for Soldiers and DACs.

h. Lead agency. DAPE-SH

i. Support Agency. OTJAG