



**ARMY TASK FORCE on  
BEHAVIORAL HEALTH**



**CORRECTIVE ACTION PLAN**  
**January 2013**



## EXECUTIVE SUMMARY

On May 15, 2012, the Secretary of the Army (SA) directed the Under Secretary of the Army and the Vice Chief of Staff, Army (VCSA) to take a holistic look and identify systemic breakdowns or concerns in the Integrated Disability Evaluation System (IDES) affecting the diagnosis and evaluation of behavioral health conditions. To accomplish this, the SA's directive established the Army Task Force on Behavioral Health (ATFBH) to assist the Under Secretary and VCSA in conducting a comprehensive review and developing a corrective action plan (CAP) to address and rectify any identified breakdowns or concerns.

### Current Situation

The Army has devoted an extraordinary amount of time, attention, and resources to care for Soldiers returning from deployments, especially those with behavioral health conditions. The Army continues to make great strides in changing the culture that stigmatized those with Post Traumatic Stress Disorder (PTSD) and to educate and encourage Soldiers and leaders to heal these invisible wounds of war. The Army has revised several policies to ensure Soldiers with PTSD are properly diagnosed, and if appropriate, considered for a medical discharge. Most recently, the Army proactively implemented several initiatives to resolve some of the findings discovered during the ATFBH comprehensive review. These changes are positive steps for our wounded, ill and injured, and this CAP details subsequent actions required to achieve a more efficient and effective disability system for Soldiers with behavioral health conditions.

Illustrative of the Army's improvements is the reduction in the time required for a Soldier to successfully go through the IDES. As of November 2012:

- 1) The U.S. Army Physical Disability Agency (USAPDA) increased its capacity 2.5 times over 6 months to a surge capacity of approximately 4,000 cases per month.
- 2) U.S. Army Medical Command (MEDCOM) improved Narrative Summary (NARSUM) productivity from an average of 30.8 days from 60 days in July 2012.
- 3) More Soldiers completed the IDES process than entered it, representing the Army's highest performance to date.

Additionally, the Army completed several actions to improve service to Soldiers in the IDES process. Among these actions are:

- 1) Standardizing and clarifying diagnosis and evaluation of Soldiers with PTSD.
- 2) Defining processes and standards for completion of the MEB phase of the IDES and improving communication between Army and VA Behavioral Health (BH) providers.
- 3) Publishing *The IDES Guidebook, An Overview of the Integrated Disability Evaluation System*.
- 4) Encouraging the use of the Wounded Soldier & Family Hotline for the Soldiers, Veterans, and their Family members if they believed their case was unduly downgraded by Forensic Psychiatry Services (FPS) and wanted a re-evaluation.
- 5) Increasing support for the Reserve Component Soldier Medical Support Center (RC-SMSC) to reduce RC backlog.
- 6) Authorizing Reserve Component (RC) Soldiers onto active duty for IDES processing.
- 7) Conducting a stand down day to inform and train BH providers on the most recent information regarding diagnosis and treatment of BH conditions.

While great strides have been made, many within the last year, this is a complex challenge that will continue to require constant leadership and energy.

### Background

After a decade of war, invisible wounds such as Post Traumatic Stress Disorder (PTSD) and other behavioral health conditions are prevalent as Soldiers return from multiple combat deployments. The Army works to ensure every Soldier receives the healthcare, including the behavioral healthcare, they need and benefits they deserve.

Concerns regarding how the Army treats Soldiers with behavioral health conditions remain high. Over the last five years, the President, Congress, the Department of Defense (DoD), the Department of Veterans Affairs (VA), and the Army have created multiple working groups to study behavioral health conditions develop legislation and policies to assist service

members, and implement improvements in the disability evaluation system as a whole. These efforts have resulted in improvements. For instance, in 2007, the DoD and the VA developed the IDES to eliminate the lag time between separation from active duty service and receipt of benefits and compensation from the VA as compared to the legacy Disability Evaluation System (DES). The transition from the DES to the IDES shortened the period until the delivery of VA disability benefits after separation from an average of 166 days to approximately 30 days (the shortest period allowed by law). In contrast to the DES legacy process, IDES provides a single disability examination and a single-source disability rating that both Departments use in executing their respective responsibilities.

The ATFBH conducted an extensive literature review of investigations, reports, and other policy documents pertaining to behavioral health and the IDES. The ATFBH worked closely with the Department of the Army Inspector General (DAIG), the Army Audit Agency (AAA), the Army Research Institute (ARI), and the Army Surgeon General's Office to synthesize the information it gathered in accordance with the Secretary's directive. The ATFBH also coordinated with several other organizations working on similar projects either related to the IDES or behavioral health treatment, including the Defense Centers of Excellence (DCOE) for Psychological Health and Traumatic Brain Injury and the VA.

### The Corrective Action Plan

The ATFBH looked at the IDES process holistically, focusing on the needs of the Soldiers and their Families. The CAP provides 24 findings and 47 recommendations to improve behavioral health diagnosis and evaluation in the context of the IDES. Many of the recommendations seek to improve the IDES as a whole. The findings and recommendations are supported by detailed discussion sections and identify key actions assigned to specific actors required for implementation. The CAP findings and recommendations consist of five focus areas:

- 1) IDES oversight, training, and tracking;
- 2) BH issues within the IDES;
- 3) Reserve Component issues and improvements;
- 4) Personnel policies that impact the IDES; and
- 5) Enhancing Support for Soldiers and their Families.

In Focus Area 1 the ATFBH found that the Army must continue to improve coordination and synchronization in order to harmonize the actions of the multiple Army organizations involved in the IDES. To achieve this, the ATFBH recommends establishing a "lead agent" for the IDES. The "lead agent" will have more than mere policy proponency, it will have authority to direct and manage the IDES and standardize all training to improve the understanding of the IDES. Additionally, the Army must fully support efforts to develop an information technology (IT) solution across the DoD and VA. A single IT solution will better manage and track Soldiers in the IDES to ensure a common operating picture of Soldiers' records as they process through the system.

In Focus Area 2 the ATFBH found that the medical community must continue to move forward with several organizational and operational changes to improve behavioral health care and diagnostic practices. This will require: (1) reorganizing the behavioral health department; (2) establishing a Director of Psychological Health at the installation level who will also serve as the Chief of Behavioral Health of the Military Treatment Facility (MTF); and (3) fully integrating psychiatry, psychology, and social work services into a multidisciplinary Department of Behavioral Health under the Director of Psychological Health.

Several MTFs, especially those in remote locations, are challenged with filling vacant behavioral health provider positions. The Army must review the effectiveness of expedited hiring authority, requesting direct hiring authority, and fully implementing tele-behavioral health capabilities. As continual improvements to the system are made and new policies are established, it is critical behavioral health providers are trained on policy and procedural changes. The Army must ensure compliance with, and implementation of, DoD and Army policy.

In Focus Area 3 the ATFBH found that U.S. Army Reserve (USAR) and Army National Guard (ARNG) Soldiers require assistance at every level to ensure they receive the diagnoses and care they need and, if necessary, to be referred into the IDES. A Director of Psychological Health is necessary for both the USAR and ARNG in each state, territory, Reserve Support Command (RSC) and Operational Functional (O&F) Command to advise senior commanders on key behavioral health-related programs. This, along with education and communication, will help to ensure RC Soldiers and Families better understand the various care options available to them and provide for optimum medical case management.

In Focus Area 4 the ATFBH found that Army policies are designed to ensure that Soldiers diagnosed with a behavioral health condition are considered for a medical separation when facing an adverse action. Those policies require clarification or reconsideration to ensure the appropriate avenues for discharge are pursued by commanders. The MEDCOM policy requiring OTSG review of all personality disorder discharges must be revised to mirror the DoD policy limiting the review to Soldiers with a combat deployment. Initial entry Soldiers who do not meet medical fitness standards due to a pre-existing BH condition are being referred to the IDES to determine if they are eligible for a medical separation, rather than being administratively discharged. The Army should seek changes to current law in order to provide up to 365 days to administratively discharge Soldiers with a pre-existing behavioral health condition who have not previously deployed.

In Focus Area 5, the ATFBH found that Soldiers with behavioral health conditions and their Families require special assistance due to the nature of the Soldiers' injuries. Family members need to be involved in the transition process. The Army and local commanders must reach out and educate Soldiers and Families about the continuity of care available from DoD, VA, and other federal and state agencies. Soldier Family Assistance Centers (SFACs) are critical to connect Soldiers and Families with education, financial, job search assistance, and other transition support.

Physical Evaluation Board Liaison Officers (PEBLOs) provide information and guidance to Soldiers during the IDES by explaining the IDES to Soldiers, assisting Soldiers with appointment management and document tracking, and keeping Soldiers informed about the progress of their cases. The PEBLO program can be improved by implementing the realignment plan and standardizing the training and information provided to Soldiers and Families. The Office of Soldier Counsel (OSC) concept plan to reorganize their structure under MEDCOM and hire civilian attorneys to fulfill their requirements should be implemented.

### Summary

Many of the recommendations of the Task Force are already being acted upon. The Army is initiating several actions to improve the Soldier's IDES processing. These include:

- 1) Expanding the Embedded BH program aligning BH providers with brigade level deployable units.
- 2) Working with DoD and the VA to develop the Integrated Electronic Health Record (iEHR), a single medical data system which will manage and integrate medical documentation with full visibility and transferability between components.
- 3) Conducting a PEBLO customer service training program designed to standardize the PEBLO support provided throughout the IDES, track efficiency, and improve customer service.
- 4) Finalizing a Concept Plan for approval of a centralized, robust Office of Soldiers' Counsel (OSC).

Finally, the Army must plan ahead to manage the requirements for behavioral health and the IDES for the next war. The Army should develop planning factors and decision support tools now for implementation at the very beginning of the next conflict. These planning factors are necessary to adequately predict sufficient resources and proactively manage the assessment, treatment, and processing of Soldiers with behavioral health conditions. Perhaps the lesson best learned by the Army from this past decade of war is the importance of proactively preparing for and addressing behavioral health and IDES concerns.



**David G. Perkins**

*Lieutenant General, U.S. Army*

*Director, Army Task Force on Behavioral Health*

**TABLE OF CONTENTS**

**Executive Summary** ..... 1

**I. The Army Task Force on Behavioral Health (ATFBH) Charter and Organization** ..... 7

**A. Prelude to the ATFBH** ..... 7

**B. Mission** ..... 7

**C. Charter** ..... 7

**D. Organization** ..... 8

**II. Comprehensive Review and Development of the Corrective Action Plan (CAP)** ..... 9

**A. ATFBH Scope and Methodology** ..... 9

**B. Organizations Contributing to the CAP** ..... 9

**III. Overview: IDES and Behavioral Health in the Army** ..... 11

**A. Evolution of the DoD Disability Evaluation System(DES)** ..... 11

**B. Understanding the Integrated Disability Evaluation System (IDES)** ..... 13

**C. Behavioral Health in the Context of the IDES** ..... 17

**IV. Improvements Implemented or In-Progress** ..... 18

**A. Actions Implemented** ..... 18

**B. Actions In-Progress** ..... 18

**V. The CAP** ..... 19

**A. Focus Area #1 – The IDES Oversight, Training, and Tracking** ..... 20

        Finding 1.1 ..... 20

        Finding 1.2 ..... 21

        Finding 1.3 ..... 22

**B. Focus Area #2 – Behavioral Health Issues within the IDES** ..... 23

        Finding 2.1 ..... 24

        Finding 2.2 ..... 24

        Finding 2.3 ..... 26

        Finding 2.4 ..... 28

        Finding 2.5 ..... 29

        Finding 2.6 ..... 31

        Finding 2.7 ..... 32

        Finding 2.8 ..... 33

**TABLE OF CONTENTS**

**C. Focus Area #3 – Reserve Component Issues and Improvements** ..... 34

        Finding 3.1 ..... 35

        Finding 3.2 ..... 36

        Finding 3.3 ..... 37

        Finding 3.4 ..... 38

        Finding 3.5 ..... 39

**D. Focus Area #4 – Personnel Policies that Impact the IDES** ..... 40

        Finding 4.1 ..... 40

        Finding 4.2 ..... 43

        Finding 4.3 ..... 45

**E. Focus Area #5 – Enhancing Support for Soldiers and their Families** ..... 46

        Finding 5.1 ..... 46

        Finding 5.2 ..... 49

        Finding 5.3 ..... 50

        Finding 5.4 ..... 52

        Finding 5.5 ..... 55

**VI. The Way Ahead and Implications for the Future** ..... 57

**LIST OF TABLES**

**Table V-1. Anticipated Cost of the OSC’s Proposal (\$ in 000s)** ..... 53

**LIST OF FIGURES**

**Figure I-1. Task Force Organization** ..... 8

**Figure III-1. Legacy DES Process** ..... 11

**Figure III-2. IDES Timeline** ..... 14

**Figure V-1. Processing Administrative & Medical Separations** ..... 42



## I. The Army Task Force on Behavioral Health (ATFBH) Charter and Organization

### A. Prelude to the ATFBH

In late 2011, fourteen Soldiers submitted separate complaints about their PTSD diagnoses to Army leaders and Members of Congress. The Soldiers claimed that Behavioral Health (BH) providers at Madigan Army Medical Center (MAMC), Joint Base Lewis-McChord, Washington, improperly changed their PTSD diagnoses, potentially impacting their medical discharge and reducing their benefits.

In February 2012, the Army responded to the Soldiers' allegations by initiating investigations to identify the sources of diagnostic variance at MAMC, determine if any wrongdoing was committed, and make any necessary corrections. Additionally, MEDCOM launched a records review for individuals potentially impacted by MAMC's diagnosis and evaluation procedures for BH conditions. MEDCOM resolved the MAMC issues by the summer of 2012.

★ ★ ★ **“The Secretary of the Army ...issued a directive on May 15, 2012, to take a holistic look and identify systemic breakdowns or concerns in the Integrated Disability Evaluation System...”**

The Secretary of the Army (SA), having been advised of the allegations at MAMC, issued a directive on May 15, 2012, to take a holistic look and identify systemic breakdowns or concerns in the Integrated Disability Evaluation System (IDES) as they affect the diagnosis and evaluation of BH conditions.<sup>1</sup> The directive established the Army Task Force on Behavioral Health (ATFBH) to assist the Under Secretary of the Army and VCSA in the execution of multiple tasks, including conducting a comprehensive review and developing this corrective action plan (CAP).

This page has been left blank intentionally

### B. Mission

The ATFBH will assist the Under Secretary and the VCSA in the development and execution of the tasks assigned to them in Secretary of the Army Directive, Comprehensive Review and Corrective Action Plan, dated May 15, 2012, to review, assess and, where needed, improve behavioral health evaluations and diagnoses in the context of the Disability Evaluation System (DES)/IDES.

### C. Charter

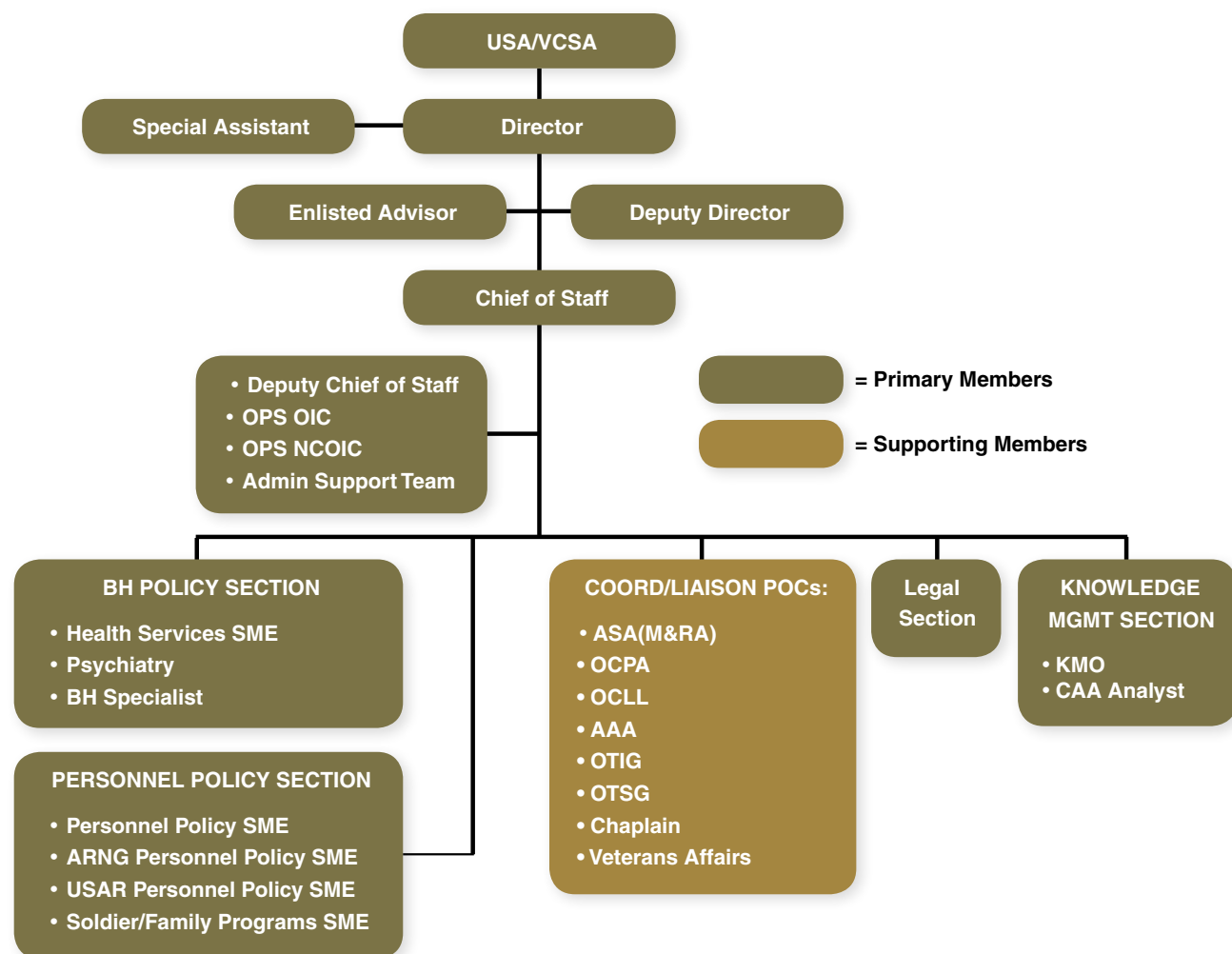
The SA approved the following objectives as part of the Task Force Charter:

1. Conduct a detailed review and evaluation of all pertinent reviews, inspections, investigations and assessments completed, as well as all ongoing reviews, investigations, inspections and assessments as they are completed, or as relevant information becomes available. Identify any remaining gaps in information or data collection as well as any additional tasks to be performed and propose how such matters should be addressed or examined.
2. Develop and present for approval a comprehensive action plan to correct any systemic breakdowns or concerns identified in the DES/IDES that affect the diagnosis and evaluation of BH conditions. Incorporate a synchronization matrix on which all recommendations for follow-on action are recorded, tracked, evaluated, acted on by appropriate authority, and, as appropriate, implemented.

1. The SA's directive also indicated that the corrective action plan (CAP) should articulate courses of action to offer redress to Soldiers with a BH condition who may have been impacted by an IDES systemic breakdown or concern. DoD recently published guidance which dictates a records review for all Soldiers who were processed through IDES with a BH diagnosis. Therefore, this CAP will not discuss the record review or the redress issues.



## TASK FORCE ORGANIZATION



### ACRONYM Key

<b>ASA(M&amp;RA):</b> Assistant Secretary of the Army (Manpower & Reserve Affairs)	<b>AAA:</b> Army Audit Agency	<b>KMO:</b> Knowledge Management Officer
<b>OCPA:</b> Office of the Chief of Public Affairs	<b>OTIG:</b> Office of the Inspector General	<b>CAA:</b> Center for Army Analysis
<b>OCLL:</b> Office of the Chief of Legislative Liaison	<b>OTSG:</b> Office of the Surgeon General	<b>SME:</b> Subject Matter Expert

Figure I-1. Task Force Organization.

### D. Organization

The ATFBH was staffed by Army personnel from a wide spectrum of backgrounds. The Task Force employed Army uniformed and civilian members with expertise in BH care, medical policy, personnel policy, Soldier/Family programs, Army National Guard (ARNG) policy, U.S. Army Reserve (USAR) policy, knowledge management, and law. Figure I-1 shows the final organization.

## II. Comprehensive Review and Development of the CAP

### A. ATFBH Scope and Methodology

Based on the SA's directive and approved charter, the ATFBH defined the scope of the review to include any issues that impact a Soldier in the IDES with a BH condition. The ATFBH utilized all resources available to identify gaps in information and problems with the IDES in order to develop the CAP. The Task Force issued a data call to all Headquarters, Department of the Army (HQDA) Agencies, Army Commands (ACOM), Army Service Component Commands (ASCC) and Direct Reporting Units (DRU) requesting all reports, reviews, inspections, investigations, and assessments pertaining to BH and the DES/IDES system completed on or after January 1, 2007. The Task Force conducted a detailed review and evaluation of over 200 documents to include medical literature, investigations, reports, policies and regulations published by the Army and DoD. The Task Force also worked closely with, incorporating the information and findings gathered by, other Army agencies tasked pursuant to the SA's directive.

Based on all of the information above, the ATFBH formulated the 24 findings and 47 recommendations contained in the CAP. The ATFBH developed a synchronization matrix and web based management system to track progress toward implementing recommendations.

### B. Organizations Contributing to the CAP

The SA directed the ATFBH and several other organizations to participate in the comprehensive review and development of the CAP. The following organizations provided key information to the ATFBH in developing the CAP:

1. Department of the Army Inspector General (DAIG) – The DAIG conducted a systematic inspection of the effectiveness of the Army BH process as it pertains to the IDES and DES, as outlined by the SA's directive. The objectives of the DAIG inspection were to:
  - a. Assess whether commanders, Soldiers and other participants in the DES/IDES, are sufficiently informed about and understand their respective roles, their rights and duties, and the sources of information and assistance available to them, in order to optimize their participation in and the overall effectiveness of the DES/IDES processes.
  - b. Review the effect of the Army's implementation of the IDES on the diagnosis and evaluation of BH conditions.
  - c. Review and evaluate the sufficiency of appeal procedures available to Soldiers participating in the DES/IDES processes.
  - d. Collect and report to the Under Secretary and the VCSA any observations that command climate or other non-medical factors affected BH diagnoses and evaluations.

The DAIG Inspection Teams gathered information from 46 sites: (1) 32 worldwide locations where MEBs occur; (2) five locations where pre-MEB activities resulted in medical curtailment of overseas tours of duty and initiation of the IDES at Continental United States (CONUS) installations; and (3) nine other associated sites. The teams conducted over 750 interviews and 80 sensing sessions<sup>2</sup> during their inspections, and conducted analysis of data accumulated from over 6,400 people to address BH IDES issues. The primary focus groups for the interviews were Soldiers, Family members, leaders, BH professionals, Physical Evaluation Board Liaison Officers (PEBLOs), MEB doctors, and Veterans Affairs (VA) personnel.

2. Sensing sessions are an informal forum from which to gather information from a group in an objective setting free from undue influence.

The DAIG found that several factors hampered the processing of Soldiers going through the DES/IDES: (1) lack of knowledge about the IDES across all echelons of the Army; (2) insufficient proponent oversight for the program; (3) varying degrees of program implementation and interpretation; (4) lack of standardized IDES training; (5) use of multiple tracking systems; and (6) lack of Medical Treatment Facility (MTF) compliance with established policies and guidance.

2. Army Audit Agency (AAA) – The AAA was tasked to complete the audit of the MEDCOM Ombudsmen<sup>3</sup> Program to verify whether: (1) ombudsmen provide Soldiers and their Families with the intended support in accordance with program guidance; and (2) the ombudsman program provides information to MEDCOM to improve business operations. The audit focused on the conduct of ombudsmen activities in the performance of their responsibilities, the effectiveness of training, and how the program collected, classified, and analyzed data.

From February 2012 through July 2012, auditors visited MTFs and interviewed Soldiers, ombudsmen, and MTF/Warrior Transition Unit (WTU) command personnel. They reviewed case issues for WTU and non-WTU Soldiers. The AAA reviewed the classification of data, the method and frequency of data reporting, and information provided to program stakeholders.

★ ★ ★ “AAA found that the type of support provided by ombudsmen was consistent with the support listed in program guidance, and typically resolved issues in a timely manner”

The AAA found that the type of support provided by ombudsmen was consistent with the support listed in program guidance, and typically resolved issues in a timely manner. Most Soldiers expressed satisfaction with ombudsmen assistance. The AAA determined that the effectiveness of the program could be improved by monitoring essential key functions. Command personnel expressed concerns regarding the role of the ombudsman office, the integration of ombudsmen into the WTU organization, program organization, and the quality of information contained in reports.

Ombudsmen implement administrative practices differently. The program does not establish a training program that addresses the full range of skills and knowledge ombudsmen require. The ombudsmen offices classify issues in a similar manner, but do not implement consistent processes for records management or reporting.

3. Army Research Institute (ARI) – The ARI was tasked to develop and administer a survey of every BH provider or evaluator, regardless of professional discipline and geographic location. The purpose of the survey was to determine whether considerations other than the appropriate diagnostic criteria influenced the diagnosis or evaluation of PTSD or other BH conditions in the Army.

The ARI conducted a voluntary, on-line survey of military and civilian BH providers and evaluators from August through October 2012. A total of 542 providers met eligibility criteria and provided data. 80 percent to 94 percent of respondents felt confident to very confident in diagnosing adjustment disorders, PTSD, substance abuse disorders, other anxiety disorders, and depression. Respondents stated the most important factors that influenced their decision to diagnose PTSD were: (1) the clinical diagnostic interview (87 percent); (2) the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV-TR, fourth edition, text revision) used by all civilian and military BH providers (66 percent); and (3) a review of the Soldier’s medical record (57 percent). Seventy-one percent of respondents indicated they felt able to

3. Ombudsmen function as independent, neutral, and impartial mediators for Soldiers and their Family Members to facilitate communication and resolve medical-related issues.

provide high quality BH services free of undue influence. Sixty-eight percent responded that inadequate time to fully assess a Soldier reduces the likelihood that they would diagnose a Soldier with PTSD.

4. Army Medical Command (MEDCOM) – MEDCOM reviewed and analyzed the diagnoses for Soldiers evaluated for BH conditions in the DES/IDES from October 7, 2001, through April 30, 2012. MEDCOM was further instructed to evaluate the need for the collection and analysis of additional data, recommend follow-on actions, and propose courses of action, if needed, to offer redress to any Soldier or group of Soldiers adversely affected by any identified breakdown or concern.

MEDCOM reviewed over 146,000 MEB records, extracted information, and performed a statistical review and analysis as the first phase to address issues involving BH diagnoses in the IDES. The ATFBH reviewed MEDCOM’s analysis as part of its comprehensive review and to aid in developing the CAP.

Key findings from the MEDCOM statistical review and analysis include:

- a. The rates of diagnostic change for PTSD in comparison with other BH diagnoses were similar, suggesting that PTSD is not handled differently than other diagnoses.
- b. Over 6,400 Soldiers had BH diagnoses adjusted during the MEB process. Approximately the same number of Soldiers had a PTSD diagnosis added as had changed during the MEB process.
- c. Two MEB locations had a slightly higher BH diagnostic variance than the Army’s aggregate variance, which ranged from 11-22 percent. TSG directed a review of the cases at those locations to ensure no Soldiers were inappropriately affected.

### III. OVERVIEW: IDES and BH in the ARMY

#### A. Evolution of DoD DES

Before 2008, the DoD used what is now called the “legacy” DES to assess fitness for duty. The legacy DES evaluated personnel with conditions that called into question their ability to continue military service. For example, in the Army, upon receiving a level 3 or 4 permanent profile, Soldiers received both a medical evaluation and a disability evaluation by the Army. Soldiers received multiple opportunities for appellate review during the process, and the Army’s Physical Disability Agency made a final fitness and rating determination resulting in medical separation, retirement, or return to duty.

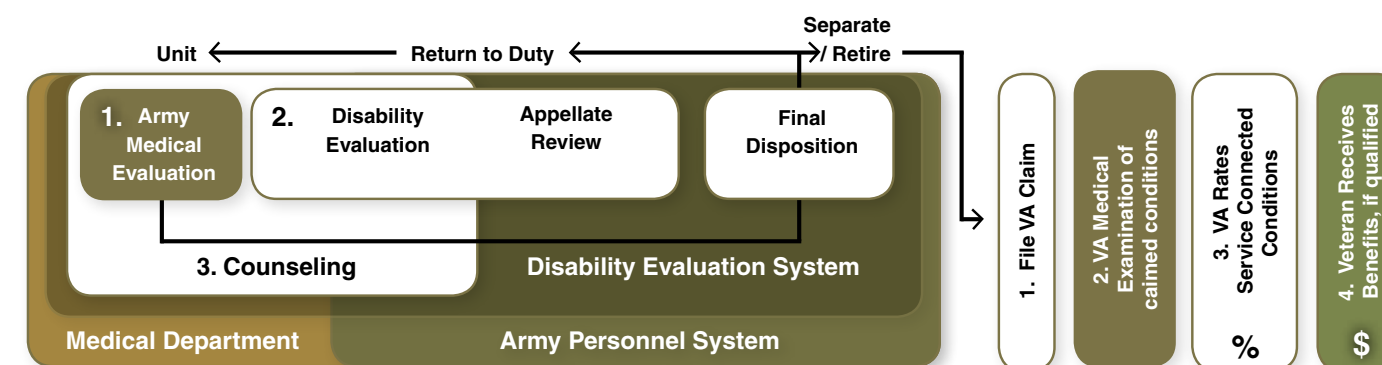


Figure III-1 depicts the legacy DES process

Following separation, the Soldier, now a Veteran, went through a separate disability evaluation process with the VA. The Veteran prepared a claim to the VA identifying conditions for evaluation as part of the VA Compensation and Pension (C&P) examination. The VA evaluated the results of the C&P Exam and provided disability ratings for all service-connected conditions. Veterans began receiving benefits six to nine months, on average, following separation or retirement.

In the spring of 2007, the Secretary of Defense directed the creation of a committee of senior military and civilian officials to oversee the development of programs and initiatives to support Soldiers who have deployed to a combat zone. As a result of the directive, the Senior Oversight Committee (SOC) for Wounded, Ill, and Injured (WII) was established with the authority to make recommendations and issue mandates in response to several reports, a Presidential Commission's recommendation and legislative actions. The SOC was designated as the main decision body for oversight, strategy, and integration of proposed actions for DoD and VA improvements. The SOC established eight different lines of action, with the first being to revamp the DES.

The SOC set out to develop and establish one solution for a DoD and VA DES using an integrated disability rating system that is seamless, transparent, and administered jointly by both Departments. The SOC determined the system must remain flexible and able to evolve as necessitated by trends in injuries, supporting medical documentation, and treatment. The intent was to streamline the process for the Soldier separating from DoD and entering the VA system of benefits and care

In November 2007, the SOC launched the DoD and VA DES Pilot Program. The pilot program merged the two disability systems into one VA/DoD process which was tested in the National Capital Region (NCR). In June 2009, the SOC began implementing the pilot program beyond the NCR. By the end of March 2010, 27 sites were using the pilot program covering 47 percent of the DES population. In July 2010, the co-chairs of the SOC agreed to expand the DES Pilot and rename it the IDES. Senior leadership of the VA, the Services, and the Joint Chiefs of Staff strongly supported this plan and the requirement to make the benefits of this improved process available to all Soldiers. On December 19, 2011 DoD issued Directive Type Memorandum (DTM) 11-015, Integrated Disability Evaluation System, formally establishing IDES and instituting broad IDES policy throughout the DoD.

★ ★ ★ **In contrast to the DES legacy process, IDES provides a single disability examination (the VA Compensation and Pension (C&P) examination) and a single-source disability rating that both the Army and the VA use in executing their respective responsibilities.**

The transition from the DES to the IDES shortened the period until the delivery of VA disability benefits after separation from an average of 166 days to approximately 30 days (the shortest period allowed by law). In contrast to the DES legacy process, IDES provides a single disability examination (the VA Compensation and Pension (C&P) examination) and a single-source disability rating that both the Army and the VA use in executing their respective responsibilities. The integrated process, by design, allows both departments to inform Soldiers about their respective processes, eliminating some of the uncertainty associated with working through two separate and vastly different disability programs. This results in more consistent evaluations, faster decisions, and timely benefits delivery for those medically retired or separated. IDES has enhanced all non-clinical care, administrative activities, case management, and counseling requirements associated with disability case processing. As a result, VA can deliver benefits in the shortest period allowed by law following discharge, thus eliminating the "pay gap" that previously

existed under the legacy process, i.e., the lag time between a soldier separating from DoD due to disability and receiving his or her first VA disability payment.

In the IDES, the VA's claim development process begins while the Soldier is still in a duty status, decreasing the lag time for him or her to receive VA benefits after a discharge. This happens because the VA's C&P examination now serves as the medical examination of record, and the military services determine whether the Soldier meets retention standards based on that exam. The inclusion of the VA in the MEB phase decreases the variance in diagnoses between the two Departments and the time it takes for a Soldier to receive his or her VA benefits.

The Army restated and disseminated the standards in DTM 11-015 by publishing HQDA Execution Order (EXORD) 080-12, "Army IDES Standardization." EXORD 080-12 instituted a uniform process of identification, referral, counseling and adjudication from point of injury, illness or disease to return to duty or transition from service. EXORD 080-12 established a standard method for determining whether wounded, ill, or injured Soldiers are fit for continued military service. Importantly, EXORD 080-12 also designated the Deputy Chief of Staff (DCS), G-1 as the Army proponent for IDES policies and procedures, and directed the DCS G-1 to develop, staff, and disseminate a consolidated regulation promulgating all updated IDES policies and procedures in a single, comprehensive source.<sup>4</sup> EXORD 080-12 expired in August 2012, but the designation of the Deputy Chief of Staff (DCS), G-1 as the Army proponent for IDES was reissued in HQDA EXORD 037-13, "Ready and Resilient Quick Wins."

The EXORDs tasked MEDCOM to assist the DCS G-1 in this process. Since that time, however, MEDCOM has purported to set Army-wide IDES policies and procedures, despite the EXORD's tasking that mission to DCS G-1. MEDCOM has done this by issuing documents purporting to be Army-wide policy in the form of OPORDs, FRAGOs, and a "guidebook."

Although MEDCOM reasonably sought to provide guidance, its publications were not formally staffed with all Army stakeholders and, as will be discussed below, this has created confusion about authoritative policies concerning IDES.

## B. Understanding the IDES

As discussed above, DoD established broad process steps for IDES in DoD DTM 11-015. The Army is currently developing a comprehensive regulation to fully implement IDES. Given that the regulation and policy development process is still ongoing, the following sections contain ATFBH's best effort to describe current Army practices, but this description may or may not reflect practices Army-wide, best practices, or the process to be implemented via forthcoming regulation.

Figure III-2 illustrates the IDES timeline: (1) treatment; (2) MEB; (3) Physical Evaluation Board (PEB); and (4) transition or re-integration.

### 1. TREATMENT

The treatment phase begins when a medical provider issues a Soldier a temporary profile for a medical condition that limits duty performance. This phase can last up to one year with providers assessing and treating Soldiers while managing temporary profiles. During this phase, providers determine if a Soldier's condition warrants referral to the IDES for consideration of a medical discharge.

Soldiers reach the Medical Retention Determination Point (MRDP) when: (1) a medical provider determines that at least one of the Soldier's conditions has stabilized and the provider can reasonably determine that the condition will

<sup>4</sup> Prior to EXORD 080-12, proponenty for the DES/IDES was split between MEDCOM and the DCS, G-1.



## INTEGRATED DISABILITY EVALUATION SYSTEM (IDES) TIMELINE

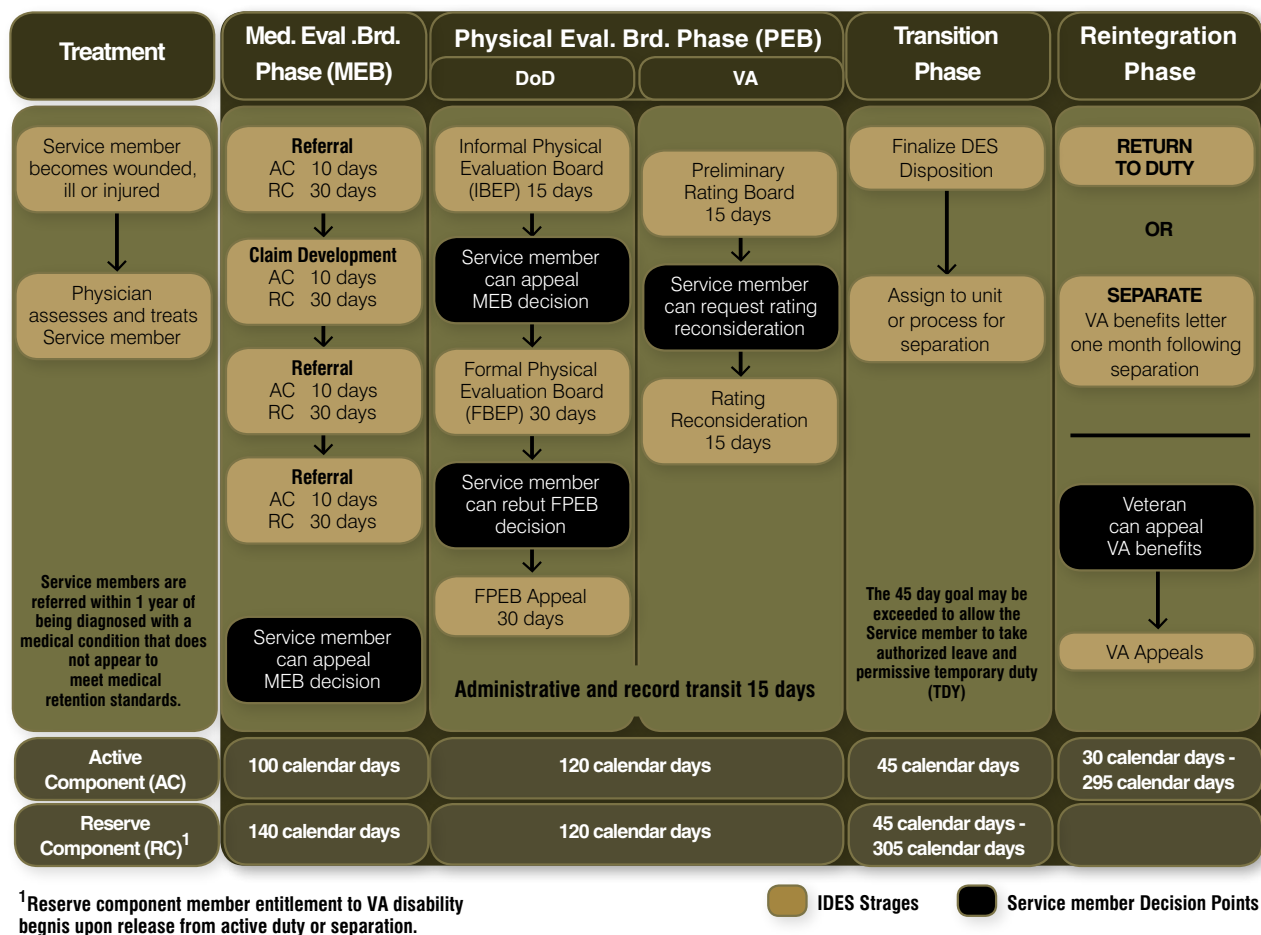


Figure III-2 IDES Timeline

prevent him/her from meeting retention standards; or (2) the Soldier is unable to return to full duty status within 12 months of the onset of the injury or illness. If either of those occurs, a provider will issue the Soldier a permanent profile.

The designated physician approving authority confirms the Soldier has reached MRDP and signs the permanent profile. This critical second signature initiates a Soldier's entry into the IDES. The physician approving authority initiates the VA/DoD Joint Disability Evaluation Board Claim Form (VA 21-0819, Section 1), refers the case to the PEBLO supervisor, and notifies the Soldier's command of the initiation of the IDES.

### 2. MEB PHASE

The purpose of this phase is to determine if a Soldier meets medical retention standards, to begin the VA claims process, and to provide the Soldier with case management and legal assistance. The MEB is informal and comprised of two or more members. At least one board member is a credentialed provider with knowledge of the directives pertaining to standards of medical fitness and disposition of patients, disability separation processing, and the Veterans Affairs Schedule for Rating Disabilities (VASRD). The Soldier is not required to appear before the MEB provider, but a MEB provider may ask the Soldier to appear in order to obtain or clarify key information.

When a Soldier is referred to the MEB, the PEBLO creates a case file in the Veterans Tracking Application (VTA)

database and electronic MEB (eMEB). The PEBLO contacts the Soldier by phone for introductions, schedules an initial meeting, and prepares orientation materials. During the initial PEBLO information meeting, the PEBLO reviews the VA/DoD Joint Disability Evaluation Board Claim form (VA Form 21-0819) and answers the Soldier's questions. Administrative actions are coordinated by the PEBLO to include: (1) routing the case file packet through the MEB; (2) coordinating additional appointments; (3) informing the Soldier on MEB findings and Soldier options for review; and (4) referring the Soldier to legal counsel.

Soldiers receive a mandatory legal briefing regarding their rights and responsibilities during the IDES from the Soldiers' MEB Counsel (SMEBC). The Soldier initials the MEB/PEB Counseling Checklist (DA Form 5893) at each step of the IDES to verify that the Soldier comprehends his or her role and responsibilities.

MEB packets are prepared by the states for ARNG Soldiers and the Regional Support Commands (RSCs) for USAR Soldiers. Completed packets are forwarded to the Reserve Components Soldier Medical Support Center (RC-SMSC) for validation. The RC-SMSC sends validated MEB packets to MEDCOM who assigns the cases to military medical treatment facilities for processing.

The Soldier's chain of command is responsible for assessing a Soldier's duty limitations from a non-medical perspective using the Commander's Performance and Functional Statement Form (DA Form 7652). This statement provides critical information to the MEB and PEB about the impact of medical impairments on a Soldier's ability to perform his or her duties. It is not intended to assess or make comment on specific medical diagnoses, but to provide detailed performance information from a non-medical perspective.

The VA Military Services Coordinator (MSC) contacts the Soldier to further explain the VA's role in the IDES disability rating process. The MSC explains the VA service connection policy, i.e., compensation will be awarded only for chronic illnesses, injuries and diseases that were incurred in, or aggravated by, service. The MSC coordinates with the Soldier regarding any conditions the Soldier wishes to claim (on Section 2 of VA Form 21-0819). If the Soldier desires to later add additional claims, the MSC will accept them, but conditions claimed after the initial interview may not be evaluated until after separation. The MSC requests the necessary VA C&P exam appointments and either the MSC or the C&P provider notifies the Soldier, PEBLO and commander of the scheduled appointments.

The VA C&P Qualified Medical Examiner(s) provides a general medical examination which addresses not only those conditions claimed by the Soldier and referred by the MEB provider, but also a comprehensive screening medical examination. Specialty examinations, in addition to the comprehensive medical examination, are performed for cases involving vision, hearing, mental health conditions, or other complex medical conditions. When conditions are identified that cannot be addressed in the course of the VA C&P exam, the exam provider indicates this in the examination report provided to the MSC.

MEB providers review all available medical records and write a NARSUM describing the Soldier's medical conditions. The NARSUM contains a list of all referred and claimed conditions and a determination regarding the impact of each medical condition (alone or in combination) on the Soldier's further performance of duty in accordance with Army Regulation (AR) 40-501, Standards of Medical Fitness. If possible, the MEB provider will review the NARSUM with the Soldier to ensure all conditions and concerns are addressed.

Following the completion of the MEB, the approval authority reviews the completed NARSUM and MEB case file to determine if a Soldier's medical conditions meet retention standards. If one or more condition(s) fail(s) to meet retention standards, the case is referred to the PEB for further adjudication. If the conditions meet retention standards, the Soldier is returned to duty (RTD).

If the Soldier is not satisfied with the findings from the MEB, there are two opportunities to review the process and decisions, each with a unique and specific purpose. First, the Soldier can request an Impartial Medical Review (IMR) to conduct a clinical review of the MEB case for completeness. An IMR is conducted by a physician not otherwise involved in the Soldier's MEB, ideally the treating provider most familiar with the Soldier's medical history. The IMR provider reviews the final MEB packet to ensure all diagnoses and notes are accurately recorded on the NARSUM and the DA Form 3947. This review is completed and returned to the PEBLO. Second, the Soldier can appeal the MEB findings by submitting a written rebuttal, frequently called an appeal, to the MEB Appellate Authority. The MEB Appellate Authority sends his or her response to the PEBLO. To maintain objectivity, the MEB Appellate Authority typically is not any of the three original signatories on the DA Form 3947, MEB Proceedings. If the Deputy Commander for Clinical Services (DCCS) serves as the MEB Appellate Authority, another senior physician within the MTF is designated as the MEB Approval Authority. This ensures the integrity of the proceedings and due process for the Soldier. The MEB Appellate Authority may uphold the findings of the MEB, amend the findings with a written addendum, or return the file to the MEB for reconsideration.

Once complete, including any IMR and/or Appeal findings, the MEB packet is forwarded to the PEB electronically via eMEB to electronic Physical Evaluation Board (ePEB).

★ ★ ★ **The PEB is the only board in the Army that can determine a Soldier's fitness for continued service.**

### 3. PEB PHASE

The PEB is the only board in the Army that can determine a Soldier's fitness for continued service. A two to three member Informal PEB (IPEB) reviews administrative, medical and personnel documentation to render a fit or unfit determination. If the IPEB determines that any condition renders the Soldier unfit for duty, the Soldier's case is referred to the VA for a disability rating. However, if the Soldier is found fit for duty, the case file is not referred to the VA for a disability rating.

Army disability benefits are determined based only on those specific conditions found unfitting for continued military service. The IPEB adjudicates the Soldier's case and forwards the preliminary fitness decision on the PEB Proceedings Form (DA Form 199) to the PEBLO, and requests a preliminary (or a proposed) rating from the Disability Rating Activity Site (DRAS). The DRAS evaluates the referred and claimed conditions and provides a proposed disability rating to the IPEB for each service-connected condition with supporting rationale.

Once the IPEB receives the proposed VA rating and completes the fitness determination, the IPEB forwards the DA 199 to the PEBLO along with the VA proposed rating decision. The Soldier is notified of the findings by the PEBLO and informed of his or her options. The PEBLO should refer the Soldier to the Soldier's IPEB Counsel (SPEBC), or other legal counsel if privately represented, for legal advice and assistance on his or her options.

The Soldier has the option to accept the IPEB findings and the VA proposed ratings, or the Soldier may choose not to accept either the PEB findings or the VA rating. If the Soldier disagrees with the fitness decision, the Soldier may non-concur with the fitness decision and/or request a Formal PEB (FPEB). If the Soldier disagrees with the proposed

VA disability rating for the conditions found unfitting by the PEB, the Soldier may submit a written request for reconsideration for each unfitting condition.

The FPEB consists of a panel of medical and non-medical adjudicators. The Soldier may elect to send a written response, appear before the board in person or by video teleconference, or have legal counsel appear on their behalf. Every Soldier has the opportunity to have legal representation from the SPEBC, at no cost to the Soldier, or may seek legal counsel at their own expense. The formal board issues its findings and informs the Soldier, the Soldier's legal counsel, and PEBLO of its determination. Once the final decision is issued by the FPEB, the case file is sent to the USAPDA for review. If the USAPDA determines that the evidence of record does not support the FPEB findings and recommendations, it has the authority to issue revised findings or return the case to the FPEB for reconsideration. When the case file is reviewed and certified, the USAPDA approves the final fitness determination.

### 4. TRANSITION PHASE

The transition phase of the IDES is a 45-day process to guide the Soldier through medical separation or retirement from the Army. The precise duration of the transition phase depends on installation-specific out-processing requirements and the number of days required for permissive temporary duty (TDY) and leave. The Soldier's chain of command and the installation transition center work in close coordination to support the Soldier and his or her Family through this phase.

The transition center assigned to each unit assigns a separation date and issues separation orders on the Certificate of Release of Discharge (DD Form 214) effective after final separation. The Transition Center provides the Soldier, PEBLO, and MSC a copy of the orders and DD Form 214. The DRAS issues a final rating decision and provides a final benefits letter to the Soldier within 30 days of release from active duty (REFRAD).

### C. BH in the Context of the IDES

Many Soldiers with BH conditions serve in the Army. Approximately five percent of Soldiers are believed to have PTSD after a combat deployment.<sup>5</sup> Providers, including physicians, psychologists, licensed clinical social workers and nurse practitioners, practicing within military treatment facilities seek to identify BH conditions and treat them as early as possible.

While the prognosis is positive for the most common BH conditions, including PTSD, some Soldiers do not recover fully and residual BH symptoms remain. In cases where residual symptoms prevent Soldiers from performing their duties, providers refer them to the IDES to determine fitness for duty and consideration of medical discharge. Army Regulation (AR) 40-501, Standards of Medical Fitness, dated Aug. 4, 2011, guides military medical providers in determining when to refer Soldiers into the IDES. While the exact criteria depend on the specific diagnosis, Soldiers are generally referred to an MEB if they require: (1) repeated hospitalization; (2) duty in a protected environment; (3) have symptoms that interfere with effective military performance; and (4) are not expected to fully recover within one year.

Providers in the military medical system care for Soldiers in a more complex context than most civilian settings. When making diagnostic decisions, military providers incorporate clinical and non-clinical information from multiple sources, including commanders, non-commissioned officers, deployment screenings, Families and personnel from various supporting services such as Military Family Life Consultants, chaplains, substance abuse counselors and Family Advocacy personnel. When determining treatment plans, military providers must consider the unique challenges presented by deployments, training exercises and permanent changes of station. Military providers must remain sensitive to frequent changes in the Soldier's life to make the best diagnosis and design the optimal treatment plan.

5. Kok B, et al. Posttraumatic Stress Disorder Associated with Combat Service in Iraq or Afghanistan, *Journal of Nervous and Mental Disease*, May 2012.

## IV. Improvements Implemented or In-Progress

The Army continuously strives to improve its programs, including BH care and the IDES. Indeed, some recent actions undertaken by the Army before the publishing of this report include the following:

### A. Actions Implemented

★ ★ ★ **The Army standardized and clarified the diagnosis and evaluation of Soldiers with PTSD**

1. The Army standardized and clarified the diagnosis and evaluation of Soldiers with PTSD, and directed the use of the DSM-IV-TR and the 2010 DoD/VA Clinical Practice Guidelines for Army medical providers with the publication of MEDCOM policy 12-35, Subject: Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder (PTSD), April 10, 2012.

2. The Army provided guidance to: (1) define processes and standards for completion of the MEB phase of the IDES; and (2) improve communication between Army and VA BH providers in April 2012.
3. MEDCOM authored *The IDES Guidebook, An Overview of the Integrated Disability Evaluation System*, in October 2012, which provides information to Soldiers, commanders, and providers on the IDES phases, the advisors available to assist Soldiers and Families throughout the process, and standards used to measure compliance.
4. MAMC encouraged the use of the Wounded Soldier & Family Hotline for the Soldiers, Veterans, and their Family members if they believed their case was unduly downgraded by FPS and wanted a re-evaluation. Referrals were accepted from hospital ombudsmen, nurse case managers, the PEB, and members of Congress.
5. MEDCOM increased support for the RC-SMSC at Pinellas Park to reduce the backlog of RC cases.
6. The Army authorized bringing Reserve Component (RC) Soldiers onto active duty for IDES processing. This practice facilitates diagnosis and evaluation by enabling post-mobilization access to care and reducing the time that an RC Soldier spends in the IDES system.
7. MEDCOM conducted a stand down day to inform and train BH providers on the most recent information regarding diagnosis and treatment of BH conditions on June 12, 2012.

### B. Actions In-Progress

1. MEDCOM offered a reevaluation to 430 Soldiers examined by MAMC and had a potential adverse change in their PTSD diagnosis. MEDCOM assembled a group of BH providers (called the "Fusion Cell") to conduct the re-evaluation effort. The Fusion Cell reviewed 381 cases, and MEDCOM tasked other Regional Medical Commands (RMCs) to review an additional 49 cases for Soldiers or Veterans who re-located. The Fusion Cell cases are as follows:

**257 Soldiers were re-evaluated:**

147 (57 percent) were diagnosed with PTSD

110 (43 percent) were not diagnosed with PTSD

**Of the remaining 124 Soldiers:**

3 are still in-progress

81 declined re-evaluation

40 are being located

**Other RMC's 49 Soldiers:**

10 were re-evaluated

3 are still in progress

2 declined re-evaluation

34 cases remain for disposition

2. The Army continues to significantly reduce the time required for a Soldier to effectively go through the IDES. In November 2012, 1,380 Soldiers entered the IDES and 2,147 Soldiers completed the IDES, a 1.5 ratio representing the Army's highest performance to date. From July through December 2012, the USAPDA increased their capacity by 2.5 times to a surge capacity of approximately 4,000 cases per month. Additionally, the Army's NARSUM productivity times improved from 60 days to an average of 30.8 days.
3. The Army is expanding the Embedded BH program which aligns BH providers with brigade level deployable units by the end of Fiscal Year 2016 (FY16).
4. The Army is working with DoD and the VA to develop iEHR, a single medical data system which will manage and integrate medical documentation with full visibility and transferability between components. The iEHR will follow Soldiers from the first day of their military career and throughout their lifetime and will be the single source for Soldiers to access their medical history. The iEHR will interface with the VA system and will be fully operational by 2017.
5. MEDCOM is in the final stages of an OSC Concept Plan to be sent to DCS G-3/5/7 for approval of a centralized, robust Office of Soldiers' Counsel (OSC).
6. MEDCOM is in final stages of an OSC Concept Plan to be sent to DCS G-3/5/7 for approval of a centralized, robust OSC.

## V. The CAP

The following findings and recommendations center on improving IDES training, standardization, communication and other issues to take care of Soldiers and their Families. These are not limited to the Army, because the IDES is a DoD/VA process. The findings and recommendations are divided into five focus areas:

1. The IDES oversight, training, and tracking
2. BH issues within the IDES
3. RC issues and improvements
4. Personnel policies that impact the IDES
5. Enhancing Support for Soldiers and their Families

The CAP is outlined by a finding that states the problem, provides recommendations, discussion, action level and key actions. Key actions are linked to specific findings using the Army's Doctrine, Organization, Training, Materiel, Leadership,

Personnel and Facilities (DOTMLPF) model for problem analysis with a designated lead agency and completion date. The recommendations describe whether they require action at the strategic, operational, or tactical level. The ATFBH defined these levels as:

1. Strategic – Action is required at the HQDA level.
2. Operational – Action is at the HQDA, ACOM, or ASCC level.
3. Tactical – Action is below the HQDA, ACOM, or ASCC level.

### A. Focus Area # 1 – The IDES Oversight, Training, and Tracking

**Summary:** The IDES requires centralized control to guarantee there is proper oversight, standardized training, and to better effect the development of an information technology (IT) solution that will reach across the Army and VA to manage Soldiers and track their status in the IDES.

**Finding 1.1** – The Deputy Chief of Staff (DCS) G-1 is the proponent for IDES and responsible for the regulatory guidance governing the entire IDES. However, MEDCOM is responsible for the execution of the MEB phase of IDES but is not the proponent. For the IDES process to be successful, it is necessary that both the DCS G-1 and OTSG be involved, but this creates challenges in harmonizing, synchronizing, vetting and resolving IDES process issues.

**Recommendation:** The Secretary of the Army should designate the DCS G-1 as the Army’s lead agent for IDES.

**Discussion:** The G-1 is the proponent of the entire IDES process, but does not have authority over OTSG/MEDCOM, which, although lacking policy proponentcy, executes the MEB phase of the IDES. This, combined with the inherent complexity of the IDES makes consistent oversight and communication of policy, procedure and personnel both incremental and challenging. However, there exist several G-1/MEDCOM/TSG forums to address issues, monitor progress and make appropriate changes in a coordinated fashion.

Designating the G-1 as the “lead agency” is critical to overcoming harmonization, synchronization, vetting and resolution challenges. G-1 and MEDCOM have implemented important initiatives within their organizations but in the past have lacked unity of effort. The HQDA EXORD 080-12 (expired August 2012) established the G-1 as the “overall Army staff responsible for the Army’s disability evaluation system.” The PDA is already organized under the G-1 and responsible for the PEB. The designation of the Deputy Chief of Staff (DCS), G-1 as the Army proponent for IDES was reissued in HQDA EXORD 037-13, “Ready and Resilient Quick Wins.” Merely appointing the G-1 as the proponent, however, is insufficient to resolving this finding because, mere policy proponentcy does not, in itself, ensure unity of effort and accountability for the long-term. Such unity of effort is critical, given the requirement for MEDCOM, as executor of the MEB process, to ensure that policies, procedures, and actions affecting the MEB process are nested with the policies, procedures, and actions of the G-1. And, this unity of effort can be created by designating the G-1 as the “lead agent” for IDES. Without a singular lead agent, multiple commands and staff elements will continue to distribute policies, procedures, and orders regarding the implementation of the IDES that are potentially unclear and contradictory.

**Level:** Operational

#### Key Actions:

- (D) Expedite the revision of AR 635-40 into a single, comprehensive regulation for the IDES.
- (D) Develop performance metrics that measure both the speed in which Soldiers are processed through the IDES, but also the quality of support and care provided to Soldiers and their Families.
- (D) Draft and issue a DA Pamphlet for the IDES to enforce, inform, educate and enable enforcement.
- (O) Establish an “IDES fusion cell” with representatives from ASA(M&RA), DCS G-1, OTSG, MEDCOM and ACSIM to ensure communication, synchronization and integration across organizations involved with IDES. Examine existing organizational structure to determine if the fusion cell can be a matrix organization.
- (P) Conduct analysis to determine if G-1 requires more manpower to adequately perform the functions of the IDES proponent. The goal is to reprioritize existing work vice gaining resources.

**Lead Agency:** DCS G-1

**Support Agency:** ASA(M&RA), OTSG, MEDCOM, ACSIM, Office of General Counsel (OGC), OTJAG

**Proposed Completion Date:** 2nd Qtr, FY13

**Finding 1.2** – To reduce systemic variance across the Army, both IDES policy dissemination and training must be standardized and coordinated.

**Recommendation:** The G-1, as the lead agent of the IDES process, must ensure that IDES training materials and training are standardized, integrated and synchronized.

#### Discussion:

★★★ **There is no single organization or authoritative document ensuring standardization of IDES training and information across the Army.**

There is no single organization or authoritative document ensuring standardization of IDES training and information across the Army. Training and Doctrine Command develops, educates and trains Soldiers, civilians,

and leaders; supports unit training; and designs, builds and integrates a versatile mix of capabilities, formations, and equipment to strengthen the U.S. Army as America’s Force of Decisive Action. In this capacity, TRADOC is best suited to support the development of IDES training materials to ensure they are standardized, integrated and synchronized.

DCS G-1 as the proponent, MEDCOM as the MEB executor, and ACSIM as a key stakeholder, should provide input into all training materials. ASA(M&RA) oversight will ensure unity of message for IDES training and information. DCS, G-1, with support from TRADOC should lead a coordinated effort with ASA(M&RA), G-1, G-3/5/7, MEDCOM, ACSIM and Office of the Judge Advocate General (OTJAG) to ensure all the stakeholders have input into the training materials.<sup>6</sup>

During the 2012 DAIG BH IDES inspection, the IG found that IDES training material varies from installation to installation and between various IDES actors on a single installation and that, in training courses that lacked programs of instruction (POI), much of the training centered on instructor’s opinions and experiences. Every site evaluated had

6. This finding and recommendation highlights the need for centralized oversight of all IDES training. Other areas of the report will address the specific training issues pertaining to: BH providers, Commanders, Soldiers and their Families, and the Army advisors to include PEBLOs, Ombudsmen, counselors and attorneys.

reports of varying degrees of accuracy in their training packages. Many of the observed IDES trainers provided outdated and conflicting information.

The DAIG also found during its 2012 DAIG inspection that IDES training for local Company Commander / First Sergeant Courses (CCFSC) varied across installations. The POI for the course does not include training on the DA7652, Commander's Performance and Functional Statement. The DA7652 is a significant source document to assist MEB providers with the development of the NARSUM. Company Commanders are charged with completing DA7652 for their Soldiers in the MEB process. Poorly written DA7652s are of little use to MEB providers in preparing the NARSUM.

★★★ **Standardizing training for Army leaders, Soldiers, and their Families will increase understanding of the IDES and lead to improvements in responsiveness and overall satisfaction with the process.**

Finally, the 2012 DAIG BH IDES inspection found that more work must be done to standardize training for units, and to educate and include Family members in the process. IDES training must also

be incorporated into the Pre-Command Course for Battalion and Brigade Command Teams. Standardizing training for Army leaders, Soldiers, and their Families will increase understanding of the IDES and lead to improvements in responsiveness and overall satisfaction with the process.

**Level:** Operational

**Key Actions:**

- (T) Develop a standardized IDES training support packet and a training program to ensure instructors are presenting the most current, accurate information on the IDES. Monitor, evaluate, assess and determine the effectiveness and efficiency of the training packages.
- (M) Ensure the materials (brochures, pamphlets, etc.) are accurate and reflect the latest IDES information.
- (L) Ensure the information is being presented to Soldiers, leaders, and Family members so that they understand what they can expect from the process.

**Lead Agency:** DCS, G-1

**Support Agency:** TRADOC, G-3/5/7, ASA(M&RA), MEDCOM, ACSIM, OTJAG

**Proposed Completion Date:** 2nd Qtr, FY13

**Finding 1.3** – The management and tracking of Soldiers in the IDES is hindered due to information gaps between multiple, uncoordinated IT systems.

**Recommendation:** Develop an IT solution across the Army and VA to manage Soldiers and track their status in the IDES.

**Discussion:**

The DoD has multiple IDES data tracking systems, none of which interface directly with Veteran Tracking Application (VTA), the VA's system for tracking IDES cases. The eMEB and the ePEB are DoD data systems which track a Soldier in the respective IDES phase. The lack of interface between these systems inhibits the ability of all stakeholders in the IDES to provide accurate, consistent data and metrics.

Additionally, Soldiers and medical providers do not have access to most automated systems and rely on PEBLOs to obtain Soldiers' status in the IDES. This results in an increased workload for PEBLOs, who must continually update these tracking systems. As a result, automated systems are often outdated, resulting in inaccurate or missing data. In the end, there is no common operating picture of a Soldier's status in the IDES.

In 2009, a Congressionally-mandated effort was launched as part of the Presidential Virtual Lifetime Electronic Record initiative to create and field a joint DoD and VA health records system that would remedy the lack of a single tracking system. The Director of the Interagency Program Office is responsible for implementing the iEHR. The iEHR is a DoD / VA effort which will be a completely new system as opposed to a fusion of current systems. The iEHR will be the single source for Soldiers, Veterans and beneficiaries to access their medical history. Currently there is initial operating system testing at multiple sites, and the agencies must demonstrate significant single-site operations by 2014. Entire system fielding is set for 2017. The recommended lead for this action is for the Army's interface with the Director of the Interagency Program Office to ensure the Army's voice is heard in the development of the iEHR.

**Level:** Strategic

**Key Actions:**

- (D) Establish policy to conform to a unified IDES case tracking system.
- (T) Train DoD/VA/Army personnel to use the iEHR.
- (M) Continue to support the development and fielding of the iEHR.
- (L) Utilize iEHR to produce standardized tracking system reports, appropriately review and correct problems identified by the system.

**Lead Agency:** DCS, G-1

**Support Agency:** MEDCOM, ASA(M&RA), Chief Information Officer (CIO) / G-6, G-1

**Proposed Completion Date:** 3rd Qtr, FY17

**B. Focus Area # 2 – BH Issues within the IDES**

**Summary:** Effective implementation of Army BH requires leadership at all levels. Existing installation and MTF BH leadership is not sufficiently positioned or task organized to effectively manage the systematic challenges of a comprehensive Behavioral Health System of Care. A robust BH network requires pre-positioned BH experts at the command level to provide command consultation, guidance, and recommendations for leadership to effectively augment the health of the force requirements across the Army enterprise. Positioning and training the right BH professionals, standardizing clinical

and non-clinical processes, and ensuring unrelenting command support for adherence and compliance to BH policy are essential requirements to effectively care for the well-being of Soldiers and Families across the BH continuum of care.

**Finding 2.1** – The multiple agencies that provide BH services at Army installations need to be coordinated and synchronized.

**Recommendation:** Establish a Behavioral Health Clinical Coordinator on each installation to advise the senior mission commander on the key BH-related program level issues facing Soldiers and Families as they navigate through the IDES.

**Discussion:**

Army installations currently do not have a dedicated BH leader to provide the Senior Mission Commander essential command consultation support. The complexity of multi-level BH activities which exist on Army installations requires one BH leader with the ability to represent all BH issues to the senior commander. Issues of suicide, alcohol and drug abuse, and child and spouse abuse represent just a few of many BH issues which extend across unit structures. In addition, Soldiers and Families going through the IDES often require support from personnel assigned to multiple agencies simultaneously. Each installation's senior commander has ultimate responsibility to ensure that gaps in Soldier services are identified and corrected, but there is currently no dedicated BH subject matter expert with universal visibility of BH-related programs at the installation level to make cohesive recommendations for improvement. This recommended action supports MEDCOM's October 17, 2012, memorandum for the Office of the Assistant Secretary of Defense of Health Affairs to assign Directors of Psychological Health across the Army to provide psychological health consultation and population health monitoring in accordance with Department of Defense Instruction (DoDI) 6490.09.

**Level:** Operational

**Key Actions:**

- (D) Issue HQDA policy establishing the roles and responsibilities of the Behavioral Health Clinical Consultant on each installation to advise the senior mission commander on the key BH-related program level issues facing Soldiers and Families as Soldiers navigate through the IDES.
- (T) Train senior commanders on the roles and responsibilities of the Behavioral Health Clinical Consultant at the Senior Commander Course.
- (T) Educate directors of behavioral health on their roles and responsibilities IAW DoDI 6490.09 and MEDCOM policy.

**Lead Agency:** ASA(M&RA)

**Support Agency:** OTSG, Assistant Chief of Staff for Installation Management (ACSIM), ASCCs, TRADOC, U.S. Army Forces Command (FORSCOM)

**Proposed Completion Date:** 4th Qtr, FY13

★ ★ ★ **Establish a position of Chief of Behavioral Health at MTFs to fully integrate psychiatry, psychology and social work services into a multidisciplinary Department of Behavioral Health.**

**Finding 2.2** – Within MTF's, all BH capability needs to be coordinated and synchronized to optimize access and treatment.

**Recommendations:**

1. Establish a position of Chief of Behavioral Health at MTFs to fully integrate psychiatry, psychology and social work services into a multidisciplinary Department of Behavioral Health.
2. Establish a position of Deputy Chief of Behavioral Health for Administration, to be filled by a Medical Service Corps officer or military / civilian equivalent with experience in Health Care Administration.
3. Require all BH Chiefs and Deputies for Administration to attend the Additional Skill Identifier (ASI) producing course on the administrative aspects of leading a large and complex BH organization.

**Discussion:**

Over the past several years, the BH clinical mission has increased in size and complexity to meet the demand for increased workload. The Army Medical Department has addressed this challenge through creation of the Behavioral Health System of Care and Service Line which requires an Integrated Behavioral Health Department as a key action. However, MTFs have not sufficiently restructured, and training for BH leaders has not kept pace with the increased demand of BH services. Unified leadership of a multidisciplinary Department of Behavioral Health is essential to ensure common vision and execution of key programs. Effective implementation of the clinical and administrative systems required to diagnose, treat and support Soldiers throughout the IDES depends on how effectively the Chief of Behavioral Health and his or her key staff and subordinate leaders manage personnel, master data systems and coordinate with local, regional and Army-level agencies. The 2012 DAIG BH IDES inspection identified persistent problems with policy compliance, communication and enforcement of key IDES-related policies at the MTF level and below. These issues can be partially attributed to the personnel structure and organization of the Departments of Behavioral Health within each MTF.

Deputy Chiefs of BH can most efficiently communicate with various levels of the chain of command to receive and provide guidance to reduce variance within key programs on his/her installation. BH programs at many MTFs remain compartmentalized into distinct psychiatry, psychology and social work departments. This stove-piping inhibits the interdisciplinary communication and coordination required to efficiently diagnose, educate and treat Soldiers as they navigate the IDES. The Chief of Behavioral Health will provide regional and MEDCOM leaders with a critical single point of contact for all BH-related issues within the MTF.

A course that prepares BH professionals to serve as Behavioral Health Chiefs within large, complex systems of BH care would enhance the uniform execution of administrative and clinical BH processes. Better training for BH leaders in organizational leadership prior to assumption of the Chief role would more clearly define and standardize roles and expectations of BH leaders. The Army Medical Department does not currently have a program of instruction for BH officers or BH providers for leader preparation within the MTF Department of BH. The retirement and ETS of many senior BH officers has required more junior leaders to serve as Chiefs of BH departments. These emerging leaders would benefit from a BH leadership course similar to the one that currently exists for the preparation of Division Surgeons.



While training for clinical leaders is extremely important, ongoing administrative support and expertise is also essential to ensuring the efficient function of Departments of Behavioral Health within MTFs. Medical Service Corps officers with backgrounds in non-clinical administration and management have significant expertise in delivering healthcare in military settings. In larger BH departments (more than 25 personnel) these MSC officers would offer critical support to the BH Chief and Clinical Deputy Chiefs. This officer would directly support the BH Chief in key areas such as, personnel and resource management, policy implementation and operations. An analogous relationship between a clinically trained leader and an administratively trained deputy effectively exists within the Division Surgeon section on MTO&E division staffs, and at higher echelons in the MTF. This would better position BH Departments to track and implement policy, efficiently manage measures of effectiveness, and run clinical programs.

Fielding the development of an ASI producing course for Behavioral Health leadership will likely require two years to develop. Course planning, coordination and approval should occur throughout FY13. The course launch and execution should be scheduled for FY14.

**Level:** Operational

**Key Actions:**

- (D)** Issue policy requiring the BH leadership and administration ASI prior to assuming BH Chief or Deputy Chief of BH positions.
- (O)** Establish a multidisciplinary Department of Behavioral Health with Chief and Deputy Chief positions on MTF Tables of Distribution and Allowances (TDAs). Code these positions to require the ASI.
- (T)** Establish a training program for a BH leadership and administration ASI.
- (L)** Consultants to TSG for psychology, psychiatry, social work and psychiatric nurse collaborate to ensure well-qualified BH personnel are available to fill chief positions at large Army community hospitals and medical centers.
- (P)** Ensure adequate supply of Medical Service Corps officers to fill the administrative BH Deputy Chief positions. Review RMC staff sections to ensure that all aspects of BH operations are fully supported.

**Lead Agency:** OTSG

**Support Agency:** DCS G-1, DCS G-3/5/7

**Proposed Completion Date:** 4th Qtr, FY14

**Finding 2.3** – Several MTFs, especially those in remote locations, cannot fill vacant BH provider positions, which decreases access to and continuity of BH care.

**Recommendations:**

1. Review the effectiveness of Expedited Hiring Authority (EHA) for Licensed Clinical Social Workers and psychologists.
2. MEDCOM request Direct Hiring Authority (DHA) for all BH professionals, if EHA does not efficiently support the hiring of BH providers.
3. Modify how DoD implements the Memorandum of Agreement (MOA) between Department of Defense–United States Public Health Service (DoD-USPHS) to assign USPHS officers to the Army MTFs with the greatest need for BH professionals.
4. Fully implement tele-behavioral health capabilities to support MTFs that cannot meet BH access to care standards.

**Discussion:**

In recognition of Soldiers' increased need for BH services, the Army has increased its military and civilian BH workforce by more than 100 percent in the past five years, despite a national shortage of BH providers. However, even with this increase, some MTFs still cannot meet the need for BH services. A strategy for hiring psychiatrists and psychiatric nurses has been through the use of DHA, which allows BH leaders at the MTF level to rapidly select and hire the most qualified candidate for a vacant position. DHA serves as a critical tool to get providers on board before other healthcare agencies can recruit and hire them. In FY12, DoD replaced DHA with EHA. EHA requires MTFs to use a process lengthier than

★★★ **Several MTFs, especially those in remote locations, cannot fill vacant BH provider positions, which decreases access to and continuity of BH care.**

DHA to hire their candidate of choice. EHA has not been fully implemented and should be monitored closely by Human Resources leaders at the MEDCOM, DA and DoD levels to ensure that it supports hiring officials at the MTF level. A direct measure of its effectiveness may include the number of days between a new vacancy and the time that a new provider is hired.

A current initiative to improve BH staffing includes an agreement between the DoD and the USPHS. The DoD-USPHS MOA provides uniformed USPHS officers with BH expertise to supplement MTFs across the country. The process would improve if the positions for USPHS officers were allocated to the MTFs with the highest need. Consultants from the BH disciplines and DoD-USPHS MOA managers can allocate new slots for BH officers to remote MTFs with local challenges to hiring and retention of civilian BH providers. This action would preferentially assign USPHS officers to MTFs with the greatest need for providers.

An expansion of the tele-health programs would augment the receipt of care for beneficiaries in remote locations and/or understaffed MTFs. Tele-health addresses the shortage of provider staff at select MTFs because tele-health providers can treat patients in distant geographic locations. Thus, this enables MEDCOM to hire clinicians in geographic areas where there are local surpluses and make those individuals available to provide services to rural and other locations with recruitment challenges. When MEDCOM executes the enhanced licensure portability provisions in the Fiscal Year 2012 National Defense Authorization Act (NDAA), tele-health will enable clinicians to provide care across state lines.

**Level:** Strategic, Operational

**Key Actions:**

- (D)** Modify application of DoD-USPHS MOA to favor understaffed MTFs.
- (O)** Fully implement tele-health capabilities at understaffed MTFs.
- (L)** Review effectiveness of EHA.

**Lead Agency:** OTSG

**Support Agency:** ASA(M&RA)

**Proposed Completion Date:** 3rd Qtr, FY13

**Finding 2.4** – Army BH providers’ clinical documentation inconsistently describes symptoms and does not adequately substantiate key diagnoses. Referring Soldiers into the IDES with inadequate documentation increases the opportunity for conflicting diagnostic conclusions between providers and confusion for the Soldiers.

**Recommendations:**

1. Revise the options available to military clinicians in the military’s electronic medical record to reflect the current edition of the Diagnostic and Statistical Manual (DSM).
2. Fully field the Behavioral Health Data Portal (BHDP) to better assess, monitor, document and communicate Soldiers’ BH conditions.

**Discussion:**

Armed Forces Health Longitudinal Technology Application (AHLTA) is the single source for all medical documentation for military BH providers. AHLTA contains a menu of preloaded symptoms from which providers can select. The menu of symptoms is not consistent with DSM-IV-TR, the sole-source document that sets the diagnostic criteria for BH providers worldwide. Because of this inconsistency, many military BH providers do not use the preloaded symptoms but rather enter the symptoms using free text. Free text fields allow for variance and can result in diagnostic conclusions not supported with sufficient symptom documentation. Rewriting the preloaded symptoms options to include all symptoms essential to support a diagnosis in the DSM would significantly enhance the quality and consistency of clinical documentation. This change would have several benefits pertinent to the IDES, including: (1) clinicians can more easily support their diagnostic conclusions with symptoms found in the DSM; and (2) MEB evaluators and VA C&P examiners can more readily understand the diagnostic conclusions of BH providers.

The BHDP is an Army developed/owned web-based application in Medical Operations Data System. The BHDP will be used as a provider tool to assist in collecting standardized patient self-report BH data for assessments and tracking clinical outcomes. The BHDP also links to other medical and non-medical data systems to provide a single viewing portal for data relevant to BH care. For example, BHDP can display a Soldier’s eProfile, deployment history, WTU, and MEB status on this unified dashboard. BHDP will also connect to deployment health assessments in the near future along other U.S. Army Installation Management Command (IMCOM)-owned data systems as data use agreements are executed.

MEDCOM Operations Order (OPORD) 12-47, as published on August 30, 2012, mandated the use of BHDP for all routine individual BH care in Army BH clinics. Equipment procurement and training are ongoing at MTFs. Over FY13, BHDP will be expanded to support multiple interventions for different patient populations and clinical actions, to include standardizing Soldier data collection for administrative separation and school evaluations. Incorporating the current edition of the Diagnostic and Statistical Manual (DSM) will require synchronization with APA’s upcoming release of the DSM-5 as projected for MAY 13. BHDP allows for improved documentation by creating a specific view of data collected at the beginning of a structured BH intake template. This data filled template can be copied, pasted, and edited in AHLTA. This process will markedly decrease BH documentation time, currently taking at least 20-30 minutes to document each initial BH assessment. A critical objective of BHDP is to support improved communication between commanders and providers by technically supporting the collaboration process enabled by the Embedded BH model of care. BHDP’s multiple tools and applications directly support BH and medical provider and commander visibility on Soldiers in the IDES.

**Level:** Strategic, Tactical

**Key Actions:**

- (T) Complete BHDP training through MEDCOM mobile training teams.
- (M) Modify the menu selections within the current version of the electronic medical record. Procure and complete fielding for BHDP equipment.

**Lead Agency:** MEDCOM

**Support Agency:** DCS G-1, ASA(M&RA), G-6

**Proposed Completion Date:**

1. 4th Qtr, FY13 to modify electronic medical record.
2. 1st Qtr, FY15 to complete BHDP training.

**Finding 2.5** – Commander’s statements on the Physical Disability Evaluation System (PDES) Commander’s Performance and Functional Statement, DA Form 7652, are insufficient and the form is not user friendly. This information is especially important for diagnosing and evaluating Soldiers with BH conditions. Commanders do not understand the utility of the form, and the commander’s input is not overseen by a more seasoned commander.

★★★ **Commander’s statements on the Physical Disability Evaluation System (PDES) Commander’s Performance and Functional Statement, DA Form 7652, are insufficient and the form is not user friendly.**

**Recommendations:**

1. Create standardized training requirements regarding the completion of DA Form 7652 during installation CCFSCs.
2. Update DA Form 7652 to include the requirement for a second signature from the next higher commander for senior review.
3. Establish policy and guidance for a minimum number of days a commander must have direct performance-based observations of the Soldier to complete the form and or alternate means to provide a fair statement of the Soldier’s performance.

**Discussion:**

The Physical Disability Evaluation System (PDES) Commander’s Performance and Functional Statement, DA Form 7652, is a requirement of the IDES Case File, for all cases of Soldiers referred to the PEB under the duty-related process. DA Form 7652 is the commander’s opportunity to provide command and personnel information on a Soldier’s capabilities and limitations for consideration by the PEB. The 2012 DAIG inspection found commanders are required



to complete a form for which they have received no training or instruction regarding how the form supports the IDES or how they can best complete the form to serve the needs of their Soldiers and the MEB/PEB. This lack of education or understanding about the importance of the form and the need for commanders to thoroughly complete it has led to significant variability regarding the relative weight given DA Form 7652.

The DAIG assessment is that one in five commanders' first exposure to DA Form 7652 will occur after a formal request to complete the form. Based upon the DAIG survey data, a substantial portion of Army leaders indicated a poor understanding of the form and its importance in the IDES. Specifically, few leaders surveyed by the DAIG (148 of 1,471 or ten percent) indicated they "Somewhat Disagreed" to "Strongly Disagreed" with the statement they were familiar with DA Form 7652 and its impact on a Soldier in the IDES. Moreover, few leaders surveyed by the DAIG (247 of 1,471 or 19 percent) indicated they either "Did Not Know" about DA Form 7652, or DA Form 7652 was not applicable to them in their leadership role. Combined, these results suggest more than one in four leaders surveyed indicated that they were generally unfamiliar with the role and importance of DA Form 7652.

Their poor understanding of the role and requirements of DA Form 7652 is in part due to inconsistent education and training regarding the IDES in general and DA Form 7652 in particular. A majority of leaders surveyed (823 of 1,469 or 56 percent) rated their familiarity with the IDES as being "aware of the process but not familiar with the details," or worse. A few of the leaders surveyed by the DAIG (294 of 1,469 or 20 percent) indicated that they were not familiar with the IDES system at all. Moreover, some leaders surveyed (396 of 1,403 or 28 percent) indicated that they had "never received any information or awareness" of the IDES.

The DAIG found that IDES personnel expressed concerns with the commander's statement when there is a Soldier who has not been assigned to a commander for a sufficient period of time for the commander to make an accurate assessment. A Soldier's current unit commander is responsible for completing DA Form 7652, in accordance with HQDA Letter 635-08-1, DA Form 7652, PDES Commander's Performance and Functional Statement. However, if a Soldier reaches the MRDP shortly after a change in leadership in his or her unit, after a recent transfer to a new unit, or following a recent Permanent Change of Station, the new commander may not have had sufficient opportunity to observe the Soldier's duty performance to the degree necessary to complete the form. Similarly, Soldiers who reach MRDP while at the Community Based Warrior Transition Unit (CBWTU), the CBWTU commander may not have any direct performance-based observations of the Soldier to complete the form thoroughly. Therefore, the Army must establish policy and guidance for a minimum number of days a commander must have direct performance-based observations of the Soldier to complete the form and or alternate means to provide a fair statement of Soldier's performance.

**Level:** Operational

**Key Actions:**

- (D) Update and revise AR 635-40, Physical Evaluation for Retention, Retirement, or Separation to include guidance on use of DA Form 7652 with provisions to address: (1) the requirement for a second signature from the next higher commander; (2) the minimum number of days a commander must have to direct performance-based observations of the Soldier; and (3) training requirements for the use and completion of DA Form 7652.
- (T) Develop, implement, monitor and assess standardized training requirements regarding the completion of DA Form 7652 in CCFSCs.

**Lead Agency:** DCS G-1

**Support Agency:** OTSG, DCS G-3/5/7

**Proposed Completion Date:** 4th Qtr, FY13

**Finding 2.6** – It is critical as DoD and Army policies are updated and changed, implementation procedures are in place to ensure compliance.

**Recommendation:** Ensure compliance and reinforce implementation of DTM 11-015 and HQDA EXORD 080-12.

**Discussion:**

DoD DTM 11-015 prescribes a single medical examination to be conducted by the VA (the VA Compensation and Pension (C&P) Examination), as the basis for all IDES processing.

During the 2012 DAIG inspection, teams observed the process for disseminating authoritative guidance from MEDCOM through RMCs to MTF leadership. This process was ineffective as many providers and other personnel involved in the MEB/IDES process were unaware of policies and procedures set forth in DTM 11-015. On 16 July 2012, MEDCOM attempted to reiterate DoD policy regarding the single VA C&P examination by publishing Annex O to MEDCOM Operations Order (OPORD) 12-31 (Implementation of the IDES). Unfortunately, Annex O is ambiguous and could be read as permitting additional diagnostic efforts by Army doctors even after the Soldier's completion of the VA C&P examination. Moreover, inspection teams made observations that Annex O was not received in a timely manner. There were instances where it appeared the inspection teams were the first to provide the MTF with a copy of Annex O.

Providers and others involved in the MEB/IDES process expressed a significant concern that they were losing their roles as clinicians and simply becoming administrators. Additionally, some providers expressed their belief they were being marginalized by the new process. This was compounded by the MEB physicians' belief that the VA C&P BH examinations were, at times, of substandard quality. MTF providers indicated that they would continue to conduct follow up examinations on Soldiers who have completed the VA C&P examination to validate BH diagnoses, which is contrary to IDES guidance.

MEDCOM is planning an Army-wide video teleconference with RMCs/MTFs to discuss all of the recently published initiatives. Local IDES leadership is continuing to engage MEB Providers and PEBLOs to ensure compliance and provide clarity when needed, and the MEDCOM IG inspections are currently ongoing and are specifically looking at compliance measures. The DCS G-1's publication of comprehensive IDES guidance, as required by EXORDs 080-12, will help clarify and reinforce this process.

**Level:** Operational, Tactical

**Key Action:**

- (L) OTSG to continue development of an IDES Compliance Team to visit RMCs/MTFs.

**Lead Agency:** OTSG

**Support Agency:** None

**Proposed Completion Date:** 2nd Qtr, FY13

**Finding 2.7** – Some BH providers expressed concern regarding the perception of potential conflicts between MEDCOM guidance and the professional diagnostic standards contained in the DSM-IV-TR.

**Recommendation:** Clarify, and if necessary modify, OTSG/MEDCOM Policy Memorandum 12-035 to decrease the perceived conflicts with DSM-IV-TR.

**Discussion:**

Some BH providers have interpreted Policy Memorandum 12-035 to direct them to practice in a manner that is inconsistent with their training and their perception of the national standards of care. Close inspection of Policy 12-035 shows that the critical paragraphs addressing the diagnostic issues surrounding PTSD do not direct providers to change their current practice. Instead, the policy extends MEDCOM's support for providers if they make a PTSD diagnosis without

the presence of criteria A2 (The person's response involved intense fear, helplessness, or horror) in the DSM-IV-TR, a source of controversy within the behavioral health community across the country.

OTSG/MEDCOM Policy Memorandum 12-035 effectively identifies the latest relevant guidance on the assessment and treatment of PTSD and represents the best available interim guidance on the diagnostic challenges regarding PTSD until DSM-V is published in 2013. To communicate several aspects of the policy, MEDCOM conducted a BH Stand Down day in June 2012. Further discussion between key MEDCOM staff and MTF Chiefs of the Departments of BH would better address local concerns by informing key BH leaders of the intent and responding to direct questions.

MEDCOM can also collaborate with the relevant professional organizations to establish mutually agreed upon standards of diagnostic practice until DSM V is published. This would further support a culture of trust between Army BH providers, MEDCOM, and the professional organizations that govern national diagnostic practices.

**Level:** Operational

**Key Actions:**

- (T)** Collaborate with national professional organizations to establish interim guidance for providers in the military setting with regard to criterion A2.
- (L)** Conduct focused discussions with MTF Chiefs of BH to address concerns at the local level. Clarify the intent of the policy and specifically explain that policy 12-35 does not obligate Army BH providers to modify their existing diagnostic practices.

**Lead Agency:** OTSG

**Support Agency:** None

**Proposed Completion Date:** 4th Qtr, FY13

**Finding 2.8** – The treating provider should not be used to conduct an Impartial Medical Review (IMR).

**Recommendation:** Ensure the treating provider conducting the Impartial Medical Review is not directly involved during the MEB Process or Soldier's care.

**Discussion:**

An IMR serves a similar purpose as compared to the Independent Medical Review commonly used in civilian worker's compensation and disability claims. DoD's practice of using the treating provider who is most familiar with the Soldier's medical history to conduct an IMR is a fundamentally flawed concept. Typically this provider is the Soldier's primary care provider and is now projected into an often contentious relationship with his or her patient. In civilian disability evaluations, treating physicians do not conduct impartial or independent reviews as treating providers when a provider/patient relationship has been developed.

Leadership at Walter Reed National Military Medical Center (WRNMMC) understood the conflict of interest that this mission caused and identified a group of physicians representing the major services to conduct reviews of cases. For instance, in Warrior Transition Unit (WTUs) where conflicts exist between a Soldier in Transition (ST) and the Primary Care Manager (PCM), there are frequent requests for a PCM change. However, there are limited options for a change of PCM in a WTU. This may cause significant disruptions in continuity of care as the multidisciplinary team is disrupted because the ST is unhappy with a PCM who does not support their claim for a particular disability. Identification and utilization of an individual or group of reviewers, external to the Soldier's MEB or healthcare, provides objectivity to the process.

**Level:** Operational

**Key Action:**

- (D):** Establish policy and guidance to ensure IMR is conduct by providers independent of the Soldier's MEB and healthcare.

**Lead Agency:** OTSG

**Support Agency:** None

**Proposed Completion Date:** 4th Qtr, FY13

**C. Focus Area # 3 – Reserve Component (RC) Issues and Improvements**

Summary: Over the last twelve years, the Army has greatly improved services for RC Soldiers. Implementing TRICARE Reserve Select, availability of pre- and post-deployment TRICARE eligibility, extended VA services for combat veterans, and the outreach of Military OneSource have made health care more accessible for many RC Soldiers and Families.



However, implementing these services, with no single line of authority to synchronize and coordinate policy, guidance, and information, resulted in a patchwork system of agencies and programs that do not always share information. This produces problems with continuity of care, duplication of effort, and confusion to the intended beneficiaries and to commanders charged with medical record keeping and positive control over the health of their Soldiers.

Statutory differences exist in the organization and resourcing of the RC that create potential issues in the development of medical and personnel policy. DoD Directive

(DoDD) 1200.17, Managing the Reserve Components as an Operational Force, “provides an overarching set of principles and policies to promote and support the management of the RC as an operational force.” This directive includes the requirement that RC Soldiers maintain the same medical readiness standards as active duty Soldiers. Even though this directive was published in 2008, the RC has yet to fully benefit from a comprehensive RC healthcare system compatible with the continued use of the RC as an operational force. Health care policies and practices are often specific to a particular service component, and many remain as a Cold War legacy of utilizing the RC as a strategic reserve. Within the RC, emphasis varies due to the inherent differences between the regionally-organized USAR and the state-organized ARNG, whose command and organizational authorities span the 50 states, three territories, and the District of Columbia.

For most RC Soldiers, access to the military healthcare system is greatest during Initial Entry Training (IET) or mobilization. Once assigned to a drilling unit, access to care is greatly reduced for the RC Soldier who must often take time off from civilian employment and possibly travel long distances to the nearest MTF, VA medical facility, or other TRICARE-contracted provider. Inflexibility in scheduling, insufficiency of providers at the MTF or VA, and a shortage of TRICARE authorized contract providers can further discourage an RC Soldier seeking care. Funding shortfalls at the state or regional level reduce the availability of the man-days necessary to pay for the associated time and travel to and from the care location. RC Soldiers living in remote areas present an administrative and fiscal challenge for the states and regions seeking to support them.

★★★ **RC Soldiers living in remote areas present an administrative and fiscal challenge for the states and regions seeking to support them.**

To address issues in forecasting BH and IDES requirements, the RC would benefit from a study to evaluate the most feasible and cost-effective manner to enable comprehensive access to health care for the RC. The study must include the flow of dollars and resources necessary to support concepts such as leadership structure, staffing models, and interoperability of data systems as well as a comprehensive evaluation of the process necessary to get an RC Soldier into the IDES.

To enhance RC medical readiness and to fence resources for BH initiatives such as force structure, data systems, and program requirements recommended by this CAP from becoming bill-payers for other interests and programs, funds for these initiatives must be programmed in the Future Years Defense Program (FYDP), included in the Program Objective Memorandum (POM) and the President’s Budget.

**Finding 3.1** – The RC is not organized at the state and regional levels to optimize access, communication, and management of Soldiers with BH issues.

#### Recommendations:

1. Establish a Director of Psychological Health for both the ARNG and USAR in each state, territory, Regional Support Command (RSC) and Operational and Functional (O&F) Command to advise the senior commander on the key BH-related program level issues facing Soldiers and Families as Soldiers navigate through the IDES.
2. Task the U.S. Army Medical Research and Materiel Command to conduct a formal study to determine how to best coordinate and implement comprehensive access to health care for the RC.

#### Discussion:

On October 17, 2012, the OTSG published the Army’s strategic plan to establish Directors of Psychological Health across the Army with additional guidance to be issued in an operations order by February 28, 2013.<sup>7</sup> The memorandum does not specify the establishment of a Director of Psychological Health for the Reserve Component, and implies that establishment of this function will be an additional duty using current resources such as uniformed social workers or psychologists, vice creating a new TDA position. Appointing a Director of Psychological Health is critical for both the ARNG and USAR to ensure continuity of care for all Soldiers. The director should be a behavioral health provider in a permanent full-time duty position.

The creation of a system of Directors of Psychological Health and dedicated mental health management teams for the RC will place the highest priority on the full continuum of BH in each state, territory, RSC, and O&F Command. ARNG and USAR involvement in the development of such a governance structure is critical for the effective resolutions of BH care matters specific to each state and region. The authorization of a Director of Psychological Health position with Title-5 Civilians and with AC officers in RC TDA positions would facilitate increased staffing capability and flexibility.

The Army would benefit from a formal study of how to best coordinate and implement comprehensive access to health care for the RC. The ability to plan, program, and provide sufficient resources will better synchronize and coordinate the delivery of and access to health care for the RC. Elements of such a study should address the goals set forth in DoDD 1200.17,<sup>8</sup> how those goals are met through the Army Campaign Plan, and how coordination of responsibility for jurisdiction and oversight among the three components is best achieved while anticipating BH requirements and enabling the supporting lines of operation. The goal of such a study would be to establish increased continuity in care, reduced duplication of effort, reduced confusion to the intended beneficiaries, improved support to the commanders charged with medical record keeping and positive control over the health of their personnel.

**Level:** Operational

#### Key Actions:

- (D) Issue HQDA policy establishing the position of the Director of Psychological Health for the ARNG and the USAR and guidance regarding the role and responsibilities.
- (O) Initiate a U.S. Army Manpower Analysis Agency manpower study.
- (O) Initiate a U.S. Army Medical Research and Materiel Command study.
- (T) Train Senior commanders on the roles and responsibilities of the Director of Psychological Health at the Senior Commanders Course.
- (T) Train incoming Directors of Psychological Health on their roles and responsibilities prior to assignment to these positions.

7. See OTSG Memorandum For Office of the Assistant Secretary of Defense (Health Affairs), Directors of Psychological Health Strategic Plan in Compliance with Department of Defense Instructions (DoDI) 6490.09, October 17, 2012.  
8. DoDD 1200.17, Managing the Reserve Components as an Operational Force, October 29, 2008.

(P) Implement necessary allocations of RC force structure in order to provide a sufficient basis for staffing this recommendation.

(F) Make available the necessary headquarters office space and support facilities in order to facilitate the implementation of this recommendation.

**Lead Agency:** DCS G-1

**Support Agency:** OTSG, DCS G-3/5/7, ACSIM, ASCC's, TRADOC, Director, Army National Guard (DARNG), Office of the Chief, Army Reserve (OCAR)

**Proposed Completion Date:** 4th Qtr, FY13

**Finding 3.2** – RC BH providers are underutilized during inactive duty for training (IDT) and annual training (AT) training periods.

**Recommendations:**

1. Maximize RC BH providers by using their services in non-clinical roles at the unit level to include BH command consultations, unit assessments, prevention programs, classes, and early intervention and referral services.
2. Determine the feasibility of rotating BH personnel through RC units on a routine basis during IDT periods. These individuals would consult with leaders, monitor unit well being, provide training and provide Soldier referral as necessary.

**Discussion:**

Statutory limitations restrict the RC BH providers from providing medical care when they are not mobilized, but there are many other valuable functions that RC BH providers can perform. Examples include (1) consultation with leaders; (2) providing administrative oversight of BH services with local providers; (3) monitoring Soldier and Family functioning, morale, and well-being; conducting unit needs assessments; (4) giving classes and briefings on BH topics; (5) performing basic screening and referral; and (6) rendering crisis intervention when necessary. These are critical skills and core competencies necessary for BH professionals to train on in preparation for combat and operational stress control in a deployed environment. Army Field Manual 40-02.51 highlights critical non-clinical areas to include such as command consultation, unit needs assessment, Traumatic Event Management, and other areas which require ongoing training.

**Level:** Operational

**Key Actions:**

- (D) Develop and issue regulatory and policy guidance to the RC regarding how to utilize and cross-level RC BH providers to meet organizational requirements when Soldiers are in an IDT status.
- (T) Educate RC BH providers and leaders on the key regulatory and policy guidance regarding the utilization of RC BH providers and cross-leveling to meet organizational requirements.

**Lead Agency:** DARNG, OCAR

**Support Agencies:** OTSG

**Proposed Completion Date:** 3rd Qtr, FY13

**Finding 3.3** – RC Soldiers lack awareness and information on BH care options.

**Recommendations:**

1. Coordinate, synchronize, and improve current strategic communication efforts to ensure that RC Soldiers and Families better understand the various BH care options available to them.
2. Provide for the medical case management of RC Soldiers in the IDES with BH conditions.
3. Establish continuous availability of a point of contact 24/7 who can direct RC Soldiers and their Families to the most appropriate and available BH care resource.
4. Decrease financial barriers to BH care for RC Soldiers by reducing or waiving TRICARE co-pays for BH outpatient visits.

**Discussion:**

This finding is based on information and data from the VA, the DAIG, and MEDCOM. RC Soldiers and Families are often unaware of treatment services provided by Military OneSource, DoD MTFs, and other federal, state and local resources. The scope and span of agencies and available services is complex and can cause confusion for Soldiers with BH conditions. A better understanding and utilization of these BH services by RC Soldiers will improve the medical readiness of the force with timely screening, referral, and treatment for BH conditions.

★★★ **RC Soldiers and Families are often unaware of treatment services provided by Military OneSource, DoD MTFs, and other federal, state and local resources.**

RC Soldiers with BH conditions need to receive information and case management assistance, through the assignment of a case manager or other means, to help them navigate through IDES and BH services to ensure they

receive the required care. Programs to disseminate information require refinement to ensure that Soldiers and Families receive comprehensive and complete information regarding the services available to them. For example, many RC Soldiers are unaware of the VA Returning Service Member Program, which extends post-deployment veterans benefits for five years after release from active duty (REFRAD) for Veterans of combat. The Army must also develop a means for RC Soldiers to obtain timely assistance to secure medical appointments, such as expanding access similar to the former TRICARE BH Provider Locator and Appointment Assistance Service.

Reducing financial barriers to care and expanding the scope of care available would also improve treatment and services to the RC. TRICARE Reserve Select co-payments of 15 percent of the “negotiated price,” or around \$10-\$20 per outpatient session, can be cost prohibitive for Soldiers and their Families. In addition, TRICARE currently does not cover “V-Code” type mental health conditions such as marital counseling or parent-child relationship problems, often caused or exacerbated by military service, combat deployments, and/or other BH conditions such as PTSD. By waiving or reducing out-of-pocket costs, a significant barrier to care would be reduced increasing the probability that RC Soldiers will self-refer for BH care.



**Level:** Strategic, Operational

**Key Actions:**

- (D) Develop and issue regulatory policy guidance to coordinate, synchronize and improve current strategic communication efforts to ensure that RC Soldiers and Families better understand the various options available to them. Because the VA has an interest in this matter, Congressional action could be necessary to properly align efforts between the agencies outside of HQDA.
- (D) Fully implement DoDD 1200.17, Managing the Reserve Components as an Operational Force.
- (O) U.S. Army Medical Research and Materiel Command conduct a formal study of how to best coordinate and implement comprehensive access to health care for the RC and develop legislative proposals for changes to TRICARE for RC Soldiers.

**Lead Agency:** DARNG, OCAR

**Support Agency:** OTSG

**Proposed Completion Date:** 4th Qtr, FY13

**Finding 3.4** – RC Commanders lack awareness and information on BH care their Soldiers are receiving or require.

**Recommendations:**

1. Develop a medical data sharing system that collects information about RC Soldiers from medical data systems, to include AHLTA, VISTA, TMA, the Medical Protection System (MEDPROS) and the VA. eProfile requires the capability to capture information from these systems to provide commanders more accurate and timely data relevant to RC Soldier readiness. If eProfile cannot be modified to work with all these systems, then an alternate system must be developed. Soldiers remain responsible for self-reporting limiting conditions treated by private practitioners outside of the DoD system.
2. Train Soldiers and reinforce the importance of ensuring that the Army receives and maintains complete and accurate BH medical records in order to ensure the best delivery of care possible.
3. Train VA and TRICARE network providers to understand what may constitute a significant limiting condition and to provide feedback to the DoD for possible profiling or referral to the IDES.

**Discussion:**

RC health related information must reside in the MEDPROS data system. Currently, information pertaining to care delivered by the MTF ultimately feeds to AHLTA. Information pertaining to care delivered by the VA feeds to the Veterans Health Information Systems & Technology Architecture (VISTA), and information pertaining to care delivered by TRICARE feeds to the TRICARE Management Agency (TMA). What currently does not exist, other than the reliance on Soldiers to self-report, is a data sharing mechanism among AHLTA, VISTA, TMA and MEDPROS, to auto populate medical information relevant to the fitness for duty of the Soldier. Reliance on Soldier self-reporting limits the identification of potentially limiting conditions.

RC commanders, as part of an operational force, are required to monitor their Soldiers' health and readiness. RC commands can review and monitor Soldier medical readiness in eProfile and MEDPROS databases. ARNG health information is in MEDHART (eCase and eLOD). There are several reasons medical readiness information may not be in

MEDPROS, or why RC commanders have no knowledge of the medical readiness of RC Soldiers. The primary reason information is not in MEDPROS is because RC Soldiers receive their care from many different sources, unlike AC Soldiers, who primarily receive healthcare from the MTF. Non-DoD healthcare providers are usually unaware of the need to provide feedback to DoD regarding the identification of significant service-limiting conditions and some believe they are prohibited from doing so due to medical confidentiality requirements. Although there are provisions within the Health Insurance Portability and Accountability Act (HIPAA) to allow for such disclosures, Soldiers are often reluctant to have their medical information released to their unit commanders for fear of stigmatization or limitations on their continued service. The incompleteness or absence of the healthcare information of RC Soldiers available to RC commanders prohibits the ability of the RC to accurately know the full and complete medical readiness in units.

DoD direct care medical providers require feedback from TRICARE Network and VA providers who treat Soldiers for BH conditions that limit the Soldier's ability perform military duties, regardless of the Soldier's duty status at the time of treatment. VA and TRICARE Select network providers who treat Soldiers when the Soldiers are not on active duty must be aware that when BH conditions limit the Soldier's military job performance, that feedback should be shared with DoD medical providers. A program of training and quick-reference materials should be developed and fielded to improve provider understanding and feedback. Such training should include the information the DoD needs, why the DoD needs it, what laws and regulations apply to the communication of such information, and how to communicate required information back to the DoD.

**Level:** Strategic

**Key Actions:**

- (D) Develop and issue regulatory policy guidance and memorandums of understanding between DoD, VA, and TRICARE to coordinate, synchronize, and improve the integration of medical data information systems and increase the level of sharing of Soldier medical information.
- (T) Develop and implement a training program to increase VA and TRICARE network providers' understanding of what may constitute a significant limiting condition and how to provide feedback to the DoD for possible referral to the IDES.
- (T) Train Soldiers to reinforce the importance of ensuring that the Army receives and maintains complete and accurate BH medical records in order to ensure the best delivery of care possible.

**Lead Agency:** DCS G-1

**Support Agency:** ASA(M&RA), DCS G-3/5/7, OTSG, DARNG, OCAR

**Proposed Completion Date:** 4th Qtr, FY13

**Finding 3.5** – The Army does not adequately plan for the resourcing of the IDES as part of the mobilization planning process.

**Recommendation:** Develop and use IDES planning factors to anticipate the programming of resources necessary to expand the IDES system to accommodate surges in demand due to mobilizations, deployments and combat operations.

**Discussion:**

In the last ten years, the Army's DES structure has been unable to meet the increase in demand created by flow of Soldiers



returning from combat with BH conditions. Although MEDCOM resourced some additional personnel to address DES processes over time, such additions were usually in reaction to emergent demand – rather than in a proactive, anticipatory manner. The result is an overtaxed health care system and a drawn-out DES process – which, unfortunately, the Army, the DoD, and the VA have spent the better part of the past five years trying to repair.

An analysis of the number of Soldiers referred to the DES/IDES since September 11, 2001, indicates that Soldiers returning from deployments enter the IDES and utilize BH services at a consistent rate.<sup>9</sup> Given the fact that for every 100,000 Soldiers deployed, 4,100 or 4.1 percent will ultimately end up in the IDES with a BH diagnosis, proactive planning factors, especially non-IDES BH care and VA BH care, should be established to institute a standing surge capability into the IDES at the beginning of combat operations to effectively manage the probable increase in demand. This will ensure that the flow through the IDES is continual and does not become overwhelmed.

**Level:** Strategic

**Key Actions:**

- (D) Program resources to reduce the existing backlog of IDES cases and to prevent subsequent backlogs due to emergent conditions.
- (D) Program resources into the FYDP in order to resource the ability to respond to future surges in the IDES system due to mobilization and to provide sufficient access to care for the RC.

**Lead Agency:** OTSG

**Support Agency:** ASA(M&RA), DCS G-3/5/7, DARNG, OCAR

**Proposed Completion Date:** 2nd Qtr, FY13

**D. Focus Area #4 – Personnel Policies that Impact the IDES**

**Summary:** The Army’s policies are designed to ensure Soldiers diagnosed with an unfitting condition are considered for a medical separation, but some of those policies require clarification or reconsideration to ensure the appropriate avenues are being used based on the Soldiers conduct, history, and condition. This focus area analyzes three instances when another action or an administrative discharge may be more appropriate than a medical discharge, even though a Soldier may have a BH condition: (4.1) when a Soldier with a BH condition engages in misconduct; (4.2) when a Soldier who has never deployed has a pre-existing personality disorder; or (4.3) when an initial entry Soldier has a pre-existing BH condition. In all three of these instances, if the BH condition does not meet medical retention standards, referral to the IDES takes precedence over separation for personality disorder.

**Finding 4.1** – Leaders lack knowledge regarding the use of UCMJ in the IDES process.

**Recommendations:**

1. Develop quick references for unit commanders to explain the parameters of Uniform Code of Military Justice (UCMJ) or adverse actions and administrative separation procedures for Soldiers referred to the IDES.
2. Revise AR 635-200, Active Duty Enlisted Administrative Separations, dated September 6, 2011, paragraphs 1-33b(1) and 1-33c to specify the meaning of “UCMJ action has been initiated.” The paragraphs should be rewritten to clearly state that the initiation of UCMJ action constitutes the referral of court-martial charges.

<sup>9</sup> This conclusion is based on an analysis of the information gathered from MEDCOM’s review of over 146,000 MEB records from 2001-2012.

3. Develop quick references to provide information regarding alternative personnel actions for Soldiers in the IDES and maintain information on DCS G-1 and OTJAG websites with links to the appropriate regulations.

**Discussion:**

Commanders must decide when and how to initiate adverse action against a Soldier with a BH condition who engages in misconduct. The procedures for adverse actions applicable to Soldiers who engage in misconduct while in the IDES are confusing. Soldiers, commanders, and leaders need easy references incorporating information from all the relevant regulations to help them understand the options available while going through the IDES. FIGURE V-1 illustrates the options, which are:

**Administrative Options:** Soldiers who engage in misconduct or performing below Army standards while in the IDES are subject to adverse administrative action. Commanders may consider a wide array of administrative options to include:

★ ★ ★ **Commanders must decide when and how to initiate adverse action against a Soldier with a BH condition who engages in misconduct.**

- (1) corrective training (AR 600-20, paragraph 4-6, Army Command Policy, dated September 20, 2012); (2) suspension of favorable personnel actions, also known as a flag (AR 600-8-2, Suspension of Favorable Personnel Actions, dated December 23, 2004); (3) suspension or revocation of security clearance (AR 380-67, Personnel Security Program, dated August 4, 2011); (4) revocation of privileges; (5) administrative reprimand (AR 600-37, Unfavorable Information, dated December 19, 1986); (6) bar to reenlistment (AR 601-280, Army Retention Program, dated January 31, 2006); (7) reduction in grade (AR 600-8-19, Enlisted Promotions and Reductions, dated December 27, 2011); (8) referred or negative evaluation report (AR 623-3, Evaluation Reporting System, June 5, 2012); and/or (9) a relief for cause (AR 600-20, Army Command Policy, dated September 20, 2012, and AR 623-3, Evaluation Reporting System, dated June 5, 2012).

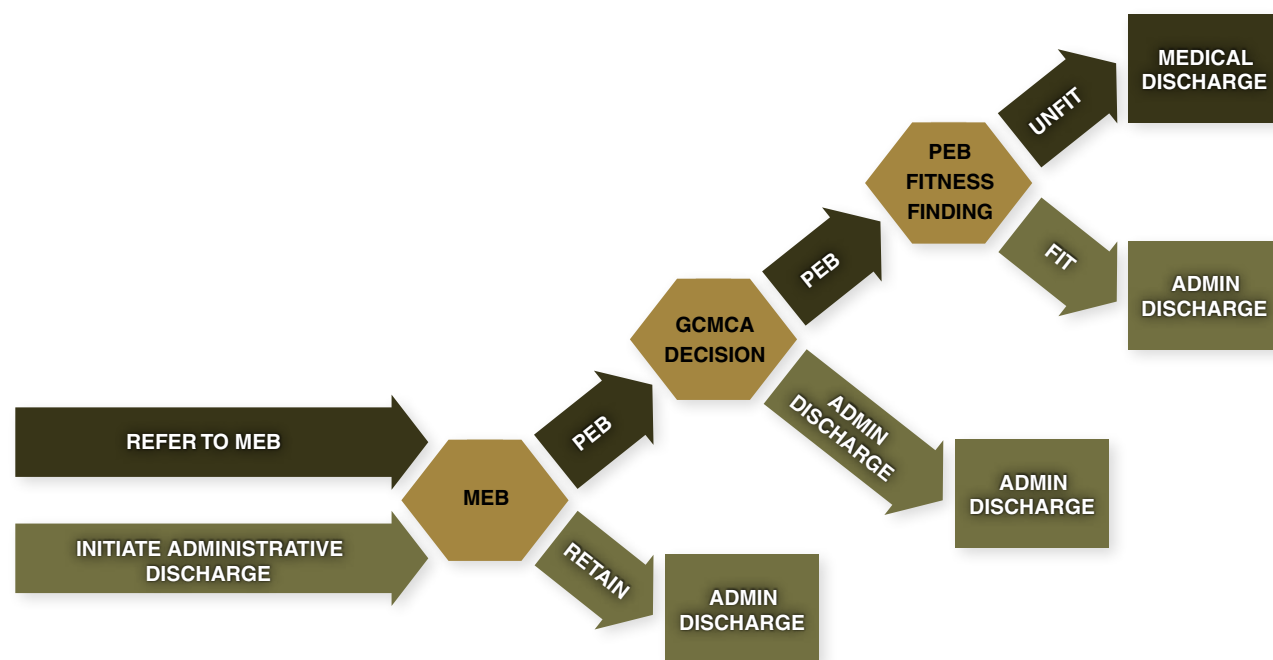
**UCMJ Options:** A commander may administer non-judicial punishment pursuant to Article 15, UCMJ, or prefer court-martial charges when a Soldier is going through the IDES. A Soldier continues processing through the IDES when pending action under Article 15, UCMJ. A Soldier is no longer eligible to process through the IDES when a commander prefers court-martial charges under the UCMJ. If a Soldier elects an administrative discharge in lieu of a court-martial pursuant to AR 635-200, chapter 10, Active Duty Enlisted Administrative Separations, dated September 6, 2011; the Soldier is barred from the IDES due to the initiation of UCMJ action.

**Administrative Discharges for Misconduct:** Simultaneous processing for administrative discharge and medical discharge is possible.<sup>10</sup> However, suspension of final action for administrative discharge must occur at three key decision points to determine whether the Soldier will proceed through the IDES or receive an administrative discharge. Those three decision points occur: (1) at the completion of the MEB; (2) with the General Court-Martial Convening Authority (GCMCA) decision; and (3) when the PEB renders the fitness determination.

1. **MEB Recommendation:** If the MEB recommends retention, then the separation authority can administratively separate the Soldier. If the MEB findings indicate that referral of the case to a PEB is warranted, then the MTF commander will furnish copies of the approved MEB to the unit commander and the GCMCA.
2. **GCMCA Decision:** The GCMCA must decide to pursue either administrative separation, or to direct the Soldier’s referral to a PEB. In making this decision, the GCMCA must consider whether the Soldier’s medical condition is the direct or substantial contributing cause of the misconduct that led to the recommendation for administrative separation,

<sup>10</sup> A commander can initiate an administrative separation for misconduct pursuant to AR 635-200, Active Duty Enlisted Administrative Separations, Chapter 14, while a Soldier is pending an MEB. Likewise, a MTF commander or medical officer can refer a Soldier to an MEB in accordance with AR 40-400, Patient Administration, dated January 27, 2010, if it determines that the Soldier does not meet retention standards, even if an administrative separation is pending. See also AR 635-200, paragraph 1-33, Active Duty Enlisted Administrative Separations, dated September 6, 2011, for active duty Soldiers. The process is identical for ARNG and USAR Soldiers pending an administrative discharge pursuant to AR 135-178, paragraph 1-9, Army National Guard and Army Reserve Enlisted Administrative Separations.

## PROCESSING ADMINISTRATIVE & MEDICAL SEPARATIONS



**Figure V-1.** Processing Administrative & Medical Separations.

and whether other circumstances of the individual case warrant disability processing. The GCMCA's decision and the basis for that decision must be documented.

- a. If the GCMCA does not refer the Soldier to the PEB, then the unit commander can finalize the administrative discharge.
- b. If the GCMCA continues to process the Soldier through the IDES, the unit commander will suspend the administrative separation pending the PEB results.
3. **PEB Fitness Determination:** If the PEB finds the Soldier fit for duty, then the administrative separation action will resume. If the PEB finds the Soldier unfit for duty, the administrative action will be terminate and the Soldier will receive a medical discharge.
4. **The need for the development of quick references for commanders:** The Army has taken several initiatives to provide clear guidance to commanders. In June 2012, ODCS G-1 issued All Army Activities (ALARACT) message 159/2012 to clarify enlisted administrative separation processing for Soldiers identified as not meeting medical retention standards. The Judge Advocate General Corps also published the Commander's Legal Handbook on June 15, 2012. While this handbook provides information for processing administrative separations, it lacks guidance on how to process Soldiers involved in the IDES.

Despite the efforts to provide policy guidance on separation procedures, the DAIG found confusion still exists regarding all of the options available to commanders when Soldiers are in the IDES. Therefore, the Army must develop a quick reference that is easy for commanders to understand the administrative and UCMJ actions that are permissible to take when Soldiers are also eligible for consideration of a medical discharge. The DCS G-1 and the Judge Advocate General's Corps maintain websites which should be used to provide information regarding alternative personnel actions for Soldiers in the IDES and there should be links to the appropriate regulations.

In addition to relying on these references, commanders who consult with their Judge Advocate and medical providers will achieve better outcomes for their Soldiers and the unit. The Army guidance must remind commanders to consult with their Judge Advocate to ensure that any contemplated adverse action is consistent with the law and regulation. Commanders taking actions involving Soldiers with BH conditions must exercise their independent, personal discretion and evaluate each case individually. Commanders should consider the effect that a loss of medical benefits will have on the Soldier as a result of administrative discharge. Commanders must also contact their supporting BH and MEB providers to ensure they fully understand the condition of the Soldier.

**Level:** Operational, Tactical

### Key Actions:

- (D) Prior to taking adverse action, commanders must consult with the Soldier's BH provider and MEB physician to ensure he/she understands the Soldier's condition and whether it contributed to the misconduct.
- (T) Create a separation process alternatives training package for JAG officers, paralegals, Soldiers, leaders, and medical providers. Incorporate information from the various regulations into a summary slide package with vignettes to help illustrate the processes. Introduce that information into commander and first sergeant leadership development courses.
- (T) Update the Commanders Legal Handbook to include information in Chapter 28 on administrative separations and the IDES.
- (L) Widely disseminate clarifying guidance on administrative separations and the IDES. Additionally, populate DCS G-3/HRC and Judge Advocate General Corps Network (JAGCNET) websites to provide links to regulations and make the information easily accessible.

**Lead Agency:** OTJAG

**Support Agency:** DCS G-1, OTSG

**Proposed Completion Date:** 2nd Qtr, FY13

**Finding 4.2** – Soldiers diagnosed with a personality disorder, who have not deployed to a combat environment, are processed unnecessarily through the IDES rather than administratively discharged.

**Recommendation:** Revise OTSG/MEDCOM Policy Memo 11-010, dated February 22, 2011, paragraphs 5a(1) and (2) to make it consistent with Army Regulations requiring only Soldiers who have served or are currently serving in a hostile fire / imminent danger pay area to have their diagnosis of personality disorder corroborated by the MTF Chief of Behavioral Health (or an equivalent official), with a final review and confirmation by the Chief, Behavioral Health Division, OTSG.

### Discussion:

The OTSG/MEDCOM policy is overly inclusive because it requires all Soldiers receiving an administrative separation for a personality disorder to be subject to OTSG medical review/approval. It is important for OTSG to revise OTSG/MEDCOM Policy Memo 11-010, dated February 22, 2011, paragraphs 5a(1) and (2) to be consistent with Army AR 635-200, Enlisted Separations, dated Sept. 6, 2011, which does not require OTSG review/approval for Soldiers who have

not deployed. Providers are referring Soldiers who have never deployed to the IDES, rather than recommending they be administratively discharged for a personality disorder, because of OTSG's review requirements and lengthy approval process. As a result, Soldiers with pre-existing personality disorders, who are not at risk of having combat related PTSD, are unnecessarily considered for a medical discharge.

In 2007-2008, there were concerns that local installations were administratively separating Soldiers who should have otherwise gone through the IDES. In order to verify the provider properly diagnosed the Soldier with a personality disorder rather than combat related-PTSD, the Army centralized the approval process for administrative personality disorder discharges for previously deployed Soldiers. The risk of misdiagnosing personality disorders in Soldiers who have not deployed is low. Therefore, the OTSG policy requiring approval for all administrative discharges due to personality disorder

★★★ OTSG policy requiring approval for all administrative discharges due to personality disorder inappropriately includes non-deployed Soldiers and should be changed to mirror the regulatory requirements of the DoD

inappropriately includes non-deployed Soldiers and should be changed to mirror the regulatory requirements of the DoD.

The Army revised AR 635-200, Enlisted Separations, dated September 6, 2011, Chapters 5-13 and 5-17 to centralize the approval process for administrative separations due to personality disorder for Soldiers who have deployed in accordance with DoDI 1332.14, Enlisted Administrative Separations, dated August

28, 2008. The regulation specifies that for Soldiers who have been deployed to an area designated as a hostile fire/imminent danger pay area, the personality disorder diagnosis must be corroborated by the MTF Chief of Behavioral Health (or an equivalent official). The corroborated diagnosis will be forwarded for final review and confirmation by the Chief, Behavioral Health Division, Office of the Surgeon General.

The OTSG/MEDCOM Policy Memo 11-010, paragraphs 5a(1) and (2) extended the requirement for the MTF Chief of Behavioral Health and OTSG to approve the personality disorder diagnosis of all Soldiers who are pending a Ch. 5-13 or Ch. 5-17 discharge. OTSG should change the paragraphs to reflect the DoDI and Army regulation which only requires the approval of personality disorder administrative discharges for Soldiers who have previously deployed. In addition to having the unintended consequence of sending non-deployed Soldiers to IDES, the OTSG policy limits local provider autonomy, undermines local commanders' confidence in the BH system, and removes final fitness for duty and readiness determinations from the local decision making authorities.

**Level:** Operational

**Key Action:**

- (D) Revise OTSG/MEDCOM Policy Memo 11-010, dated February 22, 2011, paragraphs 5a(1) and (2) to be consistent with Army AR 635-200, Enlisted Separations, dated September 6, 2011.

**Lead Agency:** OTSG

**Support Agency:** OTJAG

**Proposed Completion Date:** 2nd Qtr, FY13

**Finding 4.3** – Rather than being administratively discharged, initial entry Soldiers who do not meet procurement medical fitness standards due to a pre-existing BH condition are being referred to the IDES to determine if they are eligible for a medical separation.

**Recommendation:** Seek a legislative change to the 10 USC 1201 and 12-3 to allow for the administrative discharge of Soldiers who have not deployed, who suffer from a pre-existing behavioral health conditions within 365 days of entering active duty. Revise DODI 1332.38 and Army Regulation 635-200, Active Duty Enlisted Administrative Separations, dated September 6, 2011, Ch. 5-11 to reflect this change. Soldiers separated within the first six months of active service should receive an uncharacterized discharge. Soldiers discharged with 181-365 days should be eligible to receive an Honorable discharge with the associated benefits.

**Discussion:**

Administrative discharges for Soldiers with pre-existing BH conditions are infrequent because the conditions are often not discovered until Soldiers arrive at their first duty stations following basic training and advanced individual training (AIT). Currently 10 USC 1201 and 1203 allow the Army to separate Soldiers for pre-existing conditions rather than consider them for medical retirement or discharge.<sup>11</sup> 10 USC sections 1201 and 1203 govern medical retirement and medical discharges. The statute requires that if a BH condition is not noted at the entrance on active duty, the Secretary must determine that "clear and unmistakable evidence demonstrates that the disability existed before the member's entrance on active duty and was not aggravated by active military service." The current statute does not contain time limitations for discovering pre-existing medical conditions and does not specify who must make that determination for the Secretary. Therefore, an entrance physical standard board could be used to determine whether the disability existed before the member entered active duty rather than an MEB and a Soldier could be administratively discharged pursuant to Chapter 5-11 instead.

DoDI 1332.38, Physical Disability Evaluation, dated July 10, 2006, section E3.P2.5, states that Soldiers who are identified with non-waivered medical conditions or physical defects that existed prior to entry onto active duty service, may be administratively separated without referral into the IDES. However, the medical impairment must be identified prior to or within 180 days of the Soldiers' initial entry on active duty, active duty for training or full-time National Guard duty. Army Regulation 635-200, Active Duty Enlisted Administrative Separations, dated September 6, 2011, Ch. 5-11, Separation of personnel who did not meet procurement medical fitness standards, mirrors the DoDI, and requires referral to an entrance physical standards board for the Soldier recommended for separation within his or her first six months of active duty because of a pre-existing medical condition.

Neither DoDI 1332.38 nor AR 635-200 reflects the change in the law which now permits discharges for pre-existing conditions beyond the initial six months of active duty service. The initial six month period allows the separation to be described as an entry level separation with an uncharacterized discharge.<sup>12</sup> An uncharacterized discharge does not prejudice a Soldier in the civilian sector, but it does not provide for any benefits either. Pre-existing BH conditions, however, often do not manifest during the highly structured and regimented periods of basic training and advanced individual training. Allowing 365 days to discover these conditions will to give leaders and physicians additional time to detect these illnesses.

The proposed statutory revision to DoDI 1332.38 and AR 635-200 to allow for an initial entry separation, would allow up to 365 days for the detection of a pre-existing BH condition in Soldiers who have not deployed, to help alleviate strain

11. The FY2009 NDAA changed the language in the statutes governing medical retirement and medical separation, 10 USC sections 1201 and 1203. The statutes still authorize administrative discharges for pre-existing conditions in lieu medical retirement or separation. The statute was amended by deleting language that provided medical discharges for Soldiers with more than six months of service. The statute does not specify who must make that determination for the Secretary of the Army.



on the IDES and to provide an alternative to administrative separation for Soldiers with pre-existing BH conditions. An entrance physical standards board would determine if clear and unmistakable evidence exists that the BH condition existed prior to, and was not aggravated by, active service. No change to existing policy is required for Soldiers in their first 180 days to receive an uncharacterized discharge. Soldiers discharged with 181-365 days of service would be eligible to receive an honorable discharge and the associated benefits. In accordance with DODI 1332.28, Soldiers who qualify for an entrance physical standards board who disagree with a determination of no aggravation should be allowed to have their case forwarded to the PEB for review.

**Level:** Strategic, Operational

**Key Actions:**

- (D) Revise DoDI 1332.38, Physical Disability Evaluation, to include the changes proposed above.
- (D) Revise AR 635-200, Active Duty Enlisted Administrative Separations, Chapter 5-11, Separation of personnel who do not meet procurement medical fitness standards, to include the proposed exception.
- (T) Develop and send out an ALARACT to inform the Army of changes to AR 635-200.

**Lead Agency:** DCS G-1

**Support Agency:** ASA(M&RA), OTSG, OTJAG

**Proposed Completion Date:** 4th Qtr, FY13

**E. Focus Area # 5 – Enhancing Support for Soldiers and their Families**

**Summary:** Soldiers and Families require additional assistance from commanders to connect with supportive services as they undergo the IDES and transition from the Army. Family members are often responsible for completing IDES paperwork, helping their Soldier get to appointments and assisting with decision making throughout the IDES. Families experience a unique set of transition requirements, particularly when their Soldier has BH issues. The supportive role the Family plays for the Soldier is critical to the transition back to duty or to civilian life. Lack of coordination in the delivery of IDES services makes the IDES navigation difficult for Soldiers and their Families.

**Finding 5.1 –** Soldiers and Families require extensive training and assistance with the IDES process.

**Recommendations:**

1. Designate installation senior commanders as the person responsible for the synchronization of medical, legal, administrative, non-clinical and other IDES-related services, to include coordination between Army IDES advisors, such as PEBLOs, Ombudsmen, MEB and PEB Counsel, VA Military Service Coordinators (MSCs), and other support personnel.
2. Ensure unit leaders establish and maintain contact with their Soldiers and Family members to assist Soldiers with BH conditions as they go through the IDES. The chain of command must be responsible to provide education, awareness, inclusion and support for Soldiers and their Families.

**Discussion:**

The 2012 DAIG inspection determined there is no consistent or clear method for receiving Soldiers into the IDES or for providing general education about the IDES to the involved parties, including Family members. Soldiers and Families often lack clear, meaningful information regarding the IDES. 37 percent of Soldiers surveyed either never received any information about the IDES or had to seek information pertaining to the IDES on their own. Ten percent of Soldiers currently in the IDES indicated they were not familiar with the IDES system at all. Family members complained they were not informed about IDES briefings, told they could not attend, or the briefings were conducted during hours when Family members were not available.

The Family plays a key role in the identification, support, and management of the Soldier with a BH condition. This is critical to both the Soldier and Family members in the transition back to duty or to civilian life and to the overall fitness of the unit. The Chairman of the Joint Chiefs of Staff's Instruction (CJCSI) on Total Force Fitness (CJCSI 3405.01) defines unit fitness 'as the healthy connections within the social network of the unit structure for overall well-being and optimal unit performance.' The military Family serves as an extension to the unit structure. Therefore keeping Family members engaged in the transition process is important.

★ ★ ★ **The Family plays a key role in the identification, support, and management of the Soldier with a BH condition. This is critical to both the Soldier and Family members in the transition back to duty or to civilian life and to the overall fitness of the unit.**

While Soldier care must remain a top priority, Families must understand the needs of their Soldier and may require supportive counseling to do so. A Soldier's BH condition often affects his or her Family, and may include adjustment challenges for children and spouses (including marital role reversals and the risk of divorce), potential Soldier violence, and stress resulting from financial uncertainty. Treatment or medication changes can also affect the behavior of a Soldier. In addition,

Soldier and Family concerns regarding the uncertainty of what the future may hold, combined with the length of time required to process through the IDES, can potentially aggravate a Soldier's BH condition and increase stress on the Family.

Soldiers and Families are also often unaware or confused about the variety of services available to them while a Soldier is going through the IDES and transitioning out of the Army. Installation IDES service agencies often offer duplicative services, complicating the process of care for Soldiers and Families. Personnel working in one agency are unaware of services provided by their sister organizations. Installation senior commanders should be responsible for the overall synchronization of medical, legal, administrative, non-clinical and other IDES-related services. This would include coordination between Army IDES advisors, such as PEBLOs, Ombudsmen, MEB and PEB Counsel, VA MSCs, and other support personnel.

Unit level commanders can help their Soldiers by engaging Family members early in the process. Command encouragement of Family participation and inclusion in routine information briefs will make the Family members feel more a part of the team. Units with Soldiers in the IDES must provide one point of contact to remain available to guide the Family through the IDES, from start to finish. The unit point of contact must ensure Family members have access to information and connect them with the array of services available to support them, to include the PEBLO, the SFAC, and the MTF.

12. See DoDI 1332.14, dated September 30, 2011.

Providing information to Family members about the IDES processes and timelines will reduce uncertainty as supported by the 2012 DAIG BH IDES inspection which found that communication with Family members reduced anxiety and confusion while in the IDES.

Where a Family member is also designated as a caregiver for a Soldier, the command must make special efforts to reach out to that Family member. The caregiver is often responsible for ensuring the Soldier takes his or her medications and arrives on time to appointments. If the BH condition is debilitating, the caregiver may be the Family representative in completing IDES paperwork.

The Warrior Transition Command (WTC) maintains an IDES familiarity briefing for all Soldiers and their Families assigned to WTBs prior to entering the IDES. In addition, the WTUs and CBWTUs work collaboratively with IDES teams to provide information briefings to Soldiers once they enter the IDES. However, more work is required. The Army should develop a robust protocol for contacting Family members and caregivers, to include encouraging Soldiers to consent to unit communication, briefing Soldiers on the benefits of Family involvement, and making Family support a commander's responsibility.

**Level:** Operational, Tactical

**Key Actions:**

- (D) Designate senior commanders as responsible for the synchronization of medical, legal, administrative, non-clinical and other IDES-related services.
- (D) Synchronize IDES provider communication to Soldiers and Families.
- (D) Publish a guide, similar to the new IDES Guidebook that is Family-friendly and includes understandable, complete information about the process, various organizations available to assist, installation resources, and agency resources after transition.
- (D) Standardize and designate a unit point of contact responsible for proactively reaching out to Soldiers and Family members.
- (T) Educate Family members regarding the needs of their Soldiers, how to navigate the medical and administrative appointment systems, and how to access required services.

**Lead Agency:** DCS G-1

**Support Agency:** OTSG, ACSIM

**Proposed Completion Date:** 4th Qtr, FY13

**Finding 5.2** – Consistent use and training of PEBLOs is necessary to reduce systemic variance and to support Soldiers.

**Recommendations:**

1. Fully implement and monitor MEDCOM FRAGO 3 to OPORD 12-31 (MEDCOM Implementation of the Integrated Disability Evaluation System), dated September 25, 2012, which pertained to the alignment of PEBLOs.
2. Assess PEBLO training programs for their uniformity and effectiveness to include resident, online and mobile training teams.
3. Standardize the information that PEBLOs provide to Soldiers and Families within the first ten days of referral for active Soldiers and 30 days for RC Soldiers.

**Discussion:**

PEBLOs play a key role in the IDES process by liaising with Soldiers and their commanders throughout the IDES process. They provide information and guidance to Soldiers throughout the IDES by explaining the IDES to Soldiers, assisting Soldiers with appointment management and document tracking, and keeping Soldiers informed about the progress of their case. During the DAIG 2012 BH IDES inspection, the DAIG found inconsistencies in PEBLOs' performance and a lack of rigor among MTFs regarding in-briefs with Soldiers and coordination with the local chain of command. The implementation of MEDCOM FRAGO 3 to OPORD 12-31, which aligns PEBLOs with units, should mitigate these issues. However, the program must continue to be monitored for effectiveness.

Current training for PEBLOs and Contact Representatives is insufficient. OTSG must publish utilization and training guidance for PEBLOs and Contact Representatives. The DAIG inspection found some certified PEBLOs and Contact Representatives lacked a thorough understanding of the IDES. The PEBLO resident course at Joint Base San Antonio cannot meet the demands and lacks current information on the IDES. PEBLOs unable to attend the resident course are directed to complete the online course consisting of 14 modules and 22 hours of content. The online course is inconsistent with resident course curriculum and is outdated, using legacy DES information. The resident course and online training also do not include training on all required IT systems utilized by PEBLOs and Contact Representatives. The IDES Service Line is working with the U.S. Army Medical Department Center and School (AMEDD C&S) to standardize current on-line and resident IDES courses to address these deficiencies.

MEDCOM efforts to address PEBLO training are ongoing. A mobile customer service training team has been mobilized, a training annex to OPORD 12-31 has been published and a model to assess PEBLO competency is in its trial stage. Additionally, PEBLOs and Contact Representatives should receive customer service training to hone their personal interaction skills, especially with Soldiers who are struggling with BH conditions. The Army must continue to develop and monitor the effectiveness of the PEBLO program and because they truly are integral to the success of the IDES.

**Level:** Operational, Tactical

**Key Actions:**

- (D) Standardize the information that PEBLOs provide to Soldiers and Families within the first ten days of referral for active duty Soldiers and 30 days for RC Soldiers.
- (D) Ensure PEBLO and Contact Representative training is current and consistent.
- (O) Complete alignment of PEBLOs with units in accordance with FRAGO 3 of MEDCOM OPORD 12-31.
- (T) Monitor and enhance effectiveness of PEBLO training teams in order to ensure uniformity and effectiveness of resident, online and mobile training.
- (T) Ensure IDES PEBLO and Contact Representatives attend customer service training.

**Lead Agency:** OTSG

**Support Agency:** MEDCOM, DCS G-1, ACSIM

**Proposed Completion Date:** 4th Qtr, FY13

**Finding 5.3** – Uniform guidance on Ombudsmen use, training, and records is critical.

**Recommendation:** Develop and publish Standing Operating Procedures (SOP) to ensure program uniformity in the Army's Ombudsmen Program. The SOP should standardize the following: (1) client intake assessment procedures; (2) medical records access; (3) ombudsmen resources; (4) case documentation; (5) data collection and analysis; (6) report content; (7) reporting methods; and (8) quality control /quality assurance procedures.

**Discussion:**

During AAA's audit of the MEDCOM Ombudsmen Program, AAA found the program did not establish SOPs for ombudsmen, which would help improve the program's ability to deliver consistent and efficient services. A documented SOP, such as a manual or handbook, will provide purpose, direction, and guidance with respect to the consistent and efficient delivery of services.

OTSG must develop, monitor and evaluate the implementation and execution of such SOPs for the Ombudsmen Program. Specific areas that the AAA recommended addressing include:

1. Client intake assessment procedures: The ombudsmen program does not have a standard form for client intake assessment. Currently, the ombudsmen gather basic demographic and contact information as well as a brief description of the issue.
2. Medical records access: Ombudsmen do not follow consistent practices to access confidential information they need to review to perform their duties. Personally identifiable information and personal health information should only be accessed when necessary and with the written consent of the Soldier.
3. Ombudsmen resources: The program should better define the resources ombudsmen need to perform their responsibilities and to meet overall program objectives. For example, some ombudsmen had access to the electronic health systems (e.g. AHLTA, the Composite Healthcare System), and some did not.
4. Case documentation and records retention: The ombudsmen program should provide guidance on the type of documents or records that ombudsmen should maintain. Records management is the process of managing records from initial creation to record destruction. The ombudsmen offices do not have standardized records management processes.
5. Data collection and analysis: The ombudsmen program should standardize and implement procedures to analyze the data collected. Specifically, it should identify the critical data elements and develop a method to gather and document the data and implement a standard report format that contains the contributing factors and causes to issues. The MEDCOM Medical Assistance Group (MMAG) does not track whether an ombudsman resolved an issue either favorably or unfavorably. The MMAG can improve its data collection practices if it further defined the information it needed and it had a method to capture this information.
6. Report content: The ombudsmen program should standardize the content and data that is reported to program stakeholders. The content of the reports the MMAG and the ombudsman offices submitted to the AAA only provided information about the total number of issues for each major category they lacked the key factors that caused the issues to occur. The quality of information ombudsmen provide to the MTF and WTU personnel is not sufficient to base decisions about how to fix or improve ombudsmen operations and processes.
7. Reporting methods: The ombudsmen program should standardize the process for reporting to the program's stakeholders. The AAA audit stated that ombudsmen did not consistently report on the issues Soldiers encountered to program stakeholders. Ombudsmen communicate issues in different ways, including e-mails, briefings and verbally. The frequency ombudsmen provide issues to the program's stakeholders vary from as frequent as every week to only once a quarter.

8. Quality control and quality assurance procedures: The ombudsmen program should implement quality control and quality assurance procedures. The AAA found that various offices implemented different administrative practices for common business activities. The ombudsmen program lacks quality control to monitor program effectiveness and to mitigate potential problems.

The AAA audit also found that the program does not have a training program that addresses the full range of skills and knowledge ombudsmen need to perform their responsibilities. There is no training on data analysis, data presentation or communication skills. These skills are necessary for ombudsmen to identify systemic issues and to communicate these problems to the appropriate personnel to improve business operations.

**Level:** Operational, Tactical

**Key Actions:**

- (D) Develop an SOP manual to standardize Ombudsman Program processes and procedures.
- (T) Revise the ombudsmen training program to incorporate the instruction of data analysis, data presentation, and communication skills.

**Lead Agency:** OTSG

**Support Agency:** N/A

**Proposed Completion Date:** 4th Qtr, FY13

**Finding 5.4** – Current structure and personnel authorizations for the Office of Soldier Counsel (OSC) is insufficient to meet the high demand for legal support for Soldiers processing through the IDES.

**Recommendation:** Reorganize the OSC to fall under MEDCOM and increase the authorization for DA Civilians in accordance with the OSC Concept Plan.

**Discussion:**

★★★ The AAA audit stated that ombudsmen did not consistently report on the issues Soldiers encountered to program stakeholders.

The OSC consists of attorneys and paralegals that provide legal advice, representation, and support to Soldiers during the MEB and PEB phases that provide advice, representation, and advocacy for Soldiers in the IDES. The Soldiers' MEB

Counsel (SMEBC) and PEB Counsel consist of attorneys credentialed as subject matter experts in medical issues to assist Soldiers processing through the IDES. While there are other advisors assisting Soldiers with case management and providing transition support, no other service provider or stakeholder provides the independent and professional legal representation for the Soldier within the IDES.

★★★ In the last several years, as the number of Wounded, Ill, and Injured (WII) Soldiers going through the IDES has drastically increased, so has the demand for the OSC's legal assistance.

In the last several years, as the number of Wounded, Ill, and Injured (WII) Soldiers going through the IDES has drastically increased, so has the demand for the OSC's legal assistance. Prior to September 11, 2001, approximately 6,000 Soldiers were being processed through

the IDES annually. By November 30, 2011, there were 20,468 Soldiers in the IDES. The population is forecasted to grow to over 25,000 by FY13. There are no organizations staffed to meet this surge in demand for legal counsel.

MEDCOM leadership, with the support and approval of The Judge Advocate General, transformed the method of providing legal representation to WII Soldiers. In 2007, the Army Medical Action Plan began implementing solutions by mobilizing a Reserve Legal Support Organization to provide PEB-level legal support to the WTU. In 2008, MEDCOM added 19 attorney-paralegal teams to the WTU TDAs, plus an additional attorney and paralegal for the Ft. Hood WTU. Mobilized Reservists continue to be the primary source for Soldiers' PEB Counsel staffing and Soldier's MEB Counsel surge staff. Final mobilization is planned for 2012-2013, with a 30 percent decrease in Reservists supporting the mission for the next two years. All of these Reservist tours must end by the beginning of FY15 to eliminate the reliance on Contingency-Active Duty for Operational Support. As a result, it will no longer be possible to staff this specialized legal mission with annual Reserve mobilizations without increasing resources for the ARNG and USAR to support an increase in the utilization of Active Duty for Operational Support as a mechanism to place RC Soldiers in an active status outside of mobilization authority.

The SMEBC legal personnel are distributed throughout WTC. This decentralized organization has limited effectiveness due to conflicting priorities and multiple layers of command structure, creating confusion in the mission and utilization of MEB legal teams. The current structure potentially discourages Soldiers from seeking essential legal services which slows down the delivery of legal services to the WII Soldiers. Therefore, the OSC identified a requirement to centralize legal services by region and to align legal teams with the three PEBs.

The OSC developed a detailed concept plan to request a restructure of the OSC with the establishment of 107 permanent full-time equivalent requirements for DA civilians. Specifically, the proposed staffing consists of four new permanent DA civilian requirements in the Office of the Director of the OSC, 24 new permanent DA civilian requirements at Soldiers' PEB Counsel Regional Offices, and 38 new permanent DA civilian requirements to supplement the 41 existing required/authorized DA civilians at the SMEBC Offices.<sup>13</sup>

OSC analyzed two additional courses of action. The other courses of action included continuing the status quo with maximum utilization of Reservists or partially manning the organization with Reservists while increasing the number of DA Civilians. While the JAG Reservists have done an outstanding job, the continued utilization of mobilized Reservists causes inefficiencies, a lack of continuity, and delays in providing services during each period of demobilization and mobilization for training. Additionally, budget analysis revealed that using Reservists was more expensive than filling the positions with DA Civilians. The table below depicts the anticipated cost of the OSC's proposal to use all DA Civilians to fill the OSC's legal services requirement.<sup>14</sup>

<sup>13</sup> The CG, MEDCOM, in conjunction with OTJAG, recommends the placement of four requirements for the OSC leadership consisting of the Director, Deputy Director, Admin Officer, and Chief Paralegal on the MEDCOM HQs TDA (W3VYAA). It is further recommended that three Regional OSC Physical Evaluation Board Offices consisting of eight requirements each, a total of 24, be placed on the Regional Medical Command (RMC) TDAs.  
<sup>14</sup> DHP O&M and OCO funding is supporting the OSC requirement in FY 12 and FY 13. OSC funding for FY 14-18 will be addressed in the POM process. The OSC requests an additional \$48,423,319 to fully fund the OSC Headquarters Office, three Regional Office of Soldiers' PEB Counsel Offices, and 24 SMEBC Offices for FY 14 thru FY 18.

ANTICIPATED COST OF THE OSC'S PROPOSAL (\$ IN 000S)						
	FY13	FY14	FY15	FY16	FY17	FY18
<b>Civilian Personnel</b>	\$13,262	\$13,348	\$13,472	\$13,708	\$14,033	\$14,367
<b>Facilities</b>	\$212	\$216	\$219	\$223	\$226	\$230
<b>Equipment</b>	\$130	\$132	\$135	\$137	\$139	\$141
<b>Travel</b>	\$371	\$377	\$383	\$389	\$395	\$402
<b>SLA</b>	\$30	\$31	\$31	\$32	\$32	\$33
<b>Security</b>	\$45	\$45	\$46	\$47	\$48	\$49
<b>Furniture</b>	\$54	\$55	\$56	\$57,128	\$58,047	\$58
<b>Office Supplies</b>	\$103	\$104	\$106	\$108	\$110	\$111
<b>TOTAL</b>	<b>\$14,211</b>	<b>\$14,313</b>	<b>\$14,452</b>	<b>\$14,703</b>	<b>\$15,045</b>	<b>\$15,394</b>

Table V-1. Anticipated Cost of the OSC's Proposal (\$ in 000s).

The recommendation to staff OSC with DA Civilians proved not only to be the most cost efficient, but also the most effective, with the continuity of staffing enhancing the legal services to Soldiers and their Families. There are several non-quantifiable benefits OSC anticipates with a DA Civilian staff. There will be an increase in customer and user satisfaction with improved response times, improved continuity of operations, and efficiency with permanent civilian staff. Additionally, there will be improved morale of Soldiers (which reduces complaints to Congress and other entities), improved IDES processing time with Soldiers receiving legal counseling earlier, and reducing the requests for formal hearings.

The consolidation of medical processing and legal support will improve the IDES for Soldiers and directly contribute to enhanced readiness for the Army. Early intervention by legal advocates in the IDES is particularly important to ensure Soldiers understand the IDES and help them manage expectations in terms of a finding of fitness and their overall ratings by the Army and the VA.

Surveys have shown that Soldiers provided the opportunity for early legal counsel, prior to the release of the IPEB results, reduces processing time and produces more accurate results. The legal representatives add validity to the process and help to ensure consistency in MEB and PEB outcomes which, in turn, reduces the number of required formal hearings. This positively impacts readiness by allowing the speedy disposition of Soldiers who cannot perform active duty mission requirements.

OSC plays an important role for the Soldier and for the system. However, OSC cannot continue to operate in the status quo due to the pending elimination of the mobilized Reservist manpower source. Failure to approve the OSC's recommendation will maintain an administrative process with choke points, due to the limited availability of legal counsel. The OSC provides the least expensive option that guarantees staffing, ensures continuity of support to Soldiers, provides a structure with minimum staffing and supports efforts to enhance force readiness. Therefore, the recommendation for restructuring and manning the OSC with 107 DA civilians should be approved.

The OSC Concept plan projects that the transition from using Reserve JAG Personnel to DA Civilians will occur over the next two years. All of these Reservist tours must end by the beginning of FY15 to eliminate the reliance on Contingency-Active Duty for Operational Support. The OSC began reducing its use of JAG Reservists by 30 percent in 2012 and will continue to do so over the next two years. Additionally, this time is needed to hire, train, and accredit the requisite 66 DA civilians without disrupting the legal support of our Soldiers.

**Level:** Operational

**Key Actions:**

- (O) Expedite approval of the OSC concept plan to centralize the OSC organizational structure to fall under MEDCOM and further re-distribute personnel under the three PEB regional areas.
- (O) Establish four leadership positions: Director, Deputy Director, Admin Officer, and Chief Paralegal.
- (T) Train new hires.
- (L) OTSG, MEDCOM and MEDCOM SJA cooperate to provide command oversight and support to OSC efforts.
- (P) The availability of appropriately credentialed attorneys is an essential baseline capability. The minimal number of requirements is identified in the recommended COA. Any decrement to the requested manpower requirement will likely reduce access to appropriate legal counsel and the negatively impact processing times. Hire 66 new DA civilians and reduce the number of JAG Reservists by 30 percent over the next two years.

**Lead Agency:** OTSG

**Support Agency:** MEDCOM, OTJAG, DCS G-3/5/7

**Proposed Completion Date:** 4th Qtr, FY15

**Finding 5.5** – Engage and educate Soldiers and Families on transition resources and opportunities.

**Recommendations:**

1. Connect Soldiers and Families with education, financial, job search and other transition support services currently available in SFACs
2. Fully staff and fund SFACs.
3. Implement a communications plan to educate Soldiers and Families about the continuity of care across the DoD, VA, and other agencies.
4. Continue to collaborate with the VA and other federal, state and non-governmental agencies to assure Families experience a smooth transition to civilian life.

**Discussion:**

Soldiers and Families will experience a smoother transition from the Army if they use the services provided by fully staffed SFACs. Leaders, Soldiers, and Families are often not aware of support services or they are confused by the array of support services on and off installations. Soldiers and Families living on an installation are accustomed to using Army support services located on-post. When they return to the civilian sector, they lose a community of friends and comrades as well

as a familiar network of installation-centric medical and non-medical services. Similarly, RC Families may have a support system established with personal connections through their units, but they may not be aware of professional support services available to them. The Army must implement a communication plan to educate Soldiers and Families about the continuity of care and services available, and maximize the use of the SFACs. SFACs can provide the solution with information, support services, and referrals to other agencies.

★★★ **The SFACs provide non-clinical support services which are critical for the Soldiers and Families who will be returning to a tough civilian job market and may not be aware of the full financial impact of their transition.**

The SFAC<sup>15</sup> is designed to provide tailored, one-stop, targeted transition and support services to WII Soldiers and their Families prior to and during the IDES transition phase. The SFACs provide non-clinical support services which are critical for the Soldiers and Families who will be returning to a tough civilian job market

and may not be aware of the full financial impact of their transition. The SFAC offers educational and financial counseling, job search assistance,<sup>16</sup> and Veterans Benefits Administration (VBA) counseling at targeted sites. A key part of SFAC support is also the referrals to Soldiers and Families to the appropriate services they need from agencies on and off post.

SFACs provide information and referrals to a wide range of support organizations to include:

1. Installation services – Army Community Service, Military Family Life Consultants, Military OneSource, Chaplains, Family Readiness Groups, Army Wounded Warrior Program and Army Substance Abuse Programs.
2. The DoD “in Transition Mental Health Coaching and Support System” program that offers support to members as they move between health care systems or providers if they are currently receiving BH care.
3. VA – Veterans Health Administration (VHA) liaisons are located in the MTFs and VA Vocational Rehabilitation Counselors are increasing their installation presence. The VA is aggressively adding to its capability to receive Veteran Families in the civilian community by adding clinics and tele-health support. The VA Caregiver Support program provides caregiver training, education, and a stipend. Benefits to Families of the most seriously WII include health care coverage, respite care, and mental health services.
4. The Social Security Administration processes disability claims filed by Soldiers who become disabled while on active military duty on or after October 1, 2001, regardless of where the disability occurs. Benefits available through Social Security are different than those from the VA and require a separate application. Social Security disability benefits are provided to the Soldier who is unable to do substantial work because of his or her medical condition(s), which must have lasted, or be expected to last, at least one year or to result in death. Certain Family members may qualify for benefits based on the work of the Soldier.
5. Other federal, state, and non-governmental support agencies.

The DAIG found that installations where leadership and IDES personnel encouraged Family participation and provided SFAC support experienced greater success with the IDES. The 2011-2012 Recovering Warrior Task Force Abridged Annual Report noted that SFACs were rated highly by Families who described SFAC staff as those who did their best to help, were honest, searched for information, and provided useful information. Family members also seem to appreciate

<sup>12</sup> SFACs were instituted in 2007 with the implementation of the Army Medical Action Plan to provide direct support to Warrior Transition Units. EXORD 080-12 Army Integrated Disability System (IDES) Standardization February 2012 expanded SFAC support to all IDES Soldiers.

<sup>16</sup> SFACs provide job search assistance with counselors from the embedded Army Career Alumni Program counselors

★★★ ...SFACs only have 68 percent of hires on board. The additional workload to support Soldiers in the IDES who are not in a WTU will result in considerable strain on the SFAC.

having the same person help them each time. SFACs provide direct communication from and with the Family rather than relying on their Soldier as a conduit.

However, the SFACs are plagued by staff hiring issues. As of November 2012, SFACs only have 68 percent of hires on board. The additional workload to sup-

port Soldiers in the IDES who are not in a WTU will result in considerable strain on the SFAC. The Recovering Warrior Task Force urged IMCOM to prioritize and fund SFACs. The ATFBH would like to reinforce that recommendation to fully fund and staff SFACs to ensure they can continue to fulfill the pivotal role in Soldier care and transition that the Army intends.

**Level:** Strategic, Operational

**Key Actions:**

- (D) Reinforce provisions of EXORD 080-12 that identify the SFAC as the principal transition support agent to Soldiers in the IDES.
- (D) Instruct leaders, Soldiers, and Families on other-agency support services a part of the IDES.
- (D) DoD continues to improve partnerships with the VA and other federal and non-federal agencies in order to smooth Soldier transition.
- (P) Authorize and provide sufficient SFAC staffing to support Soldiers and Families in the IDES.

**Lead Agency:** ACSIM / IMCOM G9

**Support Agency:** DCS G-3/5/7, ODCS G-1

**Proposed Completion Date:** 4th Qtr, FY13

## VI. The Way Ahead and Implications for the Future

PTSD remains an on-going issue. The Army must take care of its Soldiers. Soldiers diagnosed with PTSD continue to serve the Army with distinction in all ranks, branches, and components. While the Army provides excellent BH diagnosis, evaluation, care and treatment, some Soldiers are unable to continue their service due to the severity of their condition. The Army remains responsible for, and dedicated to, ensuring proper care, treatment, and transition benefits for those Soldiers who earned and deserve nothing less.

The Army must ensure that policy and procedures are driven centrally and executed locally to reduce diagnostic variance and ensure consistent outcomes for Soldiers in IDES. Key to this effort is recurrent and frequent training for Army commanders, providers, administrators and board members on system functions and the most current policies and procedures.

The Army must also consider BH requirements and demands on its personnel and medical systems, for future operations. The ATFBH analysis of MEB data from 2001 to 2012 identified a number of potential planning factors with utility for planning and decision support in future deployments. On the aggregate for all components, previously deployed Soldiers enter the IDES for BH at a rate of 4.1 percent. This indicates that for every 100,000 Soldiers deployed, 4,100 will eventually enter the IDES system with a BH diagnosis, half within the first three years after the start of deployment. The Army can use this information to plan, program, budget, acquire, and prepare the necessary resources and facilities as well as support the required treatment and processing of these Soldiers through the IDES.

The Army Senior Leadership places a high priority on continuing to improve BH care in the Army, and the IDES process. This CAP lays out a path for making continued improvements to the BH system of care, both inside and outside the IDES system, for all Soldiers. The ATFBH strongly advises that the recommendations and actions set forth in this plan be provided to the IDES lead agent for action and that the lead agent be required to provide periodic updates to the Under Secretary of the Army and Vice Chief of Staff of the Army to ensure visibility and provide a mechanism to monitor progress and measure success.



This page has been left blank intentionally





**ARMY TASK FORCE on  
BEHAVIORAL HEALTH**