REPORT TO CONGRESS

ON

REPORTS ON ARMY ACTION PLAN IN RESPONSE TO DEFICIENCIES IN THE ARMY PHYSICAL DISABILITY EVALUATION SYSTEM

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Office of the Under Secretary of Defense
Personnel and Readiness

REPORTS ON ARMY ACTION PLAN IN RESPONSE TO DEFICIENCIES IN THE ARMY PHYSICAL DISABILITY EVALUATION SYSTEM

The Secretary of Defense provides the following report on the implementation of corrective measures by the Department of Defense and the Department of the Army with respect to the Physical Disability Evaluation System (PDES) as required by Section 1645 of the National Defense Authorization Act of Fiscal Year 2008 (FY08 NDAA). The corrective measures pertain to recommendations for improvements to the Disability Evaluation System included in the following three reports: Independent Review Group on Rehabilitation Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center; Department of Veterans Affairs Task Force on Returning Global War on Terror Heroes; and the Department of the Army Inspector General Report on the Army Physical Disability Evaluation System Inspection and Follow-up Actions. Section 1645, FY08 NDAA, requires:

SEC. 1645. REPORTS ON ARMY ACTION PLAN IN RESPONSE TO DEFICIENCIES IN THE ARMY PHYSICAL DISABILITY EVALUATION SYSTEM.

(a) Reports Required- Not later than June 1, 2008, and June 1, 2009, the Secretary of Defense shall submit to the congressional defense committees a report on the implementation of corrective measures by the Department of Defense with respect to the Physical Disability Evaluation System (PDES) in response to the following:

(1) The report of the Inspector General of the Army on that system of March 6, 2007.

(2) The report of the Independent Review Group on Rehabilitation Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center.

(3) The report of the Department of Veterans Affairs Task Force on Returning Global War on Terror Heroes.

(b) Elements of Report- Each report under subsection (a) shall include current information on the following:

(1) The total number of cases, and the number of cases involving combat disabled service members, pending resolution before the Medical and Physical Disability Evaluation Boards of the Army, including information on the number of members of the Army who have been in a medical hold or holdover status for more than each of 100, 200, and 300 days.

(2) The status of the implementation of modifications to disability evaluation processes of the Department of Defense in response to the following:

(A) The report of the Inspector General on such processes dated March 6, 2007.

(B) The report of the Independent Review Group on Rehabilitation Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center.

(C) The report of the Department of Veterans Affairs Task Force on Returning Global War on Terror Heroes.

(c) Posting on Internet- Not later than 24 hours after submitting a report under subsection (a), the Secretary shall post such report on the Internet website of the Department of Defense that is available to the public.

Data in Response to (b) (1)

The tables below depict the total number of cases, and the number of cases involving combat disabled service members (see Battle Injury below), pending resolution before the Physical Disability Evaluation System of the Army, including information on the number of members of the Army who have been in a medical hold or holdover status for more than each of 100, 200, and 300 days. The tables separate those who are in Warrior Transition Units from those who remain assigned to their parent unit. A Warrior Transition soldier is a medical holdover, active duty medical extension, medical hold and any other active duty (including Active Guard Reserve) soldier who requires a Medical Evaluation Board (MEB) or, an active duty soldier (including active guard reserve) with complex medical needs requiring six months or more of treatment or rehabilitation. Initial Entry Training (IET) soldiers are only eligible if they require a MEB or when deemed appropriate by the local U.S. Medical Command (MEDCOM) commander and the IET soldier's Commander. A Soldier's mission while assigned to a WTU is to heal. Soldiers assigned to a WTU may have work assignments in the unit, but such work may not take precedent over the Soldier's therapy and treatment.

Warrior Transition (WT) and Non-WT Soldiers in the PDES

Injury	Component	WT Current	Non –WT	MEB TOTAL
Battle Injury	AC	361	66	427
Battle Injury	RC	63	8	71
Non Battle	AC	2, 786	2, 059	4, 845
Non Battle	RC	657	654	1, 311
Sub Total		3, 867	2, 787	6, 654

Warrior Transition Soldiers Pending* the PDES

Component	WT Soldiers Not in the MEB or PEB
AC	4, 748
RC	3, 227
Sub Total	7, 975

Total Warrior Transition (WT) Soldiers in PDES or Pending*

	WT Soldiers Not in the MEB or PEB
WT non PDES	7, 975
WT in PDES	3, 867
WT Total	11, 842

**Note: Warrior Transition Soldiers (WT) do not necessarily enter the PDES. Many recover and are returned to duty. The Army cites that 65 percent could return to duty within a year.*

Number of Soldiers in a "holdover" Status by Days

			-Days -					
PDES Status	**Injury**	**Compo**	**<1**	**1 – 100**	**101 - 200**	**201 - 300**	**> 301**	**Total**
PDES WT	BI	AC	0	181	103	49	28	361
		RC	1	30	12	14	6	63
	NON BI	AC	2	1, 038	1,062	510	174	2, 786
		RC	0	282	169	119	87	657
PDES Non WT	BI	AC	0	36	16	10	4	66
		RC	0	2	3	1	2	8
	NON BI	AC	3	1, 351	484	144	77	2, 059
		RC	0	219	148	99	188	654
Total			6	3, 139	1, 997	946	566	6, 654

<u>Data in Response to (b) (2)</u>

The matrices enclosed with this report contain implementation comments for respective recommendations of the three reports as required by Section 1645, FY08 NDAA. There has been much progress in implementing the recommendations of the various task forces and study groups, but much work remains to be done. The Department is currently testing a Disability Evaluation System Pilot in the National Capitol Region. The vision for the DES Pilot is a seamless and transparent DES

administered jointly by DoD and VA. The goals of the DES Pilot incorporate the recommendations of task forces, audits and study groups. These features include:

- Simplified, Service-member centric, and non-adversarial processes;
- Single-source medical exam and disability ratings to eliminate duplication;
- Faster, more consistent evaluations and compensation that honor Service members;
- Seamless transition to veteran status; and
- Strong case management advocacy and expectation management throughout.

To support and complement DES Pilot efforts, the Department has revised DES program policies and regulations, refined reporting and feedback mechanisms, re-energized and revised the charter for the Disability Advisory Council to add participation from the Veterans Benefits Administration and Veterans Health Administration, and collaborated with VA in providing input to the VA Schedule for Rating Disabilities process. There are also many other ongoing DoD-level initiatives,which include: regular DES process conferences and DES Pilot reviews; DoD-VA workgroups on DES Pilot improvement; VA training of DoD personnel on the application of VA rating schedule; numerous conferences to re-examine duties and improve seamless transitions; and customer satisfaction surveys administered at phases to include the MEB, Physical Evaluation Board (PEB) and at post-separation to ensure a continuum of care.

The matrices enclosed contain numerous references to aspects of the DES Pilot. A complete review of the DES Pilot establishment and criteria for expansion are contained in separate reports to Congress in compliance with sections 1611(a), 1612(c), and 1615(a) of the National Defense Authorization Act (NDAA) for Fiscal Year 2008 (FY08), Pub. L. 110-181, which require comprehensive reports on improvements to care and transition of service members to be submitted no later than July 1, 2008.

Conclusion

The Department has made progress in improving the many complex processes of the DES. It is important to appreciate, however, that the ongoing DES Pilot serves to test and implement process changes intended to significantly improve DES timeliness, effectiveness, simplicity, and resource utilization. The Department anticipates significant improvements in these areas given that the DES Pilot integrates DoD and VA processes, eliminates duplication, and improves case management practices. The DES Pilot currently includes disability cases originating from MEBs at

Walter Reed, Bethesda National Naval, and Malcolm Grow Medical Centers. The Department anticipates making a decision on whether and how to expand the DES Pilot by the end of fiscal year 2008.

The expansion of the DES Pilot is predicated on the data from a multi-faceted evaluation program to assess the DES Pilot. The oversight mechanisms for senior leaders include the construction of an executive-level Balanced Score Card, weekly status updates, and increasingly comprehensive quarterly, interim and final reports documenting the DES Pilot results. Although the evaluation data on the performance of the DES Pilot are limited at this time, the Department is hopeful the consolidation of the Department of Defense and Department of Veterans Affairs disability systems is feasible. The Departments will publish additional reports as the DES Pilot progresses.

As stated above, the DES Pilot consolidates the Department disability systems to the degree allowed by law. The DES Pilot does not implement the full recommendations of the President's Commission on Care for America's Returning Wounded Warriors or Dole – Shalala Commission, which called for a more complete restructure of the Departments' systems. In simplest terms, the Dole – Shalala proposal would allow the DoD to concentrate on maintaining a fit, battle-ready force and the VA to focus on what it does best, evaluating, caring for, and compensating Wounded, Ill and Injured (WII) veterans. A Dole – Shalala disability system would remove the DoD from the disability compensation process, thereby eliminating the frustrating and confusing circumstances of differing disability ratings, disability evaluations, and appeal and compensation practices by the Departments. The Department acknowledges and supports efforts to implement the full recommendations regarding these aspects of the disability system and looks forward to providing the subsequent update report in June 2009.

A PDF copy of this report is posted on the website for the Office of the Under Secretary of Defense for Personnel and Readiness at: http://www.defenselink.mil/prhome/reports.html.

Enclosures:

1) Matrix of Recommendations and Actions Taken pertaining to the reports of the Independent Review Group on Rehabilitation Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center, and the Department of Veterans Affairs Task Force on Returning Global War on Terror Heroes.

2) Matrix of Recommendations and Actions Taken pertaining to the Department of the Army Inspector General DAIG Report.

Item Reference #	Reference	Recommendation	Implementation Actions	Current Status
P-1	VA TF on Returning GWOT Heroes	Develop a Joint Process for Disability Determinations Develop in-depth plan for VA/DoD collaboration in MEB/PEB process.	The Departments implemented in November of 2008, a DES Pilot program for disability cases originating at the three military treatment facilities in the National Capital Region. The vision for the DES Pilot is a service member-centric, seamless and transparent DES, administered jointly by DoD and VA. The Departments set the following objectives: evaluate the DES Pilot, refine the mechanisms in the DES Pilot, identify training requirements, test improved case management procedures, and identify legal and policy issues to improve the DES. The DoD published these objectives in the November 21, 2007, DES Pilot Directive Type Memorandum (DTM). Key features of the DES Pilot include integrating the Departments' systems so they run concurrently instead of sequentially. Both Departments agreed to use a single medical examination and single source disability rating to determine a Service member's outcome. To ensure a seamless transition of WII Service members from the care, benefits, and services of DoD to the VA, the Pilot is testing enhanced case management practices.	The DoD and VA are developing options for expanding the DES Pilot to additional locations. The DES Pilot evaluation plan includes extensive quantitative and qualitative performance measures. The Departments will analyze and report the data from the Pilot to inform expansion decisions. The DoD and VA are defining criteria to assess the readiness of a site to implement the DES Pilot. The anticipated criteria will include: physical and human resources, IT architecture development and fielding, case management procedures, training, and costs. The Departments are prepared to train the personnel who would implement the Pilot at expansion sites. Although the primary case managers involved in the DES Pilot are PEBLOs and MSCs, the Departments are preparing plans to train other personnel who process DES Pilot cases.
9.9	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Expand the Disability Advisory Council (DAC).	The Disability Advisory Council (DAC) charter was formally updated in Dec 2006 to include a more rigorous oversight role and defined membership with additional membership from the Veterans Benefits Administration (VBA) and inclusion of the OASD(RA) included as an advisory member. To support and complement DES Pilot efforts, DoD is in the process of another revision of the charter for the DAC to add participation from the Veterans Health Administration (VHA). The Charter will also included formal collaborative processes for DoD to provide input to the changes to the VA Schedule for Rating Disabilities (VASRD) process.	The revisions to expand the DAC membership to the VHA along with the expanded role on DoD's input to the VASRD updates will be made not later than August 1, 2008.
8.2	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	SecDef should request the Secretary of VA to update the Code of Federal Regulations, Title 38, Part IV to account for the unique disabilities and needs of traumatic amputees and burn victims, focused on a loss of function and post-service needs. Would require an expedited process for publishing change.	The Departments are working together through the Senior Oversight Committee on the Wounded, Ill and Injured to address unique disabilities. The VA proposed new ratings of (Traumatic Brian Injury) TBI and Burns in the Federal Register on January 3, 2008. They are addressing the public comments at this time. For burns.the schedule proposes to revise 38 CFR 4.118, so that it defines VA's policies concerning the evaluation of scars, including multiple scars. VA proposes to incorporate, "burn scars," into the title of the diagnostic codes most appropriate for evaluating scars. Previously burn scars were generally rated only if they impacted motion and mobility. For TBI, the schedule proposes to revise 38 CFR 4.124a, diagnostic code 8045, to provide updated medical criteria for evaluating residuals of TBI. VA has proposed to change the title, provide guidance for the evaluation of the cognitive, emotional/behavioral, and physical residuals of TBI, and direct raters to consider special monthly compensation.	Ongoing
9	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Completely overhaul the DES to include changes in US Code, DoD policies and Service regulations to implement ONE DoD level Physical Evaluation Board/Appeals Review Commission with equitable Service representation Goal = one integrated solution	During August 2007, the Departments collaboratively evaluated alternative DES processes. Over 40 DES experts from the DoD and VA used previously adjudicated disability cases using five alternatives. The following alternative DES processes were tested: a sequential Mil Dept and VA evaluation with duplicate disability examinations and ratings; Joint Disability Evaluation Board (JDEB) Baseline: The Mil Depts and VA conduct independent disability examinations, the VA provides ratings, and a joint board determines fitness for duty; Dole-Shalala Variation: a single physical exam, the VA provides ratings, and the Mil Dept PEB determines fitness for duty; JDEB Quality Control Alternative: The Mil Depts conduct disability examinations, the VA provides a single rating, the Mil Dept PEB determines fitness, and a JDEB with a review function; and JDEB Appellate Review Alternative: The Mil Dept conducts disability examinations, the VA provides a single rating, the Mil Dept PEB determines fitness, and a JDEB is an appellate body. Based on an analysis it was recommended that the Departments implement a DES pilot based on a modified Dole-Shalala Variation.	Same as P1
9.2	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Review the 1998 MOU between DoD and VA, implement a common physical for use by the Services and the VA for those service members in the physical DES, and allow flexibility in the timelines test or procedures that would eliminate redundant efforts (as identified in GAO Report 2004)	See P-1 DES Pilot and Expansion Plan. The DES Pilot is testing a common physical that is acceptable to VA for rating of disabilities and the DoD for use in determining fitness and medical requirements for transition physicals. The DES Pilot also has a rigorous evaluation methodology and customer satisfaction program to identify redundancies to ensure seamless transition.	Same as P-1
9.3	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Joint VA/DoD DES. Establish ONE solution. Utilize one disability rating system that remains flexible to evolve and be updated as trends in injuries and support medical documentation/treatment necessitate	See P-1 DES Pilot and Expansion Plan. The DES Pilot utilizes the VA Rating Panel and requires the Military Departments to accept the ratings for fitness decisions and ratings.	Same as P-1

9.5	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Quickly promulgate regulatory guidelines and policies to the Service Secretaries as soon as changes to the US Code are made	To complement DES Pilot efforts, we have revised DES policies, refined reporting mechanisms, and collaborated with VA in providing input to the VA Schedule for Rating Disabilities process. The system of continuous improvement implemented last year allows for rapid publication of revisions as the Department learns from studies and the DES Pilot. To date, the Department has issued policy guidance for DES, which established standards, metrics and reporting requirements to DoD; issued new policy and procedures for DES Pilot, which established DES Pilot as a test program; issued new policy for standards for determining unfitness due to non-deployability as it relates to the performance of duty of a member's grade or rank; issued policy to comply with statute for disability-related provisions of NDAA 2008 – enhanced disability severance pay; and will issue another policy in July 2008 to address MEB Appeal, impartial medical advisor and standards for legal assistance. Additionally, the Department published two reports on attainment of standards: Disability Annual Report (DAR) and the Disability Quarterly Report (DQR).	1) DoD directive memorandum dated dated November 2`1, 2007,and accompanying DVA policy letter provides implementing guidance for the joint DoD/DVA pilot. 2) The Department published policy guidance on March 13, 2008, to implement recent NDAA 2008 modifications to the DES. Another policy change memorandum will be published not later than July 2008 that will further promulgate changes to the DES.
9.6	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Ensure implementation of recommendations made in the Army Inspector General report on the Army physical disability system and the resulting Army Action Plan on WRAMC outpatient care. Follow-up action by the Deputy Chief of Staff G1 must be undertaken to ensure this timeline is met and effectiveness of the changes adopted should be measured by September 30, 2007 and adjustments made accordingly.	The recommendations of the Department of the Army Inspector General Report on the Army Physical Disability Evaluation System Inspection and Follow-up Actions on the Army DES are being monitored by the Senior Oversight Committee (SOC) staff.	
9.7	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	The Secretary of Defense, in Conjunction with the Secretary of Veterans Affairs, should direct the transition process be streamlined for the service member separating from the DoD to the Dept. of VA.	Elimination of redundancies in the DES is occurring througout the Military Departments. Each Military Department is applying Lean Six Sigma techniques to improve processes that fall short of goals and to identify redundancies and gaps. Also, streamlining the process across the Departments of Defense and VA is a primary goal of the DES Pilot as directed by the SOC. In the Pilot, if a Service member is found unfit, a DoD separation disposition is made (separate with or without benefits, temporary disability retirement, or permanent disability retirement or) and the member is given 45 days to transition. During this time, the VA claim is adjudicated and awarded so that the claim is paid within 30 days after final separation. The concurrent application of DoD and VA benefits is transparent and greatly streamlines the process.	Same as P-1
10.5	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Review and update applicable directives to ensure there is no distinction in the care management and disability processing of Active Component and Reserve Component Service members	A comprehensive review of all Department of Defense issuances pertaining to the Disability Evaluation System was completed. Directives were updated where necessary to reflect compliance with NDAA 2008 In addition, a senior member of the Assistant Secretary of Defense for Reserve Affairs was added as a permanent member to the Disability Advisory Council (DAC).	Completed
8.1	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	SecDef should review the Physical Evaluation Board determinations of all burn cases, dating back to 2001, within one year after the update to US Code 38	The Department of the VA is currently updating CFR 38, Part 4-VA Schedule for Rating Disabilities (VASRD) with new criteria for rating TBI and Post Traumatic Stress Disorder (PTSD), and updated criteria for rating burns. Once the new rating criteria are established in CFR, DoD will publicize and solicit that those with burn case injuries request review by the newly established Physical Disability Board of Review.	In Process. The regulation updating the schedule for burns was sent to OMB as a final rule on June 20, 2008. OMB's 90-day review period expires on September 22, 2008, unless cleared earlier than that, we anticipate the final rule being published in late September.
9.8	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Conduct a quality assurance review all DES (Army, AF, Navy, Marines) decisions of 0, 10 or 20 percent disability and Existed Prior to Service (EPTS) cases since 2001 to ensure consistency, fairness, and compliance with applicable regulations.	Section 1643 of Pub. L. 110-181added section 1554a to chapter 79 of title 10, United States Code, requiring that the Secretary of Defense establish a board to be known as the Physical Disability Board of Review (PDBR). The purpose of the PDBR shall be to reassess the accuracy and fairness of the ratings of Service members who were discharged as unfit by the Military Departments with a disability rating of 20% or less and were not found to be eligible for retirement. To that end, the PDBR shall review the disability ratings for unfitness determinations by the Military Department Physical Evaluation Boards, and where appropriate, recommend that the Military Departments correct discrepancies and errors in such determinations. The Department designated the Department of the Air Force as the Lead DoD Component for the establishment, operation, and management of the PDBR for the DoD. The PDBR operates under guidelines established in this new issuance in order to comply with statute. The Air Force is required to provide reports to the Secretary of Defense.	The PDBR was established by Department of Defense Instruction, entitled: Lead Component for the Physical Disability Board of Review in June 2008. The Air Force is establishing further procedural and operational instructions for the conduct of the board. The Department anticipates receiving cases by August 2008.

Type Finding/ Tracking #	Finding	Corrective Action	Status of Completion
MEB 1	There is a need for (PEB Liaison Officer) PEBLO Training.	Establish PEBLO Training and Certification Policy.	Completed - Jul 07, OTSG/MEDCOM Policy 07-029, Physical Evaluation Board Liaison Officer (PEBLO) Training and Certification. Requires PEBLOs complete standard training and certification via distance learning, resident course (held 3 times per year), or PEBLO Conference (held every 2 years). Annual recertification is required. Certification is required within 180 days as a condition of employment for new hires / appointments.
MEB 2	Problem with timeliness of MEB processing stemming from excessive PEBLO workload.	Evaluate and standardize PEBLO to workload ratio	Completed - Jun 07, Ratio established as 1:30 based on Lean Six Sigma study of WRAMC workload. Additional PEBLO resources were and continue to be added. Current PEBLO to caseload ratio for 2nd QTR 08 is 1:34.
MEB 3	Inadequate management and oversight for Soldiers undergoing MEBs.	Assign dedicated MEB Physicians at the rate of 1 for every 200 MEB cases at all locations that process MEBs.	Completed - Jun 07, Established MEB Physicain ratio of 1:200 MEB cases. Currently re-evaluating standards with a proposal to lower it to 1:120.
MEB 3a	Inadequate management and oversight for Soldiers undergoing MEBs.	Establish mechanisms for weekly management and oversight of Soldiers going through the MEB process.	Completed - Sep 07, OTSGMEDCOM Policy 07-040, Metrics and Continuous Process Improvements for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing.
MEB 4	Need to reduce return rate of MEBs from the PEB.	Implement Office of the Surgeon General (OTSG) tracking and oversight of returned MEBs.	Completed - Sep 07, OTSGMEDCOM Policy 07-040, Metrics and Continuous Process Improvements for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing.
MEB 5	Inadequate monitoring of process and timeliness in MEB processing.	Establish Medical Treatment Facilities (MTF) centralized processing centers to oversee all support requirements for MEB processing.	Completed - Sep 07, OTSGMEDCOM Policy 07-040, Metrics and Continuous Process Improvements for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing.
MEB 5a	Inadequate monitoring of process and timeliness in MEB processing.	Implement mandatory use of MEB tracking application by PEBLOs.	Completed - Sep 07, OTSGMEDCOM Policy 07-040, Metrics and Continuous Process Improvements for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing.

MEB - Medical Evaluation Board
PEB - Physical Evaluation Board
WCTO - Warrior Care and Transition Office
AR - Army Regulation

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MEB 6	Knowledge deficit for providers responsible for contributing to MEB process.	Conduct MEB training and education for Providers contributing to MEB process	Initiated Jul 07, ongoing. Developed a Provider distance learning modul with an anticipated launch in 4th QTR, FY 08.
MEB 7	Inadequate knowledge-base for Soldiers going through MEB process. Need to improve and expedite MEB management.	Implement additional training and education for Soldiers, to include: a. initial standardized briefing; b. creation and distribution of Physical Disability Evaluation System (PDES) pocket handbooks; and c. creation of AKO-based "MyMEB/MyPEB" where Soldiers can monitor progress.	a. Completed - Jun 07, Initial standardardized MEB Soldier Brief. b. Completed - May 07, PDES Pocket Handbook. c. Completed - Jul 07, MyMEB.
MEB 8	Need to improve soldier understanding of MEB and PEB processes.	Develop and administer post-counseling surveys with feedback monitored by US Army Medical Command (MEDCOM) Public Affairs Detachment and routed to PEBLOs at the MTFs.	Initiated Jun 07. Ongoing.
MEB 9	Need to reduce administrative and clinical documents required for the MEB.	Develop processes to reduce and streamline documentation required for the MEB	Completed. Reduced required documentation from 38 items to 19 items.
MEB 10	MEB process should be automated to facilitate efficiency and timeliness.	Evaluate and Identify MEB processes that can be automated.	Underway. Projected implementation Jan 09.

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PEB 1	ARs 10-59 and 635-40 are not consistent with other Army ARs nor with DoD and VA policy.	a. Rescind AR 10-59. b. Revise 635-40	a. AR 10-59 rescinded. b. A rapid action revision (RAR) to AR 635-40 was staffed in November 2007 and reworked in Mar 08 due to provisions of NDAA 08. OTJAG non-concurred with portions of the RAR and it is being further developed for resubmission to the Office of The Judge Advocate General (OTJAG).
PEB 2	PDA uses an insufficient data management program (PDCAPS) to manage PEB cases.	a. Migrate current MEB Internal Tracking Tool (MEBITT system) to Forms Content Management system as the automated MEB for MEDCOM. b. Implement improvements to PDCAPS (PDCAPS 2). Write fielding plan to reflect concurrent development operation with MEDCOM as they build the automated MEB.	a. 1 Apr 08, began initial testing of automated MEB at Brooke Army Medical Center. Initial operational capability (IOC) expected in Sep 08, with full operational capability in Feb 09. b. Aug 07, User-testing for PDCAPS 2 failed, requiring removal of contractor. Second fielding of User-testing for PDCAPS 2 to launch concurrently with automated MEB, with an IOC in Oct 08. PDCAPS 2 development is contingent upon funding.
PEB 3	PDA does not consistently meet the DoDI 1332.38 40-day standard for the processing time for a final disability determination	The DAIG determined that the processing time standard of 40 days was not realistic due to due-process requirements for Soldiers. Recommendation was to change the standard in the DoDI 1332.38 to reflect the potential time necessary for all levels of Soldier appeals.	Completed. Presented the issue to the Disability Advisory Counsel (DAC) shortly after release of the DAIG report. In response, DoD modified the processing time standard via a Directive Type Memorandum (DTM) issued 3 May 2007, stating that the processing time goal of 40 days should be met 80% of the time. The 40-day processing time standard is also more fully defined to exclude appellate review. Every level of appellate review after the Formal PEB now has a separate 30-day standard.
PEB 4	Processing Continuation on Active Duty (COAD) and Continuation on Active Reserve (COAR) requests resulted in additional time beyond the DODI 40-day standard in which Soldiers are in the Army PDES.	The DAIG recommended that processing time for COAD and COAR requests not be counted against the DoDI 40-day standard.	Completed. The processing time standard in the DTM excludes time spent processing COAD/COAR requests. The DTM did not set a processing time standard for this type of action.

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PEB 5	The US Army Personnel Disability Agency (USAPDA) quality assurance program does not conform to DoD and Army policy.	Develop and implement a quality assurance program that conforms to DoD and Army policy.	Completed. The Center for Army Analysis (CAA) provided assistance with instituting a new QA program, effective 1 Oct 07, that targets quality reviews to specific, relevant ratings disparities to determine cause — guidance, policy, training, population, etc. The CAA will provide another complete analysis in October 2008.
PEB 6	The training of personnel working in the PEB process does not meet the standards as specified in DoDI 1332.38, AR 635-40, and USAPDA SOP.	Develop and implement an on-going training program for personnel involved in the PEB process that meets the standards as specified in DoDI 1332.38, AR 635-40, and USAPDA SOP; and conduct regular staff assistance visits (SAV) by the PDA Headquarters and PEB staffs.	Updated and revamped Adjudicator training program. In addition to the existing requirement for completion of the one week Senior Adjudicator Course, PDA instituted an annual 3-day intensive refresher training program and monthly 2-hour VTC sustainment training sessions for all adjudicators. The first refresher training session was held on 18-20 Sep 07 with upcoming training scheduled for for 8-12 Sep 08. The PDA conducted its most recent Senior Adjudicator course in April 08, with 28 participants from all the Services. In addition, PDA provides annual training to Judge Advocates, military and civilian, who represent Soldiers appearing before the PEB. HQ staff members have conducted multiple SAVs to all three PEBs during FY08. Since the release of the DAIG report, PEBs have participated in 24 SAVs to MTFs, and 15 more SAVs are scheduled during 2008.

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PEB 7	Some Soldiers do not return for their required periodic examinations while in a Temporary Disability Retirement List Status.	Review policies and procedures regarding the tracking of Soldiers who are required to have periodic examinations while in a TDRL status.	Completed. Soldiers who fail to complete required periodic medical examinations are notified of pending retired pay termination unless they comply. Action is taken within 30 days unless Soldiers provide a reasonable explanation for failure to make re-examination appointments. If pay is suspended, it is reinstated only after a Soldier completes the re-examination.
PEB 8	PDA and the PEBs recognized the need for additional personnel to process the increased caseload as a result of GWOT and have made some progress.	Evaluate DES manpower to identify additional requirements as result of increased GWOT; include these increased requirements in updated authorization documents; and obtain the necessary resources to complete disability cases within processing time standards.	Ongoing. The PDA developed increased staffing requirements in April 2007 to include increases to the PDA base authorization documents. Army is currently working the requests for authorization increases. The Human Resource Command (HRC) 2009 authorization document includes requirements, but not authorizations, for additional resources for the Agency and the three PEBs. The HRC 2010 document does include these authorizations. HRC has advised that we can request fill against our 2009 requirements and they will work to fill. Current resourcing is adequate to meet all Agency requirements other than PEB physicians. The PDA has adequate authorizations, but is having difficulty finding and hiring qualified medical officers. However, current manning has enabled the Agency to continue to meet processing time requirements.
PEB 9	The Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) does not accurately reflect the medical conditions and ratings in today's environment.	The Department of Defense is working with the Department of Veterans Affairs on updates to the VASRD. DoD comments and inputs to the VASRD process are now worked through the DoD Disability Advisory Council.	The Office of the Assistant Secretary of Defense for Health Affairs (OASD (HA)) is the proponent for DoD change requests to the VASRD. Following the VA SME's review, the DoD sends the package to the requestor and places the issue on the DAC agenda for review prior to submission to the joint DoD – VA Benefits Executive Committee (BEC).

Type Finding/ Tracking #	Finding	Corrective Action	Status of Completion
PEB 10	Some medical hold and medical holdover personnel in the PDES process do not understand their rights and separation entitlements.	Evaluate policies, procedures and communication tools used to counsel medical holdover personnel on the PDES process and rights and separation entitlements.	PDA reviewed the counseling requirements in AR 635-40 and determined that the information is adequate. The information was not reaching the intended audience. The following documents address that issue. PDA published the PDES Handbook in APR 07. Under AMAP, MEDCOM developed a standard PEBLO briefing and a PEBLO Training Handbook. PDA had major input to both. (Army Medical Action Plan) AMAP Survey will address this finding.
PEB 11	A few installations inspected had Americans with Disabilities Act (ADA) violations affecting disabled Soldier's access to facilities.	AMAP to task IMCOM (task 3C2G5A) to ensure accessibility for Warriors in Transition to all facilities they frequent.	Installation Management Command (IMCOM) reports a status of Green for this task. Two PEBs were inspected this year, and only minor ADA deficiencies were noted. The DC PEB main ADA deficiency (front door handi-cap accessibility) is resolved. Both Fort Sam Houston and Fort Lewis Washington PEBs are scheduled to have new PEB buildings built in 2008/9. Fort Sam Houston PEB is on course for a 3QFY09 completion of their new facility. Fort Lewis is also well on track for a 4QFY08 completion.
PEB 12	PEB personnel perceive the MOS Medical Retention Board (MMRB) is under used resulting in some Soldiers separating through the PDES unnecessarily.	Evaluate perception of MOS Medical Retention Board being under-utilized resulting in some Soldiers separating through the PDES unnecessarily.	Further discussion on this issue resulted in an G1/AMAP conclusion that having the PEB refer Soldiers to the MMRB is not appropriate or efficient. Training physicians to make the proper recommendation of MMRB vs. MEB is the best approach and MEDCOM has an AMAP task to do so. Therefore, there are no plans to revise AR 635-40 to include a PEB referral to an MMRB.
PEB 13	Most installation transition centers have additional personnel to handle the increased transition processing workload created by the GWOT in order to meet the Army (transition) time standards.	Establish and implement guidelines to eliminate errors in placing Soldiers on wrong installation transition processing notification lists.	Completed - Spring 2007, Developed a change to the Soldier election form that includes specific entries for desired transition point, as well as, contact information for the Soldier, and Unit chain of command. PDA now enters the TC reflected on the election form even if it is different from the MTF that conducted the MEB. Assignment of Soldiers to Warrior Transition Units (WTU) is also helping eliminate this problem. Staffing of transition centers has not been an issue.

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Type Finding/ Tracking #	Finding	Corrective Action	Status of Completion
WCTO 1	Clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Medical Holdover Units on active duty installations is needed.	Installation Management Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Medical Holdover Units on active duty installations.	Completed - 1 Dec 07, WTU Consolidated Guidance developed and updated on a regular basis by DA G-1 with input from AMAP stakeholders. Guidance available on the Army G-1 website for ease of access.
WCTO 2	Department of the Army Medical Holdover Consolidated Guidance needs to specify the command and control, and organizational structure of reserve component Soldiers assigned to Community Based Healthcare Organizations.	US Army Medical Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs and Deputy Chief of Staff G1, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Community Based Healthcare Organizations.	Completed - 15 Jun 07, Merged legacy Medical Hold and Medical Readiness Processing Units into 35 all Component WTUs.
WCTO 3	Standing operating procedures for Medical Holdover Operations, specifically for Medical Retention Processing Units, is needed.	Installation Management Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, develop and implement standing operating procedures for Medical Holdover Operations, specifically for Medical Retention Processing Units.	Completed - 1 Dec 07, MEDCOM Warrior Transition Office (WTO) is the proponent for developing and implementing SOPs for WTUs.

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WCTO 4	Development and implementation of the Medical Holdover Operations Systems Analysis and Review checklist to include by-item definitions and supporting standards of performance is needed.	Installation Management Command, with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, complete development and implement the Medical Holdover Operations Systems Analysis and Review checklist to include by-item definitions and supporting standards of performance.	Completed - Sep 07, As part of the AMAP, Army created a comprehensive review checklist for all WTU operating systems which was utilixed by teams of subject matter experts conducting Staff Assistance Visits to WTUs to measure progress. Currently, WTU Commanders prepare and submit to leadership monthly Unit Status Reports which utilize a robust set of metrics to track and determine operational readiness, a subset of key metrics are briefed monthly to SA as part of the Medical SRG, Senior Commanders conduct periodic Town Hall Meetings with WTs and Families and act on identified concerns, MTF Commanders brief VCSA quarterly on the status of WTUs, WTU Commanders conduct Quarterly Training Briefs and RMC Commanders provide QTBs semi-annually to the MEDCOM CG. The metrics utilized for all reporting requirements cover all WTU operations systems.
WCTO 5	Training criteria for Medical Holding Unit (MHU) cadre is needed.	The Office of the Surgeon General develop training criteria for Medical Holding Unit (MHU) cadre.	Completed - Jul 07, AMEDD Center and School has developed a certification training course for all WTU cadre. Originally a distance learning application, mobile medical training teams have been established that bring the training to WTU cadre on-sight, a resident course is being developed and will be implemented in FY 09.
WCTO 6	A by-position targeted training program for all Medical Holdover organization command and control and medical management cadre is needed.	Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Office of the Surgeon General, the Installation Management Command (IMCOM) and US Army Medical Command, complete a by-position targeted training program for all Medical Holdover organization command and control and medical management cadre.	Completed - Sep 07, Position-specific training has been developed and implemented for all WTU positions.

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WCTO 7	Medical holdover Soldiers who are able to work should have duties within the limits of their profiles.	Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations (CBHCO) continue ensuring medical hold and medical holdover Soldiers who are able to work have duties within the limits of their profiles.	Completed - Jun 07, The Comprehensive Transition Plan (CTP) developed jointly by the Warrior in Transition, the members of his/her care management, and support staff Triad was developed to assist Warriors in Transition to reset and either return to duty or transition to civilian life. The CTP establishes accountability to ensure WTs engage in cognitive enhancing activities, e.g., military education distance learning courses, college courses, and foreign language study, as well as work reintegration or vocational training.
WCTO 8	Installation support agreements to ensure the Physical Evaluation Board facilities are in compliance with Americans with Disabilities standards are needed.	US Army Physical Disability Agency, in coordination with host installations, develop installation support agreements to ensure the Physical Evaluation Board facilities are in compliance with Americans with Disabilities standards.	Completed interim renovation effort and priority housing policy. Army policy memorandum dated 18 June 2007 as an AMAP quick win directs Army garrisons to use existing authorities to assign WTs with dependents to housing on a priority basis that is on par with that afforded key and essential personnel. In FY 07, $56M in remodeling and renovation efforts were completed to include numerous interim changes to accommodate the accessibility requirements of WTs. Efforts are ongoing to fund and complete MILCON and renovations to create Warrior Transition Complexes to include barracks, WTU administrative facilities, and Soldier Family Assistance Centers all of which are accessible and located in close proximity to MTFs.
WCTO 9	Medical Retention Processing Unit facilities need to be in compliance with Americans with Disabilities standards.	Installation Management Command ensure Medical Retention Processing Unit facilities are in compliance with Americans with Disabilities standards.	Completed - Dec 07, MEDCOM completed assessment of all WTU related facilities and housing. ACSIM has completed Military Construction Project Data assessments (DD Form 1391C) for all required WTU facilities. Ongoing inspections of facilities will be conducted by MEDCOM in coordination with (Installation Management Command) IMCOM.

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WCTO 10	Medical Retention Processing Units, and Community Based Healthcare Organizations would benefit from increased personnel.	Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, examine the possibility of increasing the personnel manning of Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations.	Completed - 22 May 08, Authorization for 2,434 WTU cadre positions with an additional 416 positions approved by the VCSA.
WCTO 11	Medical Holding Unit and Medical Retention Processing Unit personnel structures would benefit from having Behavioral Health Specialists assigned.	Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, consider providing a Behavioral Health Specialist to the Medical Holding Unit and Medical Retention Processing Unit personnel structures.	Completed - 1 Jan 08, WTU staffing includes clinical social workers assigned at the battalion level who are trained in behavioral health management, to include having completed standardized certification training in behavioral health management.
WCTO 12	Unneccesary layers of Command and Control (C2) in Community Based Healthcare lnitiative Transition Plan	US Army MEDCOM, in coordination with ASA (M&RA), IMCOM, NGB and Chief, Army Reserve, review the Community Based Healthcare lnitiative Transition Plan and eliminate unnecessary layers to command and control.	Completed - 15 Jun 07, WTUs established to replace Medical Hold (MH) and Medical Readiness Processing Units and to provide C2 for all Warriors in Transition, to include CBHCOs.
WCTO 13	Standardized Regional Medical Command organizational structure needed to provide required functions for Community Based Healthcare Organizations.	US Army MEDCOM develop a standardized Regional Medical Command organizational structure to provide required functions for Community Based Healthcare Organizations.	Completed - 2005, Each Regional Medical Command with one or more CBHCOs within their area of responsibility has an established CBHCO command.

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WCTO 14	A policy outlining the assignment criteria for command and control support cadre to Medical Retention Processing Units and Community Based Healthcare Organizations is needed.	Deputy Chief of Staff, G-1, in coordination with Human Resources Command, lnstallation Management Command, and US Army Medical Command create policy outlining the assignment criteria for command and control support cadre to Medical Retention Processing Units and Community Based Healthcare Organizations.	Implementation in 2007 of the Army Medical Action Plan included the conducting of an assignment board for C2 positions for all 35 WTUs. Commanders, Command Sergeants Major, and First Sergeants were selected based on the criteria of having combat experience, demonstrated leadership ability, and the compassion and dedication required to care for the Army's wounded, ill, and injured. Although not a requirement, in many instances those chosen had been wounded in combat themselves. These criteria will continue to be key in future selection of WTU C2 personnel.
WCTO 15	Job descriptions for Medical Retention Processing Unit command and control cadre are needed.	lnstallation Management Command, in coordination with the US Army Medical Command, develop job descriptions for Medical Retention Processing Unit command and control cadre.	Completed - 1 Jan 08, All WTU TDA positions have current position descriptions and standards of practice developed.
WCTO 16	Job descriptions for Community Based Healthcare Organizations (CBHCO) command and control cadre are needed.	US Army Medical Command, in coordination with the lnstallation Management Command, complete the development of job descriptions for Community Based Healthcare Organizations (CBHCO) command and control cadre.	Job descriptions have been completed and are in effect for all C2 cadre of WTUs and CBHCOs. Currently pending approval is a TDA structure for CBHCOs that reflects their being company size elements of Warrior Transition Battalions, thus, further establishing the C2 structure for these units.
WCTO 17	Integrating MH (AC) operations with MH (RC) operations is needed.	lnstallation Management Command in coordination with OTSG and FORSCOM review the feasibility of integrating MH (AC) operations with MHO (RC) operations.	Completed - 15 Jun 07, WTUs have been established to replace all legacy MH and MHO operations. IMCOM supports WTUs with Soldier Family Assistance Centers, transportation resources, housing support. Senior Commanders are actively engaged in ensuring WTUs are fully supported.

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WCTO 18	Standardization of infrastructure to support an Installation Garrison Command in the absorption of select Soldiers in the Army Physical Disability Evaluation System (APDES) is needed.	Installation Management Command in coordination with OTSG, Deputy Chief of Staff G1 and HRC develop a standardized infrastructure to support an Installation Garrison Command in the absorption of select Soldiers in the Army Physical Disability Evaluation System (APDES).	Completed - 1 Feb 08, IMCOM has established Soldier Family Assistance Centers at installations with WTUs to provide consolidated assistance and support to WTs and their Families.
WCTO 19	C2, personnel, training and transportation for select Soldiers in the Army physical Disability Evaluation System (APDES) is needed.	Installation Management Command (IMCOM) provide the C2, personnel, training and transportation for select Soldiers in the Army physical Disability Evaluation System (APDES).	Completed - 15 Jun 07, WTUs provide C2, personnel, training, and transportation for WTs undergoing MEBs/PEBs. IMCOM has provided transportation assets.
WCTO 20	Policy is needed that projects, on a regional basis, the assignment of C2 support cadre to Community Based Healthcare Organizations (CBHCO) and Medical Retention Processing Units (MRPU) to match the mobilization and demobilization requirements of RC Soldiers.	Deputy Chief of Staff, G-3,in coordination with Human Resources Command, Installation Management Command, and US Army Medical Command develop policy that projects, on a regional basis, the assignment of C2 support cadre to Community Based Healthcare Organizations (CBHCO) and Medical Retention Processing Units (MRPU) to match the mobilization and demobilization requirements of RC Soldiers.	Completed - Jul 07, WTU TDA for 2,434 positions approved. An additional 416 positions approved in May 2008 (effective date of change is 15 October 2008). Currently, further expansion of WTU TDAs is being developed to establish the capability of providing C2, care, and support for 12,000 Warriors in Transition and medical case management for an additional 8,000 Soldiers whose condition enables them to remain assigned to their regular units while recovering. All CBHCO Warriors in Transition are assigned to WTUs. Pending is approval of CBHCO TDAs establishing them as company sized elements of battalion level WTUs.
WCTO 21	Training to educate commanders and leaders on the importance of completing Line of Duty (LOD) investigations in accordance with the required regulations/policies is needed.	US Army commands conduct training to educate commanders and leaders on the importance of completing Line of Duty (LOD) investigations in accordance with the required regulations/policies.	HRC published a policy memorandum 13 June 2007 providing clarification of the requirement for LOC investigations for Soldiers being referred into the PDES. PDA transmitted this policy to MEDCOM 14 June 2007 as an exception establishing a presumptive line-of-duty for disability cases of Soldiers on Active Duty (includes RC on AD) without requiring a form or statement.

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WCTO 22	Improved screening procedures at Military Treatment Facilities (MTF) to ensure identification of wounded or injured Soldiers requiring LODs is needed.	US Army Medical Command review screening procedures at Military Treatment Facilities (MTF) to ensure identification of wounded or injured Soldiers requiring LODs.	HRC published a policy memorandum 13 June 2007 providing clarification of the requirement for Line of Duty (LOD) investigations for Soldiers being referred into the PDES. PDA transmitted this policy to MEDCOM 14 June 2007 as an exception establishing a presumptive line-of-duty for disability cases of Soldiers on Active Duty (includes RC on AD) without requiring a form or statement.
WCTO 23	Regulatory guidance regarding the transfer of medical documentation needs enforcement.	US Army Medical Command (MEDCOM) enforce regulatory guidance regarding the transfer of medical documentation.	MEDCOM published a policy memorandum on 15 June 2007 delineating procedures for the safeguarding and transfer of medical records when WTs transfer from 1 WTU to another, including guidance on entering such information in AHLTA so the receiving WTU/MTF would have access to such information. Additionally, MEDCOM published a policy memorandum 9 October 2007 citing a JAG interpretation that Soldier medical records may be released to the VA. Also, ALARACT 034-2008 was published 19 FEB 08 which further clarified procedures for transfer of medical records to the VA that essentially follows the policy published by MEDCOM in the 15 June 2007 policy memorandum mentioned above.
WCTO 24	Fielding of Armed Forces Health Longitudinal Technology Application (AHLTA) should be supported.	US Army Medical Command continue the fielding of Armed Forces Health Longitudinal Technology Application (AHLTA).	In addition to continuing to field AHLTA, DoD and the VA continue to evaluate the ability to electronically share medical information between Vista and AHLTA. On 26 May 2008, TSG announced DoD wide utilization of MC4. As an AMAP initiative, the Joint Patient Tracking Application (JPTA) is now required to track all wounded, ill, or injured Soldiers. VA has developed the same system which it calls the Veteran Tracking Application that operates in the same manner as JPTA. With the Medical Communications for Combat Casualty Care (MC4) capability, both DoD and VA have the capability to access medical information from the site of injury, through AHLTA or Vista to accomplish a more comprehensive medical picture of Soldiers or Veterans.

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WCTO 25	Subordinate commanders compliance with AR 735-5 and Department of the Army All Army Activities 139/2006 P210236Z July 2006 Message, Policies and Procedures for Handling Personal Effects and Government Property needs improvement.	US Army Commands ensure subordinate commanders comply with AR 735-5 and Department of the Army All Army Activities 139/2006 P210236Z July 2006 Message, Policies and Procedures for Handling Personal Effects and Government Property.	The WTU Consolidated Guidance, last updated December 2007, includes guidance on the proper handling of personal effects and government property.
WCTO 26	Medical Holding Units and Medical Retention Processing Units should include a briefing during inprocessing on how to file claims with the Installation Claims Office for lost personally owned property.	US Army MEDCOM and Installation Management Command ensure Medical Holding Units and Medical Retention Processing Units include a briefing during inprocessing on how to file claims with the Installation Claims Office for lost personally owned property.	Ongoing efforts with assistance from the Warrior Transition Office. 3.C.1.H.29.A. (U) Task: Draft an Standard Operating Procedure (SOP) to govern operations of Warrior Transition Units and conduct an orientation for new WTU commanders at the June AUSA Medical Symposium.
WCTO 27	Physicians should be trained and understand when a Soldier should be referred to an Military Occupational Specialty (MOS) /Medical Retention Board versus Medical Evaluation Board.	US Army Medical Command ensure physicians are trained and understand when a Soldier should be referred to an MOS/Medical Retention Board versus Medical Evaluation Board.	Completed - Jan 08, The AMAP established MEB physicians who are experienced in knowing when to refer Soldiers for an (MOS Medical Retention Board (MMRB) and when to initiate a MEB. Standardized training has been developed for these MEB physicians who assist in assuring MEB actions are initiated, conducted, and decisions made in accordance with applicable regulations, e.g., AR 40-501 standards and AR 40 400 patient administration requirements.
WCTO 28	Procedures for screening permanent profiles to determine whether to refer a Soldier to an MOS/Medical Retention Board versus Medical Evaluation Board are needed for Commands and units with MOS/Medical Retention Board convening authority.	Commands and units with MOS/Medical Retention Board convening authority establish procedures for screening permanent profiles to determine whether to refer a Soldier to an MOS/Medical Retention Board versus Medical Evaluation Board.	Completed, 1 Jan 08, The AMAP established MEB physicians who are experienced in knowing when to refer Soldiers for an MMRB and when to initiate a MEB. Standardized training has been developed for these MEB physicians who assist in assuring MEB actions are initiated, conducted, and decisions made in accordance with applicable regulations, e.g., AR 40-501 standards and AR 40-400 patient administration requirements.

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WCTO 29	Biannual medical holdover training for Medical Retention Processing Units and Community Based Healthcare Organizations is needed.	Installation Management Command in coordination with US Army Medical Command (MEDCOM), and Human Resources Command (HRC) continue the current implementation plan to conduct biannual medical holdover training for Medical Retention Processing Units and Community Based Healthcare Organizations.	Completed - 1 Feb 08, The AMAP established Soldier Family Assistance Centers (SFAC) under IMCOM to support WTUs. Each WT receives all necessary counseling through this arrangement.
WCTO 30	Authorization for data input fields in Medical Operational Data System is needed.	US Army Medical Command, in coordination with Human Resources Command- Alexandria complete authorization for data input fields in Medical Operational Data System.	Development of the Soldier Patient Tracking System (SPTS) was recently completed and is currently being fielded to Army units. Required additional data fields necessary for patient tracking as part of the Joint Patient Tracking Application (JPTA), SPT, and other applications have been developed. As required by the AMAP, all Army activities utilize the JPTA.
WCTO 31	Funding for installation transition centers to ensure timely discharge, release from active duty, and retirement orders publishing and disability separation processing is needed.	Installation Management Command continue to fund installation transition centers to ensure timely discharge, release from active duty, and retirement orders publishing and disability separation processing.	Completed - 1 Feb 08, Through coordination and support to WTUs, IMCOM operated SFACs accomplish, IAW the AMAP and utilizing on-site VA representatives, complete transition and benefits processing for WTs. This arrangement includes targeting the 90 day period prior to anticipated separation to complete all transition processing to ensure Soldiers are approved and will receive all benefits and payments to which they are entitled.
WCTO 32	Army Physical Disability Evaluation System (PDES) training is needed in the brigade and battalion pre-command courses and the sergeants major course.	Training and Doctrine Command (TRADOC) include Army Physical Disability Evaluation System (PDES) training in the brigade and battalion pre-command courses and the sergeants major course.	Completed - 1 Jan 08, As part of the AMAP, TRADOC was tasked to complete this requirement and has successfully taken on this responsibility.
WCTO 33	Army Physical Disability Evaluation System training is needed in company commander and first sergeant courses that includes the unit's role and responsibilities.	Army Commands include Army Physical Disability Evaluation System training in their company commander and first sergeant courses that includes the unit's role and responsibilities.	Completed - 1 Jan 08, As part of the AMAP, TRADOC was tasked to complete this requirement and has successfully taken on this responsibility.

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WCTO 34	Training materials and programs to educate unit leaders on all aspects of the Army Physical Disability Evaluation System to include their responsibilities is needed.	Office of the Surgeon General develop training materials and programs to educate unit leaders on all aspects of the Army Physical Disability Evaluation System to include their responsibilities.	Completed - 1 Jan 08, The AMEDD Center and School has developed a training package in coordination with PDA and the Training Doctrine Command (TRADOC) to be used to train unit leaders on the PDES. This training is also utilized as part of the training for WTU cadre.
WCTO 35	A personnel system that allows Reserve Component commanders to track their mobilized Soldiers and those subsequently assigned to Medical Holdover status is needed.	Deputy Chief of Staff, G1 complete development of a personnel system that allows Reserve Component commanders to track their mobilized Soldiers and subsequently assigned to Medical Holdover status.	Completed - 1 Jan 08, The AMAP established the requirement to utilize the Joint Patient Tracking Application to track Warriors in Transition through the medical care chain beginning at the point of injury through recovery and disposition.
WCTO 36	Procedures to enable and require Commanders to contact Soldiers and their families while in Medical Holdover status are needed for the US Army Reserve.	US Army Reserve Command develop procedures to enable and require Commanders to contact Soldiers and their families while in Medical Holdover status.	Army is currently deploying the Soldier Patient Tracking System which provides AC and RC commanders the ability to stay in touch with their Soldiers.
WCTO 37	Procedures to enable and require Commanders to contact Soldiers and their families while in Medical Holdover status are needed for the National Guard.	National Guard Bureau develop procedures to enable and require commanders to contact Soldiers and their families while in Medical Holdover status.	Army is currently deploying the Soldier Patient Tracking System which provides AC and RC commanders the ability to stay in touch with their Soldiers.

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WCTO 38	TRICARE Management Agency (TMA) review its policy regarding reimbursement of those civilian providers authorized to provide medical treatment to DoD beneficiaries.	TRICARE Management Agency (TMA) review its policy regarding reimbursement of those civilian providers authorized to provide medical treatment to DoD beneficiaries.	Tricare Management Agency (TMA) has implemented measures to increase access to care. The future of such initiatives is no doubt dependent upon the outcome of congressional action and administration response to whether or not the FY 09 Emergency Supplemental will or will not include provider payment cuts required as a result of MEDICARE related action to cut such payments. VA is also taking action to increase access to providers through arrangements with civilian providers.
WCTO 39	TRICARE Management Agency review or revise criteria used to certify physicians in remote locations in order to provide care for Soldiers residing there.	TRICARE Management Agency review or revise criteria used to certify physicians in remote locations in order to provide care for Soldiers residing there.	TMA has implemented measures to increase access to care. The future of such initiatives is not doubt dependent upon the outcome of congressional action and administration response to whether or not the FY 09 Emergency Supplemental will or will not include provider payment cuts required as a result of MEDICARE related action to cut such payments. VA is also taking action to increase access to providers through arrangements with civilian providers.

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