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# ***AFAP ISSUE UPDATE BOOK***

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**Active Issues**

**March 2011**

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

#	Issue title	Status	Subject area	Entered
671	Military Child Development Program (MCDP) Fee Cap	Active	Child Care	02/11
524	Military Spouse Unemployment Compensation	Active	Employment	11/02
615	Donation of Leave for Department of Defense (DoD) Civilian Employees	Active	Employment	12/07
631	Career Coordinators for Army Wounded Warrior Soldiers, Family Members & Caregivers	Active	Employment	01/09
634	Death Gratuity for Beneficiaries of Department of the Army (DA) Civilians	Active	Employment	01/09
649	Compensatory Time for Department of the Army Civilians	Active	Employment	01/10
674	Strong Bonds Program for Deployed Department of Army Civilians (DACs) and Family Members	Active	Employment	02/11
677	"Virtual" Locality Pay for Department of the Army Civilians (DACs) Retiring Outside the Continental United States (OCONUS)	Active	Employment	02/11
553	Survivor Benefit Plan and Dependency & Indemnity Compensation Offset	Active	Entitlements	11/03
600	Family Care Plan Travel and Transportation Allowances	Active	Entitlements	11/06
621	Minimum Disability Retirement Pay for Medically Retired Wounded Warriors	Active	Entitlements	12/07
626	Traumatic Servicemembers' Group Life Insurance (TSGLI) for Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and Uniplegia	Active	Entitlements	12/07
633	Cost of Living Allowance (COLA) Dependents Cap	Active	Entitlements	01/09
654	Monthly Stipend to Ill/Injured Soldiers for Non-Medical Caregivers	Active	Entitlements	01/10
657	Reserve Component Inactive Duty for Training Travel and Transportation Allowances	Active	Entitlements	01/10
670	Medically Retired Service Member's Eligibility for Concurrent Receipt of Disability Pay (CRDP)	Active	Entitlements	02/11
515	Application Process for Citizenship/Residency for Soldiers and Families	Active	Family Support	11/02
574	Funding for Reserve Component Reunion and Marriage Enrichment Classes	Active	Family Support	11/04
596	Convicted Sex Offender Registry OCONUS	Active	Family Support	11/06
652	Family Readiness Group External Fundraising Restrictions	Active	Family Support	01/10
663	Eligibility Benefits for the Unremarried Former Spouses of Temporary Early Retirement Authority (TERA) Soldiers	Active	Family Support	02/11
665	Formal Standardized Training for Designated Caregivers of Wounded Warriors	Active	Family Support	02/11
667	Identification (ID) Cards for Surviving Children with Active Duty Sponsor	Active	Family Support	02/11
673	Space-Available (Space-A) Travel for Survivors Registered in Defense Enrollment Eligibility Reporting System (DEERS)	Active	Family Support	02/11
529	Retirement Services Officer Positions at Regional Support Commands	Active	Force Support	11/02
612	Army Career and Alumni Funding	Active	Force Support	11/06
653	Funding Service Dogs for Wounded Warriors	Active	Force Support	01/10
662	Comprehensive and Standardized Structured Weight Control Program	Active	Force Support	02/11
664	Flexible Spending Accounts (FSA) for Service Members	Active	Force Support	02/11
669	Medical Retention Processing 2 (MRP2) Time Restrictions for Reserve Component (RC) Soldiers	Active	Force Support	02/11
488	TRICARE Prime Remote for Fam Members Not Residing with Military Sponsor	Active	Medical	03/02
558	TRICARE Prime Travel Cost Reimbursement for Specialty Referrals	Active	Medical	11/03
583	Advanced Life Support Services on CONUS Army Installations	Active	Medical	01/06
618	Health and Wellness Centers (HAWC)	Active	Medical	12/07
629	24/7 Out of Area TRICARE Prime Urgent Care Authorization & Referrals	Active	Medical	01/09
638	Medical Nutrition Therapy (MNT) Benefits for All TRICARE Beneficiaries	Active	Medical	01/09
641	Over Medication Prevention and Alternative Treatment for Military Healthcare System Beneficiaries	Active	Medical	01/09
644	Shortages of Medical Providers in Military Treatment Facilities (MTF)	Active	Medical	01/09
646	Active Duty Family Members Prescription Cost Share Inequitability	Active	Medical	01/10
661	TRICARE Allowable Charge Reimbursement of Upgraded/Deluxe Durable Medical Equipment	Active	Medical	01/10
666	Full Time Medical Case Managers for Reserve Component (RC) Soldiers	Active	Medical	02/11
668	In-Vitro Fertilization (IVF) Reimbursement for Active Duty Soldiers and their Dependand Spouse	Active	Medical	02/11
675	TRICARE Medical Coverage for Dependent Parents and Parents-in-Law	Active	Medical	02/11
676	TRICARE Medical Entitlement for Contracted Cadets and Their Dependents	Active	Medical	02/11

#	Issue title	Status	Subject area	Entered
614	Comprehensive Behavioral Health Program for Children	Active	Medical/Command	12/07
625	Transitional Compensation (TC) Benefits for Pre-existing Pregnancies of Abused Family	Active	Medical/Command	12/07
648	Behavioral Health Services Shortages	Active	Medical/Command	01/10
650	Exceptional Family Member Program Enrollment Eligibility for RC Soldiers	Active	Medical/Command	01/10
609	Total Army Sponsorship Program	Active	Relocation	11/06
592	Post Secondary Visitation for OCONUS Students	Active	Youth	01/06
672	Reimbursement for Public School Transportation for Active Component (AC) Army Families	Active	Youth	02/11

**Issue 488: TRICARE Prime Remote for Active Duty Family Members Not Residing With Military Sponsors**

**a. Status.** Active

**b. Entered.** AFAP XVIII, Mar 02

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

**d. Subject area.** Medical

**e. Scope.** The FY01 National Defense Authorization Act (NDAA), Section 722, authorized TRICARE Prime Remote (TPR) for Active Duty family members (ADFM) who reside with members of the Uniformed Services eligible for TPR within the 50 United States. Military Service members are eligible for TPR if they live and have a duty assignment more than 50 miles (or 1 hour's drive time) from a military medical treatment facility (MTF).

**f. AFAP recommendation.** Provide TPR access for all ADFMs who reside in TPR zip code areas.

**g. Progress.**

(1) The FY06 NDAA, Section 714, provides for exceptional eligibility for TRICARE Prime Remote. In accordance with this new law, DoD may (not required) provide for coverage of a remotely located dependent or spouse who does not reside with a military sponsor if the Secretary determines that exceptional circumstances warrant such coverage. MEDCOM/OTSG had thought this provision would increase the opportunity for those SMs who must support split households, per their family care plans, to receive the benefit of TPRADFM. MEDCOM/OTSG anticipated that OSD would issue a proposed rule to implement the change.

(2) MEDCOM/OTSG monitored the status of the ASD (HA)/TMA decision to implement the NDAA FY06 provision. The ASD (HA) disapproved a proposed option/Decision Paper for implementing the TPRADFM waiver authority on 17 Jan 07. The Services received this notice on 18 Jul 07.

(3) The Acting TSG forwarded to ASD (HA) a 13 Aug 07 Memorandum formally requesting that the new ASD (HA) review the 17 Jan 07 disapproval. MEDCOM/OTSG knew that situations of Soldiers having to send their immediate Families to live in areas other than their home stations during deployment or recuperation will only continue to increase. Providing TPRADFM to additional ADFMs would give them access to the best TRICARE program with the least personal cost for these Families. It would also lessen the healthcare worry/concern for parents/Service members while they are deployed.

(4) TMA officially requested MEDCOM/OTSG 'example' criteria to help support our 13 Aug 07 Memorandum for a re-look of the disapproved TPRADFM waiver authority.

a. The formal Deputy SG reply to TMA's tasker, which provides criteria identified by MEDCOM/OTSG, was drafted by the MEDCOM/OTSG TRICARE Division and OTSG/ MEDCOM Staff Judge Advocate office.

b. The 2 criteria for TPRADFM approval are as follows:

(1) Activation of an official Family Care Plan that results in movement of the family, whole or part, to an area not classified as a Military Health System Prime Service Area.

(2) Official government authorized movement of a family under the Joint Federal Travel Regulation, Volume 1, Section U5222 (VARIOUS UNIQUE PCS ORDERS) in which the family is sent to a "designated place" that is not classified as a Military Health System Prime Service Area.

(5) TMA acknowledged receipt of the MEDCOM/OTSG supporting criteria as outlined in item #8b above. This occurred in the 2<sup>nd</sup> QTR FY08. This was followed by a 1 Apr 08 official TMA tasker to the Navy and USAF for their input to the MEDCOM/OTSG criteria. Both the Navy and Air Force concurred with MEDCOM/OTSG and our Family Care Plan criteria.

(6) On 10 Jul 08, TMA requested additional information from all the Services. The request was for the number of Service members that would be required to maintain an official Family Care Plan per Department of Defense Instruction, 1342.19, SUBJECT: Family Care Plans. MEDCOM/OTSG utilized the latest (FY06) official Army G1 demographics provided on their website; <http://www.armyg1.army.mil/hr/demographics.asp>. MEDCOM/OTSG provided numbers for both AC and RC populations as follows: Dual Military = 45,779; Single w/ Children = 38,478; Grand Total = 84,257.

(7) 21 Jan 09, TMA informed the Services that based on the criteria identified in section 8.b of this paper; a request for legislative change was submitted to the USD (P&R) office for signature. TMA added another sub-population to the legislative change request; College Bound children and we support this addition. Unfortunately, TMA informed the Services that the document has been in the USD (P&R) office since Nov 08, and the document requesting legislative change currently remains at the USD (P&R).

(8) 7 Apr 09, HQDA AFAP IPR was briefed on the status of the ASD (HA)/TMA proposed legislative proposal. The HQDA AFAP IPR acknowledged request for HQDA involvement in seeking USD (P&R) review and approval. TMA informed MEDCOM/OTSG on 6 Aug 09, that the legislative proposal is still stalled in the USD (P&R) office. The document has been in the USD (PR) office since Nov 08.

(9) 14 Apr 10, Collaborative efforts between MEDCOM, ASA (M&RA), [Medical and Health Affairs], and HA/TMA [Chief, Policy & Benefits Branch], have resulted in the determination that the stalled USD (PR) legislative proposal was not acted on. A proposed COA has been accepted by MEDCOM, ASA (M&RA) and TMA. Using the authority of NDAA FY06 exceptional circumstances, HA/TMA will attempt to push through a Rule Change to change Title 32 CFR. If approved by TMA/HA General Council and TMA leadership, this COA could be accomplished without ULB actions. The timelines for necessary action are TBD. Collaboration will continue between MEDCOM, ASA (M&RA), and TMA/HA.

(10) Attempts to support this population under existing Law, National Defense Authorization Act (NDAA) 2006, Section 714, was not supported by the Office of General Counsel (OGC) for the Assistant Secretary of Defense, Health Affairs. The OGC did not support the inclusion of relocating Active Duty Family Members based on an activated Family Care Plan as part of the "extenuating cir-

cumstances" definition described in Section 714 of NDAA 2006.

(11) Attempts for inclusion within Congressional markup process for NDAA 2011 were unsuccessful. The only option communicated by ASA (M&RA) is statutory change via the ULB process.

(12) GOSC review.

a. Nov 02. The GOSC reviewed the provisions of the FY03 NDAA as they relate to this issue.

b. May 05. GOSC did not support closing this issue. The changing Army footprint will impact the medical system.

c. Feb 11. The GOSC declared the issue active. TMA will draft/submit legislative proposal to authorize TRICARE Prime Remote for Families geographically separated from their military sponsor because of Family Care Plan activation.

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

**i. Support agency.** TMA

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

**a. Status.** Active

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

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

**d. Subject area.** Family Support

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

**f. AFAP recommendations.**

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

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

**g. Progress.**

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

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

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

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

(2) Fingerprinting and physical examinations.

a. A physical examination and electronic fingerprinting at a USCIS approved site is required to obtain an adjust-

ment of status for permanent residency, allowing individuals to receive a USCIS permanent resident card (aka green card).

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

(3) As a result of the 12 Jun 06 AFAP GOSC meeting, the Army G-6 was tasked to coordinate the military services' biometric capabilities with USCIS requirements. The Army G-6 Biometrics Task Force (BTF) reported an established process with USCIS, DoD, and the Federal Bureau of Investigation (FBI) whereby the Soldier/applicant applying for citizenship provides a signed Privacy Act statement to USCIS to allow for use of previously obtained fingerprints. This process does not exist for Family members of the Soldier.

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

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

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

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

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

vertise the availability of fingerprinting services (biometric collection).

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

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

(11) GOSC review.

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

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

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

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

**i. Support agency.** USAHRC, OTSG and OUSD (P&R)

#### **Issue 524: Military Spouse Unemployment Compensation**

**a. Status.** Active

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

**c. Final action.** No (Updated: 12 Jan 11)

**d. Subject area.** Employment

**e. Scope.** Military spouses are not entitled to receive unemployment compensation in all states when accompanying service members on a permanent change of station (PCS) move. Many states consider leaving a job due to military sponsor relocation as a voluntary departure, not involuntary; therefore, spouses do not qualify for unemployment compensation. The loss of income creates a financial hardship on the Family until the spouse is re-employed.

**f. AFAP recommendation.** Enact legislation directing all 50 states, the District of Columbia and the US Territories to establish relocation during PCS moves as an involuntary separation, thereby granting unemployment compensation to all qualified recipients.

**g. Progress.**

(1) The web links above have been added to the Army website at <http://cpol.army.mil/library/permis/> (listed un-

der Unemployment Compensation for Federal Employees (UCFE)).

(2) During 2002, the Policy and Program Development Division of the AG-1 for Civilian Personnel submitted this issue to the Civilian Personnel Management Service (CPMS) Benefits Legislative Work Group. In 2003, CPMS indicated that the issue had previously been submitted by Air Force in November 1997, but was disapproved citing a 1992 Supreme Court Decision. CPMS further indicated that they would not support further attempts to initiate this type of legislation.

(3) During the 2005 AFAP GOSC, it was recommended that Dr. Chu speak to the Governors' association. On February 27, 2006, the Secretary of Defense addressed the governors at a "Governors-only" session of the National Governors Association's winter conference.

(4) As an additional effort, it was decided during the March 2007 AFAP GOSC that support from the CASAs should be initiated. This initiative asked the CASAs to contact their state labor and employment offices to help reduce the financial hardships that our military Families experience and to ensure military spouses and BRAC affected spouses are granted UC when relocating with their sponsors. Letters were mailed to the CASAs in May 2009.

(5) To cover spouses affected by BRAC, letters to CASAs were changed to add BRAC affected spouses. This required sending letters to CASA representatives of 21 states to address only BRAC affected spouses: AL, AK, AZ, AR, FL, GA, HI, IL, KY, LA, MD, MA, MI, MO, NJ, NC, OK, OR, PA, SC, and WA.

(6) In response to the CASA support letters mailed May 2009, Hawaii and DC CASA representatives contacted AG-1 CP with willingness to help with this initiative. Continue to monitor via email for progress. Since May 2009, Hawaii provides UC eligibility.

(7) As of March 2010, IA provides UC eligibility. OH and TN are seeking state legislation to provide UC eligibility. TN has two bills that have not passed.

(8) In response to the January 2010 GOSC, coordination with the Office of Secretary of Defense, Personnel & Readiness (OSD P&R) has been established, and current state discussion on UC eligibility information is being updated on a constant basis.

(9) In response to the June 2010 GOSC, ACSIM with the assistance of AMC will convene a taskforce to focus on the remaining nine states. The taskforce was not convened, but AG-1 CP and AMC collaborated on the way ahead.

(10) In response to the 1 November 2010 AFAP Issue Review Session with LTG Lynch, recommended AG-1 CP provide a Strategic Communication Message for the CASA Luncheon on 15 December 2010 and an Action Plan to engage the three states with the largest concentration of military personnel (AL, LA, and VA) to provide UC for military spouses. The Action Plan included: ACSIM Commander communicate key messages during CASA luncheon presentation on 15 December 2010; IMCOM Commander provide Installation Commanders with STRATCOM messages to encourage State Governors to provide UC for Military Spouses; if further engagement is needed, HQDA Senior Leadership (ACSIM/IMCOM Cdr,

ASA (M&RA); & AG-1 CP) visits with State Governors to solicit support for granting UC to Military Spouses; and G-1 engagement during visits with CASA Reps.

(11) The Strategic Communication Message and Action Plan was approved and sent to ACSIM 13 December 2010.

(12) On 15 December 2010 the IMCOM Commander spoke to CASA delegates and engaged those states that provided UC to Military Spouses as well as those states which do not provide this benefit to Military Spouses. Overall the CASA luncheon and the IMCOM Commander's briefing were well received by all. The Virginia delegate was present, however, no additional feedback was provided as to the level of support for providing UC to Military Spouses to date.

(13) On 15 December 2010 IMCOM forwarded the AG-1 CP's STRATCOM message to G-6 for distribution to Alabama, Louisiana, and Virginia installation commanders in order to further engage State governors about the priority and importance of providing UC to Military Spouses.

(14) G-1 has incorporated this issue into the G-1 Talking Points to engage CASA Reps and State Governors on scheduled visits.

(15) GOSC review.

a. Jun 06. The issue remains active.

b. Jan 10. Issue remains active to continue to liaise with the 12 states that deny UC to military spouses who relocate because of military orders. The Deputy Undersecretary of Defense for Military Communities and Family Policy explained that his office has a full time staff member who is working this issue.

c. Jun 10. Issue remains active for another focused effort on the remaining ten states. The ACSIM said he would convene a task force and said he would need Army Materiel Command's assistance to work through this.

d. Feb 11. Issue remains active as the Army will monitor responses from the states of AL, LA, and VA to engagement of installation commanders from those states.

**i. Lead agency.** DAPE-CPZ

**k. Support agency.** DUSD (MCFP) & OSD (P&R)

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

**a. Status.** Active

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

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

**d. Subject area.** Entitlements

**e. Scope.** The United States Army Reserve does not have regional Retirement Service Officers to assist individual Soldiers and Families. Two Army Reserve Personnel Command (AR PERSCOM) representatives provide retirement counseling services as an additional duty. Soldiers may not receive crucial retirement counseling which adversely affects their ability to make timely and accurate decisions regarding their entitlements and benefits.

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

**g. Progress.**

(1) Reserve retirement is a two-step process. In step one, receipt of the *Notification of Eligibility for Retired Pay Age 60 (Twenty Year Letter)*, the Reserve Soldier must decide to: remain in an active status; become a "gray area" retiree, subject to recall; be discharged or separated from the military; and make an RC-SBP election.

The AR Soldier has 90 days to make these decisions and return the forms to HRC. Step two is receiving and completing the Retirement Application Packet around the age of 58. The retirement application is mailed to the Reserve Soldier and returned to HRC. HRC-STL has Career Advisors and Retired Pay analysts available to assist AR Soldiers in answering questions or specific inquiries

(2) USARC initiated its Pilot RSO Program on 3 December 2010 by putting a lieutenant colonel on temporary orders as the Pilot RSO. She will gather metrics and develop procedures while supporting the 19 states of the 88<sup>th</sup> Regional Support Command (RSC) under a "holistic approach". The lessons learned and metrics gathered during this pilot program will be used to develop permanent RSO positions at each RSC in order to provide retiring and retired USAR Soldiers, surviving spouses, and their Families retirement services on par with those received by their Active Duty counterparts. The USARC Retirement Services Program Manager has also submitted an initial budget request for one GS11 government civilian RSO in each RSC for a total cost estimate of \$1.2M. The USARC Pilot RSO program will determine an accurate cost for the total number of RSOs required to support each RSC.

(3) There is an agreement between Army Retirement Services, HRPD, G-1; and G-1, USARC that what is ultimately needed are four (4) personnel at each of the 4 Regional Personnel Support Centers. Efforts to build documentation for future POM action to justify added billets at each RSC are ongoing.

(4) GOSC review. The Feb 11 GOSC declared the issue active until USARC authorize and fund RSO positions.

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

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

#### **Issue 553: Survivor Benefit Plan (SBP) and Dependency Indemnity Compensation (DIC) Offset**

**a. Status.** Active

**b. Entered.** AFAP XX, Nov 03

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

**d. Subject area.** Entitlements

**e. Scope.** Spouses or children of active duty Soldiers are provided Survivor Benefit Plan (SBP) annuity (55% of retired pay entitlement) upon a service-connected death. Dependency and Indemnity Compensation (DIC) (current rate of \$948/month) is payable in all service-connected deaths. SBP to the surviving spouse is offset dollar for dollar by receipt of DIC. Survivors of a deceased Soldier deserve full survivor benefits from the military service and the VA.

**f. AFAP recommendation.** Eliminate the SBP/DIC offset and award full SBP and DIC for service-connected deaths.

**g. Progress.**

(1) A provision of the NDAA 2008 granted partial relief by establishing a Special Survivor Indemnity Allowance (SSIA) for spouses affected by the DIC offset of the SBP annuity. The SSIA will be \$50 per month for FY2009; increases in \$10 increments to \$100 per month in FY 2014; and SSIA will end 2016.

(2) A provision of Public Law 111-31, 22 Jun 09, changed SSIA as follows: for months during fiscal year 2014, \$150; for months during fiscal year 2015, \$200; for months during fiscal year 2016; \$275; for fiscal year 2017, \$310; and will end 1 October 2017.

(3) The United States Court of Appeals for the Federal District upheld Sharp v. United States allowing three military surviving spouses to receive both SBP and DIC payments with no offset, based upon remarriages after age 57 and being eligible for SBP and DIC.

(4) Two legislative proposals that would eliminate the SBP/DIC offset (H.R. 775 and S. 535) were introduced in the 111<sup>th</sup> Congress but were not enacted. The legislative proposals must be sponsored and reintroduced in the 112<sup>th</sup> Congress.

(5) On 24 Jul 09, the CSA signed the memorandum to the CJCS asking for support to convene an interagency working group to look at working toward a single payment that would eliminate the confusion and perception of inequality caused by the offset.

(6) The Assistant Director Military Compensation, Office of the Deputy Undersecretary of Defense for Military Personnel Policy, sent a reply for the Secretary of Defense's approval to send to the CJCS, stating that Undersecretary of Defense for Military Personnel Policy would convene the interagency working group. If the letter is approved, the Office of the Deputy Undersecretary of Defense for Military Personnel Policy plans to ask the Services and JCS for members to participate in the working group.

(7) On 26 October 2010, Mr. John Radke, Chief Army G-1 Retirement Services Office contacted Ms. Jerilyn B. Busch, Director Military Compensation, and Office of the Deputy Undersecretary of Defense for Military Personnel Policy, to confirm DOD's current position on eliminating the SBP/DIC offset. Ms. Busch confirmed that DOD continues to oppose the elimination of the SBP/DIC offset.

(8) GOSC review.

a. May 07. The GOSC concurred that this issue remain active to monitor legislative proposals.

b. Feb 11. The GOSC continues to request this issue stay active to monitor legislation in the 112<sup>th</sup> Congress and OSD's support of an interagency working group to explore a single survivor payment.

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

### **Issue 558: TRICARE Prime Travel Cost Reimbursement for Specialty Referrals**

**a. Status.** Active

**b. Entered.** AFAP XX, Nov 03

**c. Final action.** No (Updated: 29 Mar 10)

**d. Subject area.** Medical

**e. Scope.** The TRICARE Prime travel reimbursement benefit is distance based and not cost based. Reimbursement is available for non-Active Duty

TRICARE Prime enrollees and TRICARE Prime Remote beneficiaries when they are referred for specialty care more than 100 miles from the primary care manager location. The current benefit does not take into account the impact of multiple trips of shorter distance. Beneficiary travel costs for care provided by specialty providers' results in significant costs to beneficiaries. This is especially true when care requires multiple trips to the provider.

**f. AFAP recommendation.** Reimburse TRICARE Prime and TRICARE Prime Remote enrollees actual cumulative travel costs for specialty provider care.

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

(1) OTSG, in conjunction with TMA, has explored several options for meeting this recommendation, per the Required Actions/Milestone section. These options were rejected due to significant increases to the Defense Health Program and increased administrative burden on the TRICARE Regional Offices (TROs) and the MTFs. The following are a few key points related to the previously developed recommendations.

a. OTSG proposed a legislative change (Title 10, United States Code, 1074i) to the benefit allowing travel cost reimbursement for cumulative distances of more than 100 miles.

b. TMA formed a temporary workgroup to analyze and discuss the OTSG proposal. The workgroup recommended non-concurrence for a 100-mile cumulative change due to significant costs and increased administrative overhead, but did recommend changing the current benefit to 60 miles. This second proposal would allow for reimbursement of travel expenses when a beneficiary travels more than 60 miles (one-way) for specialty care.

c. The Principal Deputy, Assistant Secretary of Defense (Health Affairs) (PD ASD (HA)) was opposed to both a 100 cumulative mile change and the workgroup recommended 60-mile proposal. TMA estimated a 100 cumulative mile benefit would cost an additional \$23.1M/year over the \$8M/year for the current benefit. In addition to the increased cost, a 100-mile cumulative benefit would create an increased administrative burden on the TROs and MTFs responsible for executing the current benefit.

d. Since TMA opposed both recommendations, OTSG has re-examined the benefit proposal in order to develop an alternative approach to meeting the AFAP recommendation.

(2) OTSG's then proposed an alternative proposal (based on 100 miles or less) that would have minimized the overall cost of a cumulative travel benefit by focusing on two areas.

a. First, the proposal would eliminate the need for the patient to file a claim. Patients will receive automatic reimbursement based on analysis and calculation of data found on TRICARE claims. This would eliminate the current processing fee of \$32.50 per claim.

b. Second, the new proposal would only reimburse for mileage expenses. Since the covered trips will be 100 miles or less, there is a reduced need to cover all reimbursable expenses. Most patients making trips 100 miles or less are incurring only mileage expenses. There will

be no reimbursement for other expenses such as per diem, tolls, and hotels.

(3) A detailed cost estimate on this new alternative proposal had revealed significantly higher than expected costs. A sample of beneficiaries shows that approximately 5% of family members will qualify for this new travel benefit. This is within the 5-10% range of the original estimate. However, family members are traveling more cumulative miles than originally expected. Family members are traveling an average of 239 one-way miles per quarter. Original estimates were 150 miles. The JFTR would reimburse family members for round trip miles. Under this new estimate, the JFTR would reimburse for an average 478 miles per eligible family member per quarter. If 5% of all active duty family members are reimbursed for this benefit, it would cost \$25M/quarter or \$100M/year.

(4) This proposal will still require legislative (Title 10, United States Code, 1074i) and regulatory (Joint Federal Travel Regulations) changes.

(5) This proposal did not change any aspect of the current travel benefit. Prime enrollees traveling more than 100 miles for specialty care will experience no change in benefits.

(6) Cost methodology was then re-validated to determine accuracy. The Methodology is sound and the proposal costs were deemed valid, based on historical data from the MHS Management and Analyst Reporting Tool (M2) data warehouse.

(7) TSG briefed topic at General Officer Steering Committee (GOSC) on 27 Jan 2009. This potential benefit was seen as an important part of caring for our Soldiers and their Families.

(8) In August 2009 we received memorandums from the Surgeons General of the US Navy and US Air Force offering guarded, support for the proposal, while opining that added DHP cost may be a factor. In a 25 September 2009 email communication from the USAF, they indicated a neutral position based on the counter-intuitive logic that many USAF beneficiaries would be eligible for this benefit and the associated cost for the government.

(9) In early September we received TMA's formal response to our proposal. In the memo, TMA's Deputy Director, expressed concerns about the cost of the proposal and indicating the current travel benefit was adequate. The memo cited Section 713 language that NDAA 2010 that would have reduced the mileage limitation to 50 miles. This language for Section 713 does not appear in post-committee versions of NDAA 2010. In December 2009 a memo was then sent to the Deputy Director, TMA requesting an update on the TMA position.

(10) In January 2010 we received an email from TMA indicating that NDAA 2010 provides the latitude for reimbursement under exceptional circumstances. The TMA action officer has indicated that TMA is proposing a rule under which exceptional circumstances would be defined as travel less than 100 miles but with over an hour drive time. OTSG has been advised that TMA does not support any additional enhancement beyond this proposed rule. We are waiting for TMA guidance on this NDAA language. Currently, the proposed rule is still being reviewed at the Office of Management and Budget

awaiting publication in the Federal Register for a 60 day public comment period. Once the final rule is published the Joint Federal Travel Regulation will be changed to reflect the new medical travel benefit.

(11) GOSC review.

a. Nov 06. The GOSC requested the issue remain active.

b. Feb 11. The VCSA noted that this issue has been worked for eight years. He said to push this issue, but if we can't get movement, we may need to consider closing it out. TMA is working on a proposed rule that would define "exceptional circumstances" as travel time in excess of 1 hour but less than 100 miles.

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

**i. Support agency.** TMA

### **Issue 574: Funding for Reserve Component (RC) Reunion and Marriage Enrichment Classes**

**a. Status.** Active

**b. Entered.** AFAP XXI, Nov 04

**c. Final action.** No (Updated: 1 Sep 10)

**d. Subject area.** Family Support

**e. Scope.** Funding is not available to provide the Prevention and Relationship Enhancement Program (PREP) training required by the Deployment Cycle Support Plan (DCSP) for RC Soldiers and their Families in contrast to the Active Component. Soldier's pay and allowances, spouse travel, child care, supplies, materials, and facilities are not funded to support PREP training. Funding this program, will enhance relationships, reduce the risk for abuse and divorce, increase readiness and retention and bring the RC into full compliance with this phase of the DCSP.

**f. AFAP recommendation.** Fund PREP for the Army National Guard and the US Army Reserve.

**g. Progress.**

(1) USAR actions.

a. The CAR in the Warrior Citizen Message, dated 13 January 2005, authorized and directed the implementation of DCS Task 3.4.7(One day Marriage Workshop Training). Army Reserve submitted an Unresourced Requirement (URR) for \$12 million; however, it was not approved in the FY05 supplemental.

b. The program is referred to as "Strong Bonds" is the Army Chaplain program providing training to couples, singles and Families. This program evolved from the Building Strong and Ready Families program.

c. USARC Command Chaplain's office allocates the funding for each command per their request.

d. Marriage workshops are being planned in areas that have the highest concentration of Family members within the region of the RSC to make it as easy as possible for Soldiers and spouses to attend. Since 2004, the Army Reserve has conducted almost 1,000 events.

e. VCSA direction GOSC 4 May 2005: The VCSA said that in the near term we cannot forget that we've got a far-term issue in terms of the health of the force. He asked the Director of the Army Budget to find out why this initiative (Funding of Marriage Retreats) fell off the \$57B supplemental spreadsheet. He concluded by saying, "We'll get this resolved."

f. In FY11 \$6.9 Million OMAR provided in POM, Army Reserve commits \$4.3 Million RPA.

(2) ARNG actions.

a. The ARNG Chaplain office will request additional funding for FY11 to meet shortfalls in excess of \$6.6M. Program taxes up to \$1.3M (internal to the Army National Guard), and an additional documented shortfall of \$5.3M are essential for continuation of the program. Additionally the need for Pay and Allowances will allow for easier execution and obligation control.

b. Completed FY10: 124 more trained instructors. A total of 867 Strong Bonds trained instructors have been trained since 2005.

c. Completed FY10: over 200 of the planned 559 Strong Bonds Events held in FY10. 200 After Action Reports submitted to date. AAR's are at 98% return rate compared to 73% in FY09.

d. Each Strong Bonds program event is designed to train 60-80 people (30 couples and/or 30 families). There are cost constraints per event that the ARNG should not exceed. Each event has been cost analyzed to not exceed \$29,500 dollars for lodging and all other expenses for each weekend. Service member pay and allowance is the responsibility of the state. The JFHQ Chaplain and the State Family Program Director (SFPD) received guidance on all necessary requirements to conduct Strong Bonds Events with funding limitations from ARNG Office of the Chaplain. Operating guidance and the Strong Bonds Program MOI for FY11 will be published to the states NLT 30 Aug 2010.

e. The JFHQ Chaplain and the SFPD continue to be responsible for logistics support in the conduct of Strong Bonds events. These responsibilities include hotel procurement, meeting room negotiations, informational materials, Invitational Travel Orders for spouses, and budget management.

f. The Active Duty, USAR and ARNG Chaplains maintain the [strongbonds.org](http://strongbonds.org) website for registration, collection of metrics/AARs, submission of funding request and financial management oversight. Also available on [strongbonds.org](http://strongbonds.org) are materials, brochures, FAQ and articles about the Strong Bonds program for Soldiers and their families. This website was launched on 15 May 2006.

g. The JFHQ chaplain and JFHQ SFPD coordinate and schedule Strong Bonds program events. The Office of the Chaplain and the Family Program Office ensure that the event is within the states allocation of events and that the Chaplain training is supportable by a trained instructor. This is for quality control and tracking.

h. The Chaplain instructor administers a survey assessment tool before and after the seminar to measure the effectiveness of the seminar on improving communication, stress management, and the expectation of reunion. Data collection is ongoing for historical purpose.

i. After Action Reports (AARs) are received from each State and Territory following each training event to account for attendance and total funds expended.

(3) GOSC review.

a. May 05. The VCSA said that this is an important issue addressing the health of the force and asked for

feedback on the funding of marriage enrichment for the Reserve Components.

b. May 07. The issue remains active.

c. Jan 10. Issue remains active to pursue funding to train instructors and attendance at Strong Bonds retreats for Reserve Component Soldiers and Families. Army Materiel Command requested expansion of Strong Bonds to DA Civilians. The VCSA referenced a five-year longitudinal study that shows divorce rates are five times less for those who participate in Strong Bonds. The Chief of Chaplains clarified that the study also showed a correlation to higher marriage and Family satisfaction. The Deputy Director for Army Budget said they are addressing the funding of Strong Bonds across all components for FY10.

**h. Lead agency.** ARZ-CH; ARRC-CH

**i. Support agency.** NGB-SFSS

### **Issue 583: Advanced Life Support Services on CONUS Army Installations**

**a. Status.** Active

**b. Entered.** AFAP XXII, Jan 06

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

**d. Subject area.** Medical

**e. Scope.** The Department of the Army does not require Advanced Life Support (ALS) services on CONUS Army installations. The Army provides Basic Life Support (BLS) services; however, timely ALS services are not provided on all CONUS Army installations. In accordance with the applicable National Fire Protection Association (NFPA) guideline for ALS services, an 8-minute response time to 90% of the incidents is the accepted standard. Lack of ALS services increases response time which jeopardizes the health and safety of the CONUS Army Family.

**f. AFAP recommendation.** Mandate that all CONUS Army installations to include Alaska and Hawaii provide Advanced Life Support services on or near the installation in accordance with the National Fire Protection Association standard.

**g. Progress.**

(1) Emergency Medical Services (EMS) are available at all Army installations in the United States, but are provided in a variety of ways. EMS may be provided through the MTF, through the garrison fire department, and/or through an off-post provider. There is no single Army entity or office having overall responsibility for regulating or resourcing EMS operations. There is no Army-wide standard for ALS response time. The NFPA "8 minute" standard represents the opinion of many subject matter experts, and is accepted on a wide basis. The difference between the recently published standard in the DoDI 6055.6's Table E3.T1 and the NFPA standard revolves around definitions of response times and how it is measured. The DoDI uses an aggregate time of 12 minutes for ALS or 10 minutes for Basic Life Support (BLS) as the time from "when the call is received to an EMS team's arrival on the scene". The NFPA definition of 8 minutes measures the response time between "the EMS team leaving the station and arriving on scene".

(2) While most Army installations currently meet the proposed "8-minute response" standard, this standard

may not be feasible on some installations because of their size, mission, and geographical location. This variation in response times also exists within civilian EMS systems.

(3) On 6 Oct 05, MEDCOM published standards for EMS programs operated by Army MTF's but did not include response time mandates due to differences in EMS requirements, missions, and geographical locations. The standards require that the programs, at a minimum, meet the state and local standards of the surrounding community. Commanders may request exceptions or variances due to local circumstances or conditions.

(4) On 9 Mar 06, IMCOM and MEDCOM first met in a work group to discuss standards for all Army EMS operations and to determine a way ahead. A data call of garrisons and MTF's was initiated to determine the current baseline for EMS operations and the resources that would be needed to meet an Army-wide standard. IMCOM agreed to analyze the data call responses to determine cost estimates to conduct ALS at the installations that currently did not provide that service IAW the 8 Min/90% standard.

(5) On 22 Aug 06, the IMCOM and MEDCOM met in a Work Group (WG) to discuss the analysis of costs associated with providing ALS care to installations within the 8 minute NFPA standard. IMCOM's analysis of the available data indicates it would cost about \$25.1M more to provide ALS at the installations that lack this service. The analysis also estimated that it could cost up to \$88 million to conduct ALS at the 83 installations pertinent to AFAP Issue 583. However, only \$35.7M was reported in the data call responses.

(6) MEDCOM recommended that IMCOM and MEDCOM Resources Management (RM) Directorate conduct a mutual, open book analysis of EMS costs at Army installations to obtain a more accurate estimate of required costs to conduct ALS. MEDCOM EMS data was revalidated by MEDCOM's RM Directorate. Following this process, MEDCOM RM continued to recommend further study with input from each installation's RM to obtain a more accurate estimate of costs. In a Memorandum dated 1 Feb 07 to TSG from Commander, IMCOM, it was stated that they saw no need for a comprehensive open book analysis of MEDCOM pre-hospital EMS costs.

(7) On 1 Dec 06, TSG recommended by memo to CG, IMCOM that MEDCOM and IMCOM mutually adopt the EMS response standards found in DoDI 6055.6, DoD Fire and Emergency Services. CG, IMCOM subsequently indicated full agreement by memo dated 1 Feb 07. DoDI 6055.6, later published on 21 Dec 06, establishes response time standards in various functional areas.

(8) On 13 Jul 07, the MEDCOM/IMCOM WG conducted a WG meeting chaired by the MEDCOM CoS and the IMCOM Chief of Operations. The Commands agreed to the EMS response standards as outlined in DODI 6055.06, DoD Fire and Emergency Services Program, dated 21 Dec 06, and to determine the resources needed to ensure all installations meet the standard.

(9) MEDCOM/IMCOM met in San Antonio from 17-21 Sep 07 to draft the plan for implementing the recommendation and develop a memorandum of agreement (MOA) between the two Commands which will document pre-

hospital EMS responsibilities addressing BLS and ALS on each IMCOM/MEDCOM installation.

(10) On 11 Oct 07, the draft MOA was briefed to the IMCOM SEL. The document was then slightly modified and re-staffed to the IMCOM regions for feedback by 17 Dec 07.

(11) On 6 Feb 08, the MEDCOM/ IMCOM WG met in San Antonio to evaluate the regional feedback and discuss unresolved funding issues prior to developing an OPORD instructing Installations and medical tenets to develop local MOAs and transition plans prior to moving the Command level MOA forward for approval.

(12) On 16 May 2008, a joint tasking from both MEDCOM and IMCOM was sent to their respective subordinate commands instructing them to develop local MOAs (based on the draft Command MOA) and transition plans to identify required resources and costs associated the provision of EMS within each installation as provided by the draft MOA.

(13) IAW the above joint tasking, local draft MOAs and transition plans were developed as required.

(14) This topic was briefed to the DP91/.59 CoC on 28 August 2009 due to TRADOC concerns regarding EMS range support and impact of MOA on current range support arrangements. TRADOC concurred with MOA after it was agreed to add sentence in the MOA stating, "This MOA does not affect any existing EMS range support agreements in place".

(15) The MOA was signed by the TSG on 22 Sept 2009 and forwarded to IMCOM. MOA was signed by IMCOM on 6 March 2010. MEDCOM and IMCOM jointly prepared implementing instructions for completion of local MOAs.

(16) HQDA validated IMCOM's EMS UFR requirements during the POM 12-16 review but they were not approved as "critical," and therefore remain unfunded. Installations and MTFs have been advised to maintain status quo until UFR funding is secured. Requirements will be re-submitted in the upcoming POM 13-17 cycle.

(17) GOSC review.

a. Jun 06. The issue remains active.

b. Jan 10. Issue remains active pending approval of the MOA between MEDCOM and the IMCOM and subsequent resourcing.

c. Jun 10. The Surgeon General requested the issue remain active pending funding (\$12M) in the 13-17 POM.

d. Feb 11. The GOSC declared the issue active. OTSG will resubmit EMS requirements during the POM 13-17 cycle. MEDCOM and IMCOM will jointly develop implementing instructions for completion of local MOAs.

**h. Lead agency.** MEDCOM

**i. Support agency.** IMCOM

## **Issue 592: Post Secondary Visitation for OCONUS Students**

**a. Status.** Active

**b. Entered.** AFAP XXII, Jan 06

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

**d. Subject area.** Education

**e. Scope.** OCONUS high school students incur greater travel expenses to visit post secondary schools than CONUS based students. Although many informational

resources are available, on-site visits afford students the opportunity to make the most informed decision. Upon arrival at the CONUS point of entry, OCONUS Families will assume comparable travel expenses to those of CONUS Families. Minimizing the disparity in travel expenses will decrease the financial burden to OCONUS Families.

**f. AFAP recommendation.** Authorize a one-time round trip airfare to a CONUS point of entry for OCONUS students, who have been accepted to a post secondary school, and one guardian.

**g. Progress.**

(1) Army proposed a change to the JFTR and US Code to the military advisory panel (MAP) members of the Per Diem, Travel and Transportation Allowance Committee (PDTATAC). The other Services have no strong position for or against this issue.

(2) This initiative requires a change in law after gaining the support from the other Services, OSD and Congress.

(3) During the fourth QTR of FY 08, the Army ULB COC did not support the FY 11 ULB and advised pursuing a policy change for increasing the Space A travel priority for High School Seniors. We discussed the COC decision with USAREUR, and they advised DAPE-PRC to pursue a post secondary education travel program that mirrors the current dependent student travel program. The current dependent student travel program allows round trip dependent transportation at Government expense from the permanent duty station (PDS) to the school and return. Changing the Space A travel rules for High School students falls short of achieving what USAREUR proposed in this AFAP submission. As such, DAPE-PRC will re-submit a ULB for FY 12 while simultaneously eliciting support from EUCOM thru USAREUR for the ULB to allow round trip transportation at Government expense from the PDS to the prospective school and return.

(4) On September 2009, Army submitted a revised ULB for FY 12 along with updated cost estimates based on the number of high school seniors enrolled in OCONUS DoDDS schools for each Service, and estimates from the National Center for Higher Education Management Systems of High School graduates going directly to college.

(5) On September 2009, Army informed the JFTR Military Advisory Panel (MAP) of the Army's intent to convene a Principal's meeting (senior roundtable) and gain consensus on this issue. During the Principal's meeting, DAPE-PRC will also propose a revised and less ambiguous AFAP recommendation for approval that reads, "Authorize one annual round-trip for one parent to accompany their dependent senior student at any time within a fiscal year (1 Oct - 30 Sep) between the member's OCONUS PDS and the dependent student's school in the U.S. The service member senior student must demonstrate guaranteed acceptance at a post secondary institution. The purpose is to allow similar transportation allowances that are currently authorized for dependent student transportation in the Joint Federal Travel Regulations (U5260 Dependent Student Transportation) for one accompanying parent."

(6) On December 2009 OSD convened a ULB Summit. DAPE-PRC briefed this AFAP issue during this ULB Summit in preparation for the FY 12A ULB final vote.

(7) On January 2010 OSD released the results of the FY 12A ULB final vote. The voting members deferred this AFAP issue for the FY 13 ULB cycle. DAPE-PRC requested from USAREUR G-1 an updated business case and their current position on this AFAP issue. We will evaluate the comments received on February 2010 from the voting members of the FY 12A ULB Summit, integrate USAREUR input, and prepare a revised ULB for submission during the FY 13A ULB cycle.

(8) Revised FY 13A ULB to include doable recommendations from the Council of Colonels for resubmission in the next ULB cycle while adhering to the scope of the issue. Recommendation from Council of Colonels includes providing a better business case to include DOD civilians and address the inequity between CONUS and OCONUS students.

(9) Awaiting guidance on the way ahead on this issue based on a noted from the ACSIM to the USAREUR Commander. No response received from USAREUR on this issue, as of 06 Jan 2011.

(10) GOSC review. The Feb 11 GOSC declared the issue active. Initial discussion focused on whether a round trip ticket to CONUS is most needed before or after college acceptance or if online opportunities to "view" colleges are sufficient. Discussion shifted to issues raised by the Army Teen Panel regarding college application difficulties experienced by OCONUS students. The Army Teen Panel prioritized an issue that addresses standardized applications for college bound OCONUS students. G-1 will Work with USAREUR to acquire the necessary empirical data that will determine the viability to resubmit for the FY14A cycle.

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

**Issue 596: Convicted Sex Offender Registry**

**a. Status.** Active

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

**c. Final action.** No (Updated 13 Oct 10)

**d. Subject area.** Family Support

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

**f. AFAP Recommendations.**

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

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

**g. Progress.**

(1) G-1 led a working group which identified gaps in policies and procedures for identifying, tracking, and managing sex offenders. G-1 convened a working group which identified gaps in policies and procedures, and developed an action plan with 30 actions to close the gaps. SECARMY approved the action plan 17 Jul 10. G-1 identified 11 regulations that require updating. AR 27-10 (Military Justice) is at Army Publications. AR 190-45 (Law Enforcement Reporting) has completed legal review and is pending publication in the Federal Register. Three regulations (AR 420-1 Army Facilities Management, AR 614-200 Enlisted Assignments and Utilization Management, and AR 635-200 Active Duty Enlisted Administrative Separations) have had revisions submitted to the proponent. The remaining six are still being worked. At 2 Oct 10, the ACSIM identified a 12<sup>th</sup> regulation (AR 608-11) for revision.

(2) As a member of the Department of Justice's International Working Group (IWG) Army G-1 is assisting in the development of an international tracking system for registered sex offenders when they leave the United States. Army G-1 will continue to participate in the IWG to determine if Army sex offender data can be tracked in this new international tracking system. Based on the results of that initiative, and the number of sex offenders identified, the Army will then determine the cost effectiveness of establishing its own system, posting a roster to current IMCOM web sites, or utilizing the DOJ international tracking system. Army participated in IWG meeting 23 Sep 10. Based on DOJ actions and initiatives, personnel going overseas who are registered sex offenders may be turned back by the host nation. The Department of Homeland Security will notify the host nation (and DoD and the Army) that a registered sex offender is traveling to their country. The host nation will make the decision on whether to allow the registered sex offender entry into the country.

(3) Human Resources Command (HRC) is currently tracking Soldier sex offenders in the personnel database. The initial scrub identified Soldiers that required coding as sex offenders. Through separations, the number has been reduced by half. HRC also identified 8 Soldiers who require reclassification. A limited number have not been reclassified.

(4) GOSC review.

a. May 07. The issue was declared active.

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

**h. Lead agency.** DAPE-HRH

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

## **Issue 600: Family Care Plan (FCP) Travel and Transportation Allowances**

**a. Status.** Active

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

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

**d. Subject area.** Entitlements

**e. Scope.** Soldiers requiring activation of Family Care Plans (FCP) are not compensated for the travel of dependents and shipment of the dependent's household goods. Selected household goods; such as infant equipment, computers and personal comfort items, are necessary for the emotional and physical well being of the DEERS dependent(s) in their new environment during an already stressful time. Implementation of Soldier's FCP should not create additional financial hardship and emotional stress on the Soldier and Family.

**f. AFAP Recommendations.**

(1) Authorize funded travel for DEERS dependent(s) to FCP designated location for deployments greater than 179 days.

(2) Authorize funded shipment of household goods limited to 350 pounds weight allowance per DEERS dependent to FCP location for deployments greater than 179 days.

**g. Progress.**

(1) In February 2007, Army MAP member of the Army G-1 proposed a change to the JFTR to establish this authorization. The MAP members of the other Services were not supportive of this proposal. Additionally, Per Diem Committee Director advised Army MAP member that there currently is no legislative basis to add this authorization to the JFTR.

(2) A legislative change is required to establish the basis for this authorization in the JFTR and our mechanism for transacting such a change is the Unified Legislative Budget (ULB) process. Army G-1 submitted this item as a ULB for FY 10. With all the other competing priorities in the ULB process and the relatively high cost of this proposal, Army did not support sending it to the Department of Defense (DOD) for consideration.

(3) DAPE-PRC submitted this item again as a ULB for consideration in FY 11. USD P&R deferred it to FY 12. The support for the proposal was mixed in FY 11. Army, J1, SOLIC, RA, and HA supported the ULB. Air Force, US Coast Guard (USCG), and OSD PA&E voted to defer the proposal to FY 12. Air Force advised voting organizations to consider a 120 day TDY or greater and consider targeting the proposal by grade. USCG advised the proposal needs further analysis. PA&E advised voting organizations to consider targeting the proposal by grade. Navy and COMPT did not support the proposal. Navy advised this is a policy issue not statutory, and statutory authority already exists under 37 USC 406(e), therefore a ULB is unnecessary. COMPT advised if the member decides to move their dependents back and forth between the designated location and their duty station, they have basic pay and FSA to pay for doing so, and it is the individual's responsibility to take care of his/her Family. COMPT also indicated the proposal needs further analysis.

(4) The JFTR outlines a variety of options that authorize travel and transportation allowances for members to relocate dependents with secretarial waiver to CONUS or OCONUS designated location. These options are incident to a member receiving indeterminate TCS order or a PCS move to/from an OCONUS unaccompanied tour. There is no authorization for travel and transportation al-

lowances when a service member deploys greater than 179 days with a unit on TCS orders.

(5) On September 2009, Army informed the JFTR Military Advisory Panel (MAP) of its intent to convene a Principal's meeting (senior roundtable) and gain consensus on this issue.

(6) On January 2010, DAPE-PRC briefed the Deputy G-1 and the VCSA during the AFAP General Officer Steering Committee (GOSC). The VCSA concurred with the Deputy G-1's recommendation to refocus Army Strategy since the preponderance of the affected population is Army (approximately 67%) to include Sunset clause provision with Army as the "Pilot Program" or Service discretion (for deployments greater than 179 days).

(7) On January 2010, DAPE-PRC resubmitted an updated ULB with revised cost estimates after carefully evaluating data from 2003-2009 on Army losses due to parenthood, which averaged 2003 uniformed members. The ULB was deferred to the FY 13A ULB Cycle.

(8) During the 2<sup>nd</sup> quarter of FY 2010, DAPE-PRC participated in a ULB peer review with Army and Sister Service. DAPE-PRC will include ULB peer review recommendations from Sister Service to strengthen Army's business case. Revise FY 13A ULB and incorporate ULB Council of Colonels recommendations.

(9) Awaiting result of a pending meeting with the ASA M&RA, ACSIM and Director PR on the way ahead.

(10) GOSC review. The Jan 10 GOSC declared the issue remains active to explore alternative strategies to resolve this issue.

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

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

**a. Status.** Active

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

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

**d. Subject area.** Relocation

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

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

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

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

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

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

to standardize TASP. FMWRC recommended that TASP be viewed from a holistic perspective that takes into consideration the current Army OPTEMPO.

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

(3) In Apr 10, FORSCOM IG agreed to provide their findings through appropriate channels to ACSIM to consider when revising AR 600-8-8.

(4) In May 10, Command Sergeant Major (CSM), ACSIM/IMCOM convened a working group to identify ways to improve TASP. Participants included CSMs from FMWRC and Korea; Sergeant Major, DA G1; Chief, IMHR-M; Chief, OASCIM Soldier Family Readiness Division; the ACSIM/IMCOM Surgeon, and action officers from OACSIM-ISS, FMWRC and IMCOM. The group decided that the regulatory guidance for TASP is clear, but needs visibility and enforcement Army wide.

(5) May through Sept 10, ACSIM/IMCOM CSM facilitated a series of meetings with select organization to solidify issues and develop a concept plan to improve TASP.

(6) In May 10, ACSIM-ISS in collaboration with ACSIM/IMCOM CSM drafted a Strategic Communication message to update Army Soldiers and Families on the status of improving TASP, the message was updated in Dec 10.

(7) In Jun 10, IMCOM CSM briefed the ACSIM on the concept to improve TASP by directing IMCOM G-1 and the installation DHR to designate Sponsorship Integrators to implement TASP. The ACSIM approved the concept, but requested that the CSM identify those services that would not be provided in order to execute the new TASP requirements.

(8) In Jul 10, ACSIM/IMCOM CSM met with DoD Relocation and Family Programs Division regarding the newly developed e-sponsorship database. Findings concluded that the e-sponsorship training system is an effective training tool but lacks the capability to meet the intended end-state of having a live person to monitor the status of the Sponsorship Program Counseling and Information Sheet (DD Form 5434) and engage commands when necessary to ensure that Soldiers, Civilians, and Family members receive a sponsor when transitioning to gaining commands.

(9) In Jul 10, FMWRC-FP submitted a quad chart and information paper to ACSIM/IMCOM CSM that outlined Relocation Readiness requirements and emphasized that the program is not funded to provide sponsorship. There are 10 Army Community Service standards assigned to the Relocation Readiness Program, 9 out of 10 standards are congressionally mandated, therefore must be accomplished. IMHR-M provided ACSIM/IMCOM CSM a "One to N" list of tasks executed within IMHR-M and concluded the infusion of integrator duties at the level necessary would be challenging without additional resources.

(10) In Sept 10, FORSCOM Inspector General completed their TASP inspection. As a result, the FORSCOM CG directed commanders to immediately execute TASP and ensure that advance arrival sponsorship is provided to every Soldier when possible.

(11) In Oct 10, OACSIM-ISS updated The ACSIM on the status of improving TASP at the AFAP IPR. The ACSIM acknowledged meeting with IMCOM CSM and concurring with the concept to establish Sponsorship Integrator and Director Positions to be placed at IMCOM-HR to improve TASP. The ACSIM requested feedback on the S1-NET survey results and directed that the issue be finalized and A Way Ahead be provided by Nov 10.

(12) In Nov 10, Services and Infrastructure Core Enterprise began chairing TASP working group meetings and expanded the working group membership to include stakeholders across the Army active, reserve, and guard components. The group met routinely to discuss and finalize the EXORD. The TASP EXORD draft was approved by the ACSIM in Dec 10, and released for official staffing to the ARSTAF.

(13) In Jan 11, OACSIM-ISS officially staffed the TASP EXORD to the ARSTAF.

(14) In Dec 10, The Chief, IMHR-M commenced Phase I of modifying the Mobilization Planning Data View (MPDV) at Fort Hood to enhance Soldier Readiness Processing (SRP). In 3rd quarter FY11, pending a successful test, Phase II will consist of improving installation in- and out-processing and adding the new TASP requirements.

(15) In Dec 10, IMCOM G1 designated as the lead for establishing and resourcing IMCOM TASP positions based on the ACSIM's approval to realign IMCOM positions in resourcing IMCOM Sponsorship Program Manager and Integrator positions.

(16) GOSC review.

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

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

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

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

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 10 Jan 11)

**d. Subject area.** Force Support

**e. Scope.** Current and future budget cuts seriously threaten the effectiveness of ACAP. The program assists Service Members (SMs) and their Families to be

successful in their transition from federal service to civilian life. Approximately 11,000 SMs were retained on active duty in 2005 from briefings provided by ACAP. Loss of ACAP's employment assistance and support for job searches will result in higher unemployment rates, increased unemployment compensation and reimbursement costs paid by the Department of Army.

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

(1) Eliminate future ACAP budget reduction.

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

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

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

### **h. Progress.**

(1) In Jun 07, the Lean Six Sigma study conducted by ASA (M&RA) recommended improving ACAP by expanding accessibility for Soldiers to ACAP utilizing WEB services. Implemented as ACAP Express, it allows Soldiers to access the menu of available ACAP services and schedule appointments for themselves from any location via the internet 24/7 and was launched 28 Feb 08. Eligible Soldiers utilize tools such as resume writer from the world-wide web in the same manner they would at an ACAP Center. If they begin ACAP early on in the transition process, Soldiers and Family members are more able to utilize individual transition counseling and employment assistance offered by ACAP, and subsequently more prepared for their transition.

(2) ACAP Express was evaluated in Feb 09 and found to be successful. In the first year, over 12,000 Soldiers registered and utilized ACAP Express. Soldier feedback critiques are supportive of ACAP Express, and request additional tools be placed on-line. Although ACAP Express eases the burden on the ACAP staff by allowing some self-service, the mission continues to increase with support to the WTUs and AW2 populations, and supporting the G-1's Continuum of Service concept with additional emphasis on transition to National Guard and Army Reserve, as well as Army Civilian Employment. For example, the Department of Army Civilian Human Resource Agency, AW2 Operations Division and ACAP have developed a process to bypass the resumix system for all AW2 Soldiers. These focused efforts will continue and expand.

(3) For FY 09, the Army acknowledged funding requirements of \$5.3M and provided \$4.14M. A request for supplemental Overseas Contingency Operation (OCO) funding was submitted and the Army provided \$1.3M. The POM FY 10-15 submission identified a revised critical level of \$6.387M. The funded level for FY 10 is \$4.7M, further reduced by congressional and MACOM adjustments to \$4.1M. A request for \$1.329M Army OCO Funding for FY 10 was withdrawn when OSD provided \$1.3M to make-up the FY 10 shortfall.

(4) Issue was considered by the AFAP GOSC 1 Jul 09. Several attendees emphasized the value of ACAP services, in particular to OCONUS Soldiers, demobilizing National Guard and Reserve Soldiers and Wounded Warriors. Other discussion addressed a secondary issue of updating ACAP service delivery and consideration of strategies utilized by online civilian employment services.

The VCSA said that ACAP is a viable program that the Army needs to fund and said he would take this issue into budget discussions, and the issue remains active.

(5) A meeting with the Assistant Chief of Staff for Installation Management, Resource Directorate (ACSIM-RD) on 28 Jul 09 between the Director ACAP and Deputy Chief, Resource Integration Division subsequently supported AFAP 612 and a commitment was made to restore an additional \$1M if II PEG Total Obligation Authority (TOA) level permits. To date, Army has provided an additional \$800K in FY 11 in support of AFAP 612. An update will be provided to the VCSA during the next AFAP GOSC. This issue went before the II PEG for POM FY 12-17 in an effort to restore an appropriate level of funding, and was favorably received.

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

(7) On 1 Apr 10, the VCSA directed that a bottoms-up review of ACAP and commissioned the United States Army Military Academy to independently review and determine whether ACAP meets the needs of the Soldiers of the 21<sup>st</sup> Century. The VCSA received the formal report in October, which included 16 Determinative Wins.

(8) Current and future budget cuts seriously threaten the effectiveness of ACAP. In FY 10, the Army paid more than \$485M in unemployment compensation. In FY 11, unemployment compensation costs are expected to exceed \$800M. The number of Soldiers using ACAP services will increase under Secretary Gates' proposal to reduce the Army by 27,000 in fiscal 2015.

(9) ACAP will not be able to maintain its current level of support to Soldiers and Families, implement all of the USMA Study recommended 16 Determinative Wins, or provide service to the additional 27,00 Soldiers identified to leave the Army under Secretary Gates' proposed Army end strength without appropriate funding. Any decrement in funding and lack of additional resources will result in a failure to meet the VCSA's intent of caring for Soldiers and Families as a critical leader task.

(10) GOSC Review.

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

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

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

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 29 Oct 10)

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

**e. Scope.** Multiple barriers exist in providing timely, convenient and appropriate Behavioral Health Care Services for children of Active Duty Soldiers, Wounded Warriors and Veterans. There is a critical shortage of Behavioral Health Care Child and Adolescent Providers to meet the current demand. Many Behavioral Health providers are unable to dedicate their entire practice to children's therapy due to occupying administrative positions and performing adult behavioral health care. For example, 504 child psychiatric providers were contacted and only 13% stated they were providing full time child psychiatric services. The difficulty in recruiting and training direct care providers and a lack of a national educational plan to raise awareness in schools and identify treatment needs, further exacerbate the problem. Comprehensive services are not readily available, nor aligned with other ranges of services for military children, thus creating unneeded barriers to quality Behavioral Health Care.

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

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

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

### **g. Progress.**

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

(2) Throughout FY10, the CAF-BHP completed Child and Family Population Health Assessments at Fort Lewis, Fort Carson, Fort Wainwright, Fort Sill, Fort Hood, Fort Campbell, Bavaria and Landstuhl. Child and Family population data at all Army Installations has been collected and an applied algorithm has been used to determine a required number of behavioral health providers for each population.

(3) The CAF-BHP focuses on 5 key tasks designed to increase access for Military Children and Families to behavioral health services by:

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

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

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

d. Serving as a repository of knowledge and a clearing house for overarching guidelines of state-of-the-art behavioral health care for Army Children and Families.

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

(4) The CAF-BHP currently has recruited a multi-disciplinary team of 20 personnel to support the mission in the following divisions: outreach, training, evaluation, and Strategic Communication.

(5) The CAF-BHP interface with organizations, universities, and subject matter experts throughout the nation has allowed for increased marketing opportunities to recruit Child/Adolescent behavioral health providers. The CAF-BHP Strategic Communications Division has been created to play a key role in designing marketing strategies for, decreasing the stigma associated with behavioral health, collaborating with military and civilian agencies in developing systems of care, and promoting a healthy and resilient Army Community.

(6) The Outreach Division is responsible for assessing the needs and capabilities of Army Installations in providing care for Families and Children and assisting Commanders/Providers in determining best options in meeting identified needs.

(7) We are responsible for assisting in establishing Pilot Child and Family Assistance Centers (CAFAC) and School BH Programs (SBH). Multi-disciplinary Teams including psychiatry, psychology, social work, administration, program evaluation, work on-site and remotely to assist in development, ongoing consultation, and support.

(8) Fort Lewis, Fort Carson and Fort Wainwright received initial funding in FY10 to begin implementation of CAFAC Pilot Programs. The CAFAC Program Model supports the delivery of a comprehensive, integrated, behavioral health system of care, designed to provide easy access through a single entry portal.

(9) Schofield Barracks currently has an established program; originally named SAFAC (Soldier and Family Assistance Center) now rename CAFAC. The multi-disciplinary program continues its mission to treat Soldiers, Families and Children.

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

(11) The CAF-BHP is collaborating with national SMEs and organizations (American Academy of Pediatrics, American Academy Child and Adolescent psychiatry and American Psychological Association) in developing these curricula to ensure utilization of best practices.

(12) Army Primary Care providers and support personnel will be provided opportunities for behavioral health training by the CAF-BHP to assist in screening common behavioral health concerns, identification of problematic functioning, effective intervention strategies in primary

care, and referral guidelines to specialty behavioral health care.

(13) Army School Behavioral Health Programs (SBH) currently includes: Tripler, Walter Reed, Bavaria (Netzberg, Grafenwoehr, and Vilsek), Landstuhl (Baumholder), Fort Campbell, Fort Lewis, and Fort Carson.

(14) Fort Lewis and Fort Carson have recently received funding and have begun initial ground work for the new school year. The Fort Lewis MOA has been signed. The Fort Carson MOA remains in progress. Fort Campbell SBH continues to expand.

(15) The SBH Academy at Tripler has received a positive response. Plans are underway to move the program to Fort Lewis co-located with the CAF-BHP.

(16) GOSC review.

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

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

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

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 12 Jan 11)

**d. Subject area.** Employment

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

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

**g. Progress.**

(1) In FY09, in response to HQDA's inquiry concerning the establishment of a DoD-wide Leave Bank, DoD ad-

vised there was insufficient need to support a DoD-wide Leave Bank. In 2009, based on command feedback, HQDA determined there was no support to establish an Army-wide Leave Bank either. A follow up query with CPAC Employee Relations Advisors revealed an interest in establishing local Leave Banks. As a result, HQDA drafted an Army Leave Donation Policy in coordination with DFAS, which includes guidance on the VLTP, Leave Banks, and the voluntary donation of annual leave (to include use or lose). The draft was coordinated with the Civilian Human Resources Agency (CHRA) and DFAS. The policy was revised to incorporate the feedback received and an ASA (M&RA) policy memo has been drafted. Package was forwarded to the Office of the Judge Advocate General in December, 2010 and is currently under legal review.

(2) HQDA has worked with CHRA, DFAS, and other Federal Agencies on details of local leave banks, to include administration, payroll issues, the creation of an automated database, and levels of control. In March 2010, DFAS determined a payroll system change would be required to allow employees to authorize the automatic transfer of their use or lose leave into a Leave Bank at the end of the leave year. DFAS is working on the requirements internally. Costs, if any, will be relayed upon receipt of the DFAS information.

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

(4) GOSC review. The Feb 11 AFAP GOSC declared the issue active. The Army will monitor DFAS' payroll system change.

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

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

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

**a. Status.** Active

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

**c. Final action.** No (Updated 11 Jan 11)

**d. Subject area.** Medical

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

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

**g. Progress.**

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

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

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

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

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

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

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

(8) USAPHC (P) has a representative who regularly participates on the Comprehensive Soldier Fitness (CSF)

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

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

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

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

a. CONUS: FORSCOM – awaiting approval; TRADOC – questions regarding POM; AMC –revising memo from input; IMCOM – to date all RFIs addressed; MEDCOM - Signed 3 MAY 2010.

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

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

(13) Way ahead: USAPHC (P) will continue to work to

get cooperation from other organizations outside of MEDCOM needed to implement the AWC concept. Funding requirements are updated and going into the 2012 – 2017 POM.

(12) GOSC review.

a. Jun 08. The issue remains active.

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

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

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

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

### **Issue 621: Minimum Disability Retirement Pay for Medically Retired Wounded Warriors**

**a. Status.** Active

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

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

**d. Subject area.** Entitlements

**e. Scope.** Wounded Warriors involuntarily separated from the military often encounter financial hardships due to the current disability retirement pay rates. Wounded Warriors with a disability rating of 30% or higher receive a disability retirement. The amount is based on years of service, rank, and the rating percentage (10 USC, Sec.1401), which may be below the national poverty level. Insufficient financial support causes undue additional strain on both Servicemembers and Families already coping with their medical conditions.

**f. AFAP Recommendation.** Award medical retirement pay for all Servicemembers with a 30% or higher disability rating to at least the minimum equivalent retirement pay of an E-6 with 10 years' service or current entitlements, whichever is higher.

**g. Progress.**

(1) Dec 19, 2008, OSD augmented the Departments capability to sustain enhanced oversight and management of Wounded Warrior matters by establishing the Wounded Warrior Care and Transition Policy Office (WWCTP). The SOC, Co-chaired by the DepSecDef and the DepSecVA provides comprehensive management and systematic coordination to ensure seamless and transparent transition of Services members between the DoD and DVA. The Secretary of the Army and the Vice Chief of Staff, Army are the Army's representation to the SOC.

(2) On July 2, 2008, Chief of Staff, Army asked General (retired) Franks Jr. to lead an effort to review the medical evaluation board (MEB) and physical evaluation board (PEB) processes, recommend process adjustments and develop short and long range recommendations for specific action and resource. With the support of the DCS, G-1 and OTSG, GEN (Ret) Franks assembled a number of experts from across the Army to include Wounded Warriors who have been through the Physical Disability

Evaluation System (PDES) process. This included surveys of Soldiers and Families in order to be as inclusive as possible, listening to new ideas and initiatives while retaining the core mission focus. Based on the Task Force's work, three strategic recommendations were made:

a. In 2007, the WWCTP initiated the DES Pilot to eliminate the dual adjudication of disability ratings now done independently by the Service Departments and US Department of VA. The Department of Veterans Affairs is the responsible agency for administering disability ratings.

b. Begin a National Dialogue regarding the duty to our volunteer force that become wounded, ill or injured as a result of doing their duty in the era of persistent conflict.

c. Transformation of the current PDES.

(3) Coordinated with Line of Action 8 POC and this issue is tentative scheduled to be included in the SOC agenda for October 2010.

(4) The issue did not make the SOC agenda. The ASA (M&RA) LOA 8 POC will coordinate with the other military departments to determine a way forward for this initiative.

(5) GOSC review.

a. Jun 08 GOSC. The FORSCOM representative said that they think this is a great initiative and suggested that the Army look at industry disability standards. He also expressed concern about the perception of an E6 with ten years service who sees a PFC who had been on tour with him, receive a comparable retirement pay. The Surgeon General addressed the discrepancies between military and Veterans Affairs (VA) disability ratings. The VCSA said that he wanted all Wounded Warrior legislation that was not successfully codified to be "refreshed" and "sent back up one more time". The VCSA said he thought the 30 percent rating was too low, but he anticipated help on this.

b. Jun 10. Issue remains active. The VCSA voiced his support for this issue. He told G-1 to take this back to the Senior Oversight Committee (SOC), but noted that a lot of work needs to be done prior to that. He also said we should take this back to General Franks and stated that he would personally "take this one on". The Surgeon General asked that if there is a relook of medical retirement pay, that it be part of a comprehensive revision of the disability evaluation system, particularly the 30 percent disability threshold.

c. Feb 11. The issue remains active. The FORSCOM representative explained that the target audience for this issue is junior enlisted Soldiers who were medically discharged, primarily for TBI and PTSD, and have Families to support. The SMA agreed that assisting this group is the right thing to do. G-1 responded that they are working on a business case for the Senior Oversight Committee (SOC). In Jul 08, Chief of Staff, Army asked General (Ret) Franks Jr. to lead an effort to review the medical evaluation board (MEB) and physical evaluation board (PEB) processes. The Task Force made three strategic recommendations, but did not specifically address this recommendation. This issue was scheduled to be included in the Oct 10 SOC agenda, but did not make the final SOC agenda. Monitor LOA 8 work to determine way ahead.

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

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 10 Jan 11)

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

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

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

**g. Progress.**

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

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

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

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

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

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

(7) In Sep 08, at the AFAP IPR it was determined that this issue should be closed as unattainable. However, subsequent to this decision, the Veterans' Benefits Improvement Act of 2008 was passed in Oct 08. This act extends coverage to an insured member's stillborn child under the Servicemembers' Group Life Insurance (SGLI).

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

(9) In Sep 09, FMWRC FP consulted with FMWRC CJA regarding the feasibility of VA definition/legislation being applied for TC. FMWRC CJA opined that the VA's decision to include stillborn as an insurable dependent under FSGLI alone does not set a precedent for TC.

However, FMWRC CJA indicated that the military justice system has the ability to charge a Soldier for two separate offenses if a Soldier causes injury to a child in utero – one for injury to the mother and one for injury to the unborn child. As a result, FMWRC CJA considered that this recent trend within military justice and the passage of UCMJ articles to cover unborn children in certain circumstances, combined with the VA's recent decision, may be justification to support the request of legislative action to change the TC definition of "dependent."

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

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

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

(13) A final decision regarding the approval of the proposal will be made by Dr. Stanley, the Under Secretary of Defense for Personnel and Readiness, in early 2011. OACSIM-ISS will continue monitoring the progress of the proposal.

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

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

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

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

**a. Status.** Active

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

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

**d. Subject area.** Entitlements

**e. Scope.** Servicemembers and Veterans diagnosed with PTSD, TBI (other than leading to coma) as well as Uniplegia receive no immediate Traumatic Servicemembers' Group Life Insurance (TSGLI) payment under current regulatory and compensatory guidelines. These diagnoses, which may or may not stem from physical loss, can and often do lead to financial hardship for the Servicemembers, Veterans, and Families. Servicemembers and Veterans who are diagnosed with the conditions cited above may receive monetary compensation from the Physical Disability Evaluation System (PDES) in the future, but receive nothing upon initial diagnoses. Traumatic Servicemembers' Group Life Insurance (TSGLI) already covers TBI when TBI injury results in the inability to carry out at least two of the six activities of daily living and/or coma. Uniplegia (the complete and irreversible paralysis of one limb) by other than amputation is currently not considered in the table of scheduled losses. However, it is being considered for

addition. PTSD is not under consideration at this time for payment of TSGLI. Servicemembers and Veterans are forced to make life altering decisions based on the provision of their care, maintaining a viable household, and the potential loss of short and/or long term employment.

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

**g. Progress.**

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

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

(3) Coordinated with Line of Action 2, POC who is tracking this (Sec 726 of the NDAA FY10) requirement. The contract has been awarded and the contract kickoff was held on December 2, 2010, in which the COR and the DCoE Action Officer met with the Institute of Medicine (IOM) project manager. IOM is currently finalizing the slate of committee members to conduct the study and making formal invitations to those selected. Once all acceptances have been received, short biographical paragraphs for each member will be posted to the National Academies website under the committee's name for a 20-day public comment period. In addition, IOM is continuing to identify and gather background materials on PTSD for delivery to the committee in January. A follow-up meeting with the IOM team is scheduled for 13 Jan. The purpose of the upcoming meeting is primarily to discuss the public session of the first committee meeting. DoD will be asked to formally charge the committee during the public session. The first formal IOM committee meeting for the study, along with the public session, is scheduled for 28 Feb.

(4) GOSC review.

a. Jun 08. The issue remains active.

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

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

**i. Support agency.** VA

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 12 Jan 11)

**d. Subject area.** Medical

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

help beneficiaries find needed care and imposes an unnecessary demand while traveling.

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

**g. Progress.**

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

(2) The DoD/MHS Innovation Investment Process (IIP) is currently undertaking a study of NAL usage to support TRICARE Prime beneficiaries and the Medical Home model of healthcare delivery. OTSG/MEDCOM has been involved in the initial discovery and telephone conference calls to Army Military Treatment Facilities that utilize NALs. The contractor (Deloitte Consulting) has been assigned to the initial discovery and has been provided data/supporting arguments that includes this AFAP issue. The initial discovery guidance by TMA to the IIP investigating contractor did not include specifics on out-of-area and after-hours need. OTSG/MEDCOM has provided some specifics on the efficacy and need for NAL usage for out-of-area and after-hours urgent care and even emergency care encounter recording. Enterprise use of NAL (NAL like) programs has been recommended by OTSG/MEDCOM for many years.

(3) Past enterprise use of NAL (NAL like) processes has not been well received within the MHS due to limitations of 1-call/1-resolution support and the inability of the process to directly tie into the MHS' systems to record civilian urgent/emergency authorizations and/or make MTF appointments for MTF enrolled beneficiaries. Improvements in universal NAL guidelines and triage logic has provided better metrics to determine efficacy of program and 'cost avoidance' when a beneficiary is triaged and educated to assume a lower level of healthcare resolution from their initial intent. Many beneficiaries have an initial intent of needing an emergency room (ER) visit and after calling a NAL their final execution can be lowered to either a civilian urgent care facility (verses ER), waiting till next day with actual appointment to enrollment site, or "self help" to personally resolve the healthcare need. Recent experience in linking NAL programs into MTF appointing systems has provided needed information to allow improvements to support 1-call/1-resolution business design.

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

tralized HOTLINE support of all Prime enrolled beneficiaries (some official verbiage removed for this paper):

a. Standardized application of the required Title 32 Code of Federal Regulation (CFR) Health Care Finder (HCF) program from a toll-free centralized access point for global accessibility by any Prime enrollee.

b. Standardization and compliance with the HCF program design to formally authorize and record civilian encounter request(s) for a Prime beneficiary when they contact the HCF centralized toll-free call system for out-of-area and after-hours (limited by specified locations) urgent/emergent healthcare needs.

c. Locator support of the nearest MTF or civilian/host nation network provider/facility that could manage the urgent/emergent healthcare need.

d. Required notification (within 24 - 48 hours) from the HCF to the beneficiary's enrollment site regarding the Prime beneficiary's urgent/emergent healthcare request and encounter when out-of-area or after-hours. Enrollment site could be either a civilian/host nation PCM or MTF anywhere in the world.

e. Incorporation and full functional application of a Nurse Advice Line (NAL) information and triage process to the HCF centralized HOTLINE to support any DoD beneficiaries' requests (especially Prime enrollees) for medical advice and/or triage for determining self-help, urgent, or emergent healthcare needs.

(5) Aug 09 Update: On 9 Jun 09, an official memo from TMA informed the Services of TMA's decision regarding the 24/7 centralized, toll-free process tasker. TMA did not accept the AMEDD proposed solution or any of its components. TMA endorsed a different process for single out-of-area encounter authorization by the MCSCs. However, as of 18 Aug 09, the Services were informed in two separate Enterprise Working Groups that this TMA memo will be rescinded. Exact reasons for rescinding the memo are unknown; however, the ability of the MCSCs to execute without a current contract modification was cited.

(6) Aug 09 to Apr 10 Update:

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

b. On Feb 10, the IIP Board of Directors approved a call for Service representatives to assist in the review the Request for Information (RFI) from industry, and to begin the work of drafting a Request for Proposal (RFP) to solicit a vendor that would provide a CONUS-wide centralized NAL and referral assistance service. Once pro-

cured, this new contracted functionality would meet the needs of the AFAP recommendations, but only in CONUS.

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

(7) Apr 10 to Oct 10 Update:

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

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

(8) MEDCOM requests that this issue and its recommendation be reflected as COMPLETE. The movement of the Enterprise WG is on target to meet the intent of this AFAP issue and has strong backing of ASD (HA)/TMA and the Services. There is one caveat to this working NAL proposal; it is a centralized NAL for CONUS only at this time. Discussions within the WG show strong intent to move toward global application once the CONUS contract has been established. Currently our Europe-based beneficiaries have a centralized NAL for at home use, and when all our OCONUS enrollees travel, they have the use of the current TRICARE Overseas Program contractor's 24/7 Hot-Line for urgent/emergent medical assistance.

(9) GOSC review. The Feb 11 GOSC declared the issue active.

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

**i. Support agency.** TMA

### **Issue 631: Career Coordinators for Army Wounded Warrior Soldiers, Family Members and Caregivers**

**a. Status.** Active

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

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

**d. Subject area.** Employment

**e. Scope.** The Army Wounded Warriors (AW2) Program does not have a sufficient number of AW2 Career Coordinators to assist both AW2 Soldiers and their Families/Care Givers with the transition process. The AW2 Career Cell consists of four Career Coordinators that serves 3,814 Soldiers, their Families/Care Givers, and supports 120 Advocates. Last year, the number of AW2 Soldiers increased by 1,315, adding an average of 108 per month. AW2 Career Cell projections indicate a significant increase of AW2 Soldiers in the coming years. The industry standard for career management is 1:30; the ratio of Career Coordinators to Soldiers is 1:953. The insufficient number of AW2 Career Coordinators does not allow effective career coordination, employer network development or long term management for the complex

employment and education issues affecting AW2 Soldiers and their Families/Caregivers.

**f. Conference Recommendation.** Increase authorizations and funding for AW2 Career Coordinators assigned to AW2 Soldiers and their Families/Caregivers to reach the industry standard for career management of 1:30.

**g. Progress.**

(1) A review of this issue's validity in the current environment is in-process. Several mechanisms to address this issue have been put in place since it was entered into the AFAP process at the 2009 AFAP World Wide Conference. No organization has conducted a comprehensive review of the currently available career assistance products and services.

(2) When this issue entered into the AFAP process the WTC Education and Employment Initiatives (EEI) cell had not yet been stood up and the AW2 Career Cell had only been stood up for four months. At that time, the AW2 Career cell was engaged in identifying the needs of the AW2 population and the capabilities and services being provided to them.

(3) The WTC EEI and AW2 Career cells now work collaboratively with the following government and non-profit organizations: Army Career and Alumni Program (ACAP), Army Civilian Human Resources Agency (CHRA), Vocational Rehabilitation and Employment (VRE), Veterans Employment Coordination Services (VECS), and Department of Labor (DOL) REALife Lines to meet the career, educational and employment needs of AW2 Soldiers/Veterans and their Families. Each partner provides the AW2 population a wide range of transition and career preparation services including civilian and federal resume preparation. Below are brief descriptions of the services offered by these organizations.

a. ACAP provides pre-separation counseling, transition, civilian and federal resume preparation, job search information and referral services for Soldiers, Veterans, retirees, DA civilians and Family members both online and at ACAP Centers.

b. The CHRA Wounded Warrior Program allows AW2 Soldiers and Veterans to apply for Army civilian employment through CHRA's expedited application process. CHRA also provides information and referral to Soldiers, Veterans or spouses looking for employment as an Army civilian.

c. VRE provides vocational and educational counseling, work programs, self-employment programs and independent living programs to Soldiers still on active duty, as well as Veterans and Family members who are eligible for one of VA's educational benefit programs.

d. VECS provides a variety services to Veterans and their spouses such as veteran employment advocacy, hands-on employment assistance, resume review and federal application assistance, skills and qualifications assessment, placement assistance, case management, training and development counseling and one-on-one peer counseling. VECS also recruits and hires disabled veterans, create employment opportunities, and ensures that managers and supervisors are familiar with the use of special hiring authorities to hire veterans.

e. DOL REALifelines: The program provides one stop career counseling and education assistance to transitioning veterans who are wounded or injured in combat. The program supports veterans and spouses within the 50 states as well as Puerto Rico, Guam and the District of Columbia.

f. National Organization on Disabilities (NOD): AW2 is conducting a pilot with NOD at three sites in CONUS: Denver, CO; Dallas, TX; and Fort Bragg, NC. NOD provides one on one intensive employment related services, civilian and federal résumé assistance, job search information, educational resources, skills and qualifications assessments and financial assistance. NOD has assisted 200 AW2 Soldiers to obtain meaningful employment and access education opportunities.

g. The Warrior Transition Units (WTUs) now have Military Career Counselors and Transition Coordinators to assist Warriors in Transition (WTs) in exploring options and developing Comprehensive Transition Plans which include career and education goals.

(4) The Federal Recovery Coordination Program, a joint program of DOD and VA, was stood up in early 2010. This program helps coordinate and access federal, state and local programs, benefits and services for seriously wounded, ill, and injured Service Members, and their families. Federal Recovery Coordinators (FRCs) have the delegated authority for oversight and coordination of the clinical and non-clinical care identified in each client's Federal Individual Recovery Plan (FIRP). Working with a variety of case managers, FRCs assist their clients in reaching their FIRP goals. FRCs remain with their clients as long as they are needed regardless of the client's location, duty or health status. In doing so, they often serve as the central point of contact and provide transition support for their clients.

(5) The AW2 Career Cell conducted Career Expos in conjunction with the 2009 and 2010 AW2 Symposiums. We will conduct regional Career Expos, in coordination with the DOL and Job Zone, to make this service available to Wounded Warriors in their local regions. We are planning and budgeted for eight regional Career Expos, one per region, in FY2011.

(6) GOSC review. The Feb 11 AFAP GOSC declared the issue active. The proponent will establish partnership with federal, state and private sector for employment and education opportunities. Provide AW2 Advocates and WTU Transition Coordinators guidance and training on education and employment opportunities. Develop assessment tools. Conduct regional Career Expos in FY11.

**h. Lead agency.** Army Wounded Warrior Program (AW2) and Warrior Transition Command (WTC)

**i. Support agency.** Army Career and Alumni Program, Army Civilian Human Resources Agency, Department of Veterans Affairs, Department of Labor, National Organization on Disabilities

### **Issue 633: Cost of Living Allowance (COLA) Dependents Cap**

**a. Status.** Active

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

**c. Final action.** No (Updated: 12 Jan 11)

**d. Subject area.** Entitlements

**e. Scope.** Soldiers do not receive COLA entitlements for more than five dependents. The Defense Finance Accounting System (DFAS) caps the maximum dependent COLA calculation at five dependents. The COLA calculation cap negatively impacts Families with more than five dependents.

**f. Conference Recommendation.** Eliminate the five dependent cap on COLA.

**g. Progress.**

(1) This AFAP proposal to base entitlements on the number of dependents applies only to OCONUS COLA. CONUS COLA is paid at a "with" dependent rate and a "without" dependent rate, regardless of the number of dependents. OCONUS COLA considers the number of dependents in the calculation.

(2) DAPE-PRC consulted again with the Per Diem Travel Transportation and Allowance Committee (PDTATAC) [<http://www.defensetravel.dod.mil/perdiem/trvlregs.html>] to gain a better understanding of the OCONUS COLA calculation methodology and the impact on a member having five or more dependents. The PDTATAC Economics and Statistics Branch Chief explained again that the rationale the Army Family Action Plan group is advancing is based on a false premise - that as the number of dependents increase, so does the member's disposable income. In reality, the member's disposable income is essentially static.

(3) All the COLA spendable income table does is look at how members allocate their income across all possible expenditures. The major expenditures are housing and COLA types of goods and services. As family size increases, more income is devoted to housing (greater number of rooms/bedrooms), and so there is less disposable income left over to spend on COLA type items. This result in some pay grades with more than five dependents actually spending less on COLA types of goods and services - more of the set disposable income is spent on housing.

(4) It is right at the five dependent levels that the member is maxing out the percentage of income they can devote to spending on their dependents. In other words, if we expanded the table, with a very few exceptions, the amount of dollars for members with more than five dependents would not vary significantly from that at five dependents, and in some grades and years of service, be less than for the same member with less dependents and years of service. Additionally, in computing the Spendable Income table, the Economics and Statistics Branch use data furnished by the Bureau of Labor Statistics. The data they provide only goes to family size six - which translates into member plus five dependents. There is no reliable data to project COLA beyond that number.

(5) The issue was again discussed at length with the other Services representatives during the 28 September 2010 PDTATAC meeting. The Service's representatives to the PDTATAC expressed no support for lifting the dependent OCONUS COLA cap due the explanation presented by the Chief, Economics and Statistics, the fact that there is no reliable date to do so and OCONUS COLA is the only entitlement paid based on the number of dependents.

(6) GOSC review.

a. Jun 10. The GOSC declared the issue active. The VCSA said that the Army needs to explain the problem to the other services.

b. Feb 11. After comments from ASA (M&RA) and G-1 about the merit of dependent COLA cap and an explanation about the rationale for the cap, the VCSA determined that this issue should remain active. The G-1 representative noted that OHA and BAH are not based on the number of dependents and questioned why OCONUS COLA is. The issue remains active.

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

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 12 Jan 11)

**d. Subject area.** Employment

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

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

**g. Progress.**

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

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

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

(4) AG-1 CP is continuing to engage legislative process to achieve affirmative results.

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

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

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 18 Nov 10)

**d. Subject area.** Medical

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

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

**g. Progress.**

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

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

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

(4) In December 2003, the Medicare Prescription Drug Improvement and Modernization Act (H.R. 1) was passed into law. It contained two major new benefits which increased utilization of the Medicare MNT benefit including the Medicare Health Support Program and the Initial Preventive Physical Exam. The Medicare Medical Nutrition Therapy Act of 2005 (H.R. 1582 and S. 604), a bill that gives the authority to expand the MNT benefits to include

any disease, disorder, or condition deemed medically reasonable and necessary, was introduced in Congress, however was not passed. In the Medicare Physician Fee Schedule Final Rule for 2005, CMS expanded the list of Medicare tele-health services to include individual MNT.

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

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

(7) TRICARE authorizes some inpatient and outpatient nutrition therapies and specifically excludes others, like obesity and weight management. Recently, TRICARE completed a Weight Management Demonstration Project, and based on evidence from this study, may change the coverage for this particular diagnosis. In January 2009, the Army Family Action Plan raised Issue #638, Medical Nutrition Therapy, which recommended nutritional services as a TRICARE benefit to cover all categories of beneficiaries.

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

(9) The value of MNT as a TRICARE benefit has many advantages: it resolves the current lack of a uniform benefit for this clinical service; it benefits the patient by improving their quality of life and encourages active participation in managing their medical condition; and it supports the 2007 DoD Task Force on the Future of Military Health Care's recommendations to promote wellness thereby optimize readiness and beneficiary health. The current national debate on health care reform has led health care providers and payers to develop new approaches to meet the challenges of cost containment and quality care. Dietetics professionals are key members of the health care team and are uniquely qualified to provide medical nutrition therapy as an essential reimbursable component of comprehensive health care services.

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

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

(12) GOSC review. The Feb 11 GOSC declared the issue active as they await TMA analysis and decision.

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

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

### **Issue 639: Deferment of Advanced Individual Training (AIT) Soldiers with Exceptional Family Members**

**a. Status.** Completed

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

**c. Final action.** AFAP XXVII, Feb 11

**d. Subject area.** Medical Command

**e. Scope.** AIT Soldiers are preceding on assignment instructions to OCONUS locations prior to overseas command decision regarding availability of EFM care in their respective unit of assignment. If Soldiers proceed to OCONUS locations prior to decision on availability of EFM care, a change of assignment may occur if EFM is disapproved for the Soldier's OCONUS assignment location. This negatively impacts Families, the Soldier's individual readiness, accomplishment of the unit mission and can result in expenditure of additional permanent change of station funds. Decisions regarding EFM care and command sponsorship/Family travel should be accomplished prior to Soldier proceeding on assignment to OCONUS locations.

**f. Conference Recommendation.** Require deferment of AIT Soldiers with EFMs until notification is received from OCONUS travel approval authority concerning availability of services and command sponsorship/Family travel decision.

**g. Progress.**

(1) USAREUR submitted issue for consideration at the Jan 09 AFAP GOSC. In Nov 08, FMWRC coordinated this issue with Army G-1, Human Resources Command (HRC), and Army G-3/5/7.

(2) HRC initiated a formal request in Dec 08 to change AR 608-75 (paragraph 1-29e) as follows: "Defer Soldiers with EFMs (including AIT Soldiers) until notification is received from OCONUS travel approval authority about availability of EFM services. Soldiers will remain at current installation pending command sponsorship/Family travel decision from overseas command".

(3) FMWRC coordinated Rapid Action Revision change to AR 608-75 Army-wide in 4<sup>th</sup> Qtr FY09; results were consolidated for inclusion in the regulation. Collaboration with HRC to obtain concurrence continued.

(4) In Mar 10, HRC provided recommendations for minor changes to the Rapid Action Revision to AR 608-75.

(5) At the Apr 10 AFAP issue review with LTG Lynch, a recommendation was made to close the issue since Rapid Action Revision to AR 608-75 will accomplish the intent of this issue.

(6) In Jun 10, the issue was reviewed at the GOSC. The GOSC recommended, based on comments from USARPAC, that the issue remains active to modify language in the regulation that restarts the assignment process if approval is not received 30 days prior to graduation.

(7) In Jul 10, coordinated with FMWRC on GOSC recommendation and the status of Rapid Action Revision to AR 608-75. Rapid Action Revision is currently at Army Publishing Directorate.

(8) In Aug 10, coordinated with FMWRC on recommended language from USARPAC. Recommended language was reviewed by HRC. HRC non-concurred with USARPAC recommendation to modify language to "re-start" the assignment process. Final language meets intent of recommendation.

(9) In Oct 10, coordinated with FMRWC on publication date for Rapid Action Revision to AR 608-75. Rapid Action Revision is at Army Publishing Directorate (APD) for final policy review and authentication. APD has indicated they are unable to provide a publication date.

(10) In Nov 10, Rapid Action Revision is still at APD, Policy and Standards Review. Awaiting signature by Administrative Assistant to the Secretary of the Army.

(11) Resolution. Revision to AR 608-75 (paragraph 1-29e) will state (for Initial Military Training (IMT) Soldiers): "If notification of availability of exceptional Family member services has not been received from OCONUS travel approval authority 30 days prior to Soldier's graduation, contact HRC for issuance of new assignment instructions." Rapid Action Revision is at Army Publishing Directorate for final policy review and authentication.

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

**i. Support agency.** IMWR-FP, Army G-1, and HRC

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 29 Oct 10)

**d. Subject area.** Medical

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

beneficiaries contributes to over medication and adversely impacts function and quality of life.

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

### **g. Progress.**

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

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

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

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

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

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

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

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

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

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

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

(5) In September of 2010, the Comprehensive Pain Management Campaign Plan OPORD was published that directs implementation of Pain TF recommendations to provide for pain management that is holistic, multidisciplinary, and multimodal in its approach, utilizes

state of the art/science modalities and technologies, and provides optimal quality of life for Soldiers and other patients with acute and chronic pain.

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

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

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

**a. Status.** Active

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

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

**d. Subject area.** Medical

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

**f. Conference Recommendation.**

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

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

**g. Progress.**

(1) The MEDCOM HCDP is a coordinated effort between US Army Human Resources Command (HRC) and MEDCOM to properly distribute military human capital assets across the MEDCOM. All Human Capital resources (Military, Civilian, and Contractor) are taken into account during development of the plan. The HRC managers coordinate and balance the needs of the Army with the Soldier's needs to distribute personnel according to the HCDP. The Fall HCDP Conference is held to develop the HCDP for the upcoming Fiscal Year. During the Spring HCDP Conference, the HCDP approved during the Fall conference is validated and adjusted as needed to ensure the approved plan provides equitable distribution while meeting the Army, MEDCOM, and MTF Commanders' requirements. The HCDP Flag Officer Strategic Session was again held in conjunction with the annual Medical Symposium (May 2010). Topics of discussion were of strategic importance to the Army Medical Department (AMEDD), and the Flag Officers present will provide strategic manning guidance for the upcoming HCDP cycle (FY12). The HCDP process now includes Veterinary Corps officers and selected Enlisted specialties.

(2) Multiple developmental programs are available to increase the number of providers in shortage specialties at MTFs, such as the Army partnerships and the Masters of Social Work Program. The OSD is supporting legislation to establish a scholarship program for civilians in Behavioral Health occupations.

(3) Despite the best efforts of contractors, contracting offices, and MTFs to provide robust incentives, certain provider positions at remote and other hard-to-fill locations remain unfilled. In order to improve contract

administration and reduce the lead time for awarding contracts, the Surgeon General delegated expedited hiring authority on 17 July 2009 for more rapid hiring of contracting professionals. Additionally, the US Army Manpower Analysis Agency (USAMAA) concluded a manpower analysis that identified a shortfall in contracting administration and recommended an increase of 117 additional contracting authorizations to improve all phases of contracting.

(4) The MEDCOM supports the United States Army Recruiting Command (USAREC) Medical Recruiting Brigade (MRB) with military providers to leverage peer-to-peer recruitment. In FY 09, the Brigade achieved 111% of the Regular Army recruiting mission by commissioning 1,201 AMEDD Officers onto Active Duty, and reached 102% of the Army Reserve mission by commissioning 899 AMEDD Officers into the US Army Reserve (USAR). As of 25 February 2010, USAREC MRB has achieved 42% of the Regular Army mission and 37% of the Army Reserve mission for FY10.

(5) The Military Accessions Vital to the National Interest was established in February 2009. Under this pilot program, the Army recruits legal aliens who are Health Care Professionals in specific areas of concentrations necessary for present and future military operations. As of 1 March 2010, 141 providers are participating in this program (41 Active Component (AC); 100 USAR).

(6) The Officer Accession Pilot Program Option Charlie allows healthcare providers (ages 43-60) to serve in the Army (AC or USAR) with a two year Military Service Obligation (MSO) as opposed to the standard eight year MSO. As of 1 March 2010, 11 officers have accessed in FY10 (four Army Nurse Corps, three Medical Corps, one Medical Service Corps, and three Army Medical Specialists Corps).

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

(8) Major Commands were delegated direct hire authority (DHA) for 24 occupations on 26 February 2010 to appoint qualified applicants to health-care occupations listed under Public Law 111-118, Section 8078. The 24 occupations are: Psychologist, Psychology Technician, Social Worker, Social Service Assistant, Chiropractor, Physician, Physician Assistant, Registered Nurse, Licensed Practical Nurse, Nursing Assistant, Dietitian/Nutritionist, Occupational Therapist, Physical Therapist, Respiratory Therapist, Pharmacist, Optometrist, Audiologist/Speech Pathologist, Orthotist/Prosthetist, Podiatrist, Dentist, Dental Assistant, Dental Hygienist, Dental Laboratory Technician, and Industrial Hygienist. The DHA was scheduled to expire 30 September 2010. A Continuing Resolution has been signed which permits MEDCOM to continue recruiting and making appointments under the DoD DHA until the new NDAA is signed.

(9) The MEDCOM has requested 29 health-care occupations under Expedited Hiring Authority (EHA) under

Public Law 110-417. Candidates must be highly qualified, and the principles of preference for the hiring of veterans must be applied. The EHA includes 24 occupations under DHA listed in 2.a. above plus five (5) additional occupations (Health System Specialist, Medical Instrument Technician, Medical Technician, Medical Technologist, and Pharmacy Technician). The EHA has been delegated by DoD and Army to TSG for use. There are concerns on how to define highly qualifying criteria, which is absent in the DoD Instruction. The delegation will not be released for MEDCOM use while we still have the DoD DHA. The EHA authority expires 30 September 2012.

(10) The OSD expects to implement the new Physicians and Dentists Pay Plan (PDPP), which is similar to the National Security Pay System (NSPS), for all General Schedule (GS physicians and dentists. The PDPP retains the Title 5 GS grade and step pay system to establish base salary, but also leverages delegated Title 38 authorities to add a market pay comprised from current locality or special salary rate supplements, physician comparability allowance (PCA), premium pay and other factors. The new hybrid pay will allow Commanders to set competitive salaries. The date of conversion for GS physicians and dentists is now scheduled for 27 February 2011. After initial conversion, the Activity Compensation Panels (ACP) will convene to adjust market pay NLT 1 May 2011, and close the salary pay gap between our GS and NSPS physicians and dentists. NSPS physicians and dentists will convert to PDPP by mid-year 2011.

(11) From FY01 to the first quarter of FY10, MEDCOM medical positions increased by 73% overall. The Registered Nurse strength increased by 132% or 3,210 new hires; Licensed Practical Nurse strength increased by 104% or 1,178 new hires. The total on board strength for behavioral sciences occupations (Psychiatrist, Social Worker, Psychologist, Psychiatric Nurse, and Psychiatric Nurse Practitioner) is 1,618, an increase of 118% from total requirements of 1,371.

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

(13) In June 2009, CHCC awarded 75 Army Direct Care Medical Services (ADCMS) contracts valued at \$967M which allow MTFs to order clinical support services as task orders off an existing contract and shorten the acquisition lead time. The 74 CONUS based contracts and one Europe contract are composed of 3 product lines - physicians, ancillary services, and nursing services.

(14) As a result of the most recent Total Army Analysis assessment of the Generating Force, the Army has allocated to MEDCOM 545 military billets needed to meet emerging medical workload generated by Grow the Army. Documentation of this additional structure is effective October 2010. Shortages and gaps in medical capability still exist however. Numerous installations lack the healthcare infrastructure to hire, contract, or network additional capability. The MEDCOM will continue to

make its case for additional structure in the ongoing Force Management Review and upcoming Total Army Analysis.

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

**h. Lead agency.** MCHR-C

#### **Issue 646: Active Duty Family Members Prescription Cost Share Inequitability**

**a. Status.** Active

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

**c. Final action.** No (Updated: 18 Nov 10)

**d. Subject area.** Medical

**e. Scope.** There is an inequality of prescription cost share benefits for Active Duty (AD) Family Members not enrolled in a Military Treatment Facility (MTF). Prescriptions filled at a MTF are provided at no cost. AD Family Members who are not enrolled at an MTF and utilize retail or mail order pharmacies for their prescriptions are required to make cost share payments. These Family Members incur cost share fees, (\$3 generic, \$9 brand, \$22 non-formulary, per prescription, per Family member), which will quickly add up for Families with multiple prescription requirements (i.e., AW2, EFMP, Catastrophic events, etc.). These additional expenses are inequitable and create a financial burden above those who acquire their prescriptions from the MTF.

**f. Conference Recommendation.** Eliminate prescription cost shares for Active Duty Family Members not enrolled at a Military Treatment Facility.

**g. Progress:**

(1) Congress enhanced the pharmacy benefit to include the use of a mail order pharmacy and retail pharmacies with the first round of BRAC closures; providing military beneficiaries with three options for medications: the MTF pharmacy, mail order or retail. These options are not tied to a certain plan or enrollment but can be used at the discretion of the beneficiary. MTF enrollment is not a requirement for using the MTF pharmacy as all pharmacies accept prescriptions from civilian doctors, whether TRICARE providers or not. MTF pharmacies purchase medications through the Federal Supply Schedule (FSS) or DoD contracts, most at large discounts as compared to civilian pharmacies.

(2) To offset the costs of using more expensive options, Congress implemented a cost share program that requires beneficiaries to pay \$3/prescription for generic medications and \$9/prescription for brand name products. With the activation of the DoD Pharmacy and Therapeutics Committee, a 3-tier system of medications was established with the 3<sup>rd</sup> tier being non-formulary medications. Medications identified in this tier have a \$22/prescription cost-share.

(3) Active Duty personnel are exempt from this cost-share and pay nothing if using mail order or retail pharmacies. As with the three tiers of cost-share, there are essentially three tiers of preference for obtaining medications: MTF has no cost-share; mail order can be dis-

pensed with up to a 90-day supply for the \$3/\$9/\$22 co-pay; retail can be dispensed with up to a 30-day supply for \$3/\$9/\$22.

(4) OTSG will determine level of support from TMA with a request to remove co-pays for prescriptions. A Presidential Task Force recommended increasing co-pays with the DoD Senior Executive Council making their own recommendations in a final report to Congress.

(5) Eliminate prescription cost shares for Active Duty Family Members not enrolled at a Military Treatment Facility requires legislative entitlement changes at the DoD level as the change would affect all Services.

(6) The Army Surgeon General (TSG) sent a formal request asking TMA to assess the feasibility of eliminating prescription cost shares for Active Duty Family Members not enrolled at a Military Treatment Facility. TMA responded requesting a delay in any action while waiting for results from proposed legislation for FY12 budget. The Task Force on the Future of Military Health Care proposed to eliminate the copay for generic medications at the Mail Order Pharmacy (MOP) only and awaits congressional action. A second challenge is identifying individuals through the Defense Enrollment Eligibility Reporting System (DEERS), requiring a modification to include identifiers regarding patient choice not to enroll in MTF versus patient forced to use purchased care with an additional change if patient later became enrolled at MTF.

**h. Lead Agency:** DASG-HSZ

**i. Support Agency:** TRICARE Management Activity

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 12 Jan 11)

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

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

#### **f. Conference Recommendations.**

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

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

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

(1) As of 30 September 2010, the Army has 3,877.5 behavioral health providers on board and a shortage of 388; this is a slight improvement on percentage filled from 90.36 the last quarter to 90.90%. Since 1 October 2007, the Army has added 1,229 civilian, military, and contract BH providers, a 65% increase, not counting BH

technicians. Focus continues on hiring using incentives, compensation flexibilities and building the bench. Behavioral Health (BH) hiring difficulties are not due to lack of funding, but stem from remote locations, compensation limitations inherent to government employment, and a national shortage of qualified providers.

(2) Congressional funds designated specifically for enhancing access to BH totals \$193 M in the FY11 budget. This funding is sufficient to cover current BH operations, but does not allow for enhanced access to care initiatives or expansion of services to improve quality of care.

(3) The AMEDD continues to support and promote incentives to maintain and recruit quality BH professionals. In partnership with Fayetteville State University, MEDCOM developed a Masters of Social Work program which graduated 19 in the first class in 2009 (current capacity is 30 candidates). Additionally, the use of the Active Duty Health Professions Loan Repayment Program (HPLRP) was expanded; and offers a \$20K critical skills accessions bonus for Medical and Dental Corps Health Professions Scholarship Program (HPSP) applicants. MEDCOM increased the number of Health Professions Scholarship Allocations dedicated to Clinical Psychology and the number of seats available in the Clinical Psychology Internship Program (CPIP).

(4) Since the start of Operation Iraqi Freedom, the Army has significantly increased the annual number of graduate students admitted to its clinical psychology internships. Prior to 2004 the Army historically trained 12 interns per year and has progressively increased that number, admitting 33 interns in 2009. In addition, the Army is attempting to hire or contract an additional 146 psychologists. Additionally, the Uniformed Services University of Health Sciences (USUHS) Department of Medical and Clinical Psychology offers three degree producing programs, to include a PhD in Clinical Psychology. The Army is allotted three spaces per year in this five year DoD/Tri-Service program. Individuals are then fully licensed.

(5) The Annual United States Army Medical Symposium (AUSA) provided the venue for the AMEDD Flag Officer Strategic Session. One of the main topics included discussion centered on Human Capital Distribution Plan (HCDP) Purpose Refinement. All AMEDD Flag Officers (not just RMC/MSC commanders) were invited and discussed strategic human capital issues. This provided the way ahead and guidance to lead up to the Fall HCDP conference.

(6) The FY12 HCDP Conference was conducted in December 2010 and provided for the equitable distribution of FY12 behavioral health human capital resources. The Behavioral Health Capability Team briefed the comprehensive scope of all behavioral health assets, the current Army behavioral health provider strength and the way ahead to meet the growing needs of the beneficiary population: maintain an adequate provider pipeline, enhance interaction between AC and RC behavioral health providers, focus recruitment efforts, and emphasis on retention.

(7) Through 30 June 2010, the on-board strength for civilian BH providers grew from 819 on 31 March 2006 to 1,742; an increase of 113% or 923 new hires. This doubling of the workforce during a four year period re-

sulted in the following: (1) Psychologists (an increase from 288 to 557 or a 93% increase), (2) Social Workers (an increase from 369 to 887 or a 140% increase), (3) Psychiatrists (an increase from 89 to 136 or a 53% increase), and (4) Psychiatric RNs (an increase from 73 to 162 or a 122% increase). To achieve the 113% increase in civilian behavioral health providers, the MEDCOM aggressively pursued several actions to increase the staffing levels.

(8) MEDCOM currently has 354 open recruitment actions among these four occupations. For the past three fiscal years, the MEDCOM centrally funded \$1.5M annually for the student loan repayment program for registered nurses, including psychiatric registered nurses. It also set aside monies for recruitment, relocation, and retention incentives for all health care occupations. A little more than \$11M was granted to civilian employees in the four behavioral health occupations during the last 18 months through the end of March 2010. Our expenditures for these incentives have increased significantly from FY07 through FY10 (\$251.6K to \$4.48M for psychologists and \$67K to \$2.18M for social workers).

(9) There are three major actions affecting the civilian BH workforce.

a. First, by direction of the Secretary of the Army, effective 1 October 2010, MEDCOM will transfer operational and administrative control of the Army Substance Abuse Program to the Installation Management Command (IMCOM). A total of 305 positions currently on MEDCOM's rolls will be transferred; 109 psychologists, 136 social workers, plus 60 other positions to include clinical directors.

b. The second major action is attributed to BRAC 2005. The ASAP Clinics at Fort McPherson and Fort Monmouth will close effective September 2011 affecting three (3) counselors which are to be realigned to IMCOM and offered existing vacancies within the ASAP community. The eight (8) ASAP Counselors at Fort Belvoir will also be realigned to IMCOM. The nine (9) ASAP Counselors at Walter Reed will be realigned to the Joint Task Force CapMed, at Bethesda, upon the disestablishment of the Walter Reed hospital on or about 15 September 2011.

c. The third action is the ongoing DoD effort to develop a Title 38 based personnel system for the 30 health-care occupations exempted by DoD from conversion to GS. The four BH occupations are included. The intent is to develop a personnel system by not later than 31 Dec 2011 which updates occupational qualification standards, institutes a rank-in person system, and provides compensation parity with the VA.

(10) MEDCOM continues to increase Behavioral Health contracting by over 7% from a year ago. This increase was achieved through the (1) use of contracting vehicles to speed the award of contracts, (2) contractors utilizing more progressive marketing and recruiting tools to identify potential contractor candidates for BH positions and (3) converting contractor positions to government civilians. Despite the best efforts some of the BH specialties and positions at remote and other hard-to-fill locations remain a challenge to fill. The contracting community has successfully employed the following action to improve the

situation: (1) use of relocation and incentive fees, (2) speeding the credentialing process for candidates, (3) expanding marketing to all BH communities to access a larger pool of potential candidates, and (4) implementing the Army Direct Care Medical Services (ADCMS) and other Blanket Purchase Agreements (BPAs) as tools to award both sustained and contingency BH requirements.

(11) MEDCOM created a new Tele-Health division, with an initial focus on BH and mTBI issues. Services include tele-Psychiatry, tele-Psychology, Medical Evaluation Boards, Temporary Disability Retired Lists, Mental Status Evaluations, tele-Neuropsychology, the School-Based Mental Health Program, the AKO Tele-consultations Service, and the Virtual BH Program. These real-time tele-BH services are provided via video-conferencing technology through a network of 53 active sites across five Regional Medical Commands. Store-and-forward tele-BH services are also provided to theater through email exchange in the AKO Tele-Consultations Service.

(12) The Army provided over 7,000 consultations in 41 countries and in 39 specialties, including BH, through this service. Tele-health increases access to specialty care in geographically dispersed areas, enables greater continuity of care, and provides surge capacity. However, these benefits should be weighed against the costs of diverting providers away from pre-existing face-to-face appointments to perform tele-health encounters.

(13) GOSC review.

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

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

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

### **Issue 649: Compensatory Time for Department of the Army Civilians**

**a. Status.** Active

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

**c. Final action.** No (Updated: 30 Nov 10)

**d. Subject area.** Employment

**e. Scope.** DA Civilians who work irregular or occasional overtime receive compensatory time at a disproportionate rate than overtime pay. Compensatory time is granted at one hour off for each hour of overtime worked. Overtime pay is usually paid at one and one-half times the hourly

rate. Receiving one compensatory hour for each overtime hour neither acknowledges nor compensates the employee for the impact of lost evenings or weekends.

**f. Conference Recommendation.** Increase compensatory time for DA Civilians to 1.5 hours off for each hour of overtime worked.

**g. Progress.**

(1) Costs associated with increasing compensatory time off for employees to 1.5 hours for each hour of overtime worked will vary depending upon the total number of hours of compensatory time worked and the employee's salary. Compensatory time earned is paid at the overtime rate after 26 pay periods if not used. The increased hours of compensatory time earned can result in more time off from work, an additional loss of productivity.

(2) When DFAS provided requested data in raw form in late April 2010, HQDA conducted a cost analysis to determine Army-wide implications and potential costs. The cost associated with implementing the AFAP recommendation could be significant just within Army alone. The AFAP recommendation would impact all Federal agencies and would require a legislative change to implement. Current media reports of Federal workers being paid at higher levels than private sector workers would draw even more negative attention to the Federal salary schedule.

**h. Lead agency.** G-1, DAPE-CPZ

**i. Support agency.** AARP-RM and DFAS

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 29 Nov 10)

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

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

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

**g. Progress.**

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

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

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

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

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

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

(7) On 20 Oct 10, the EFMP Working group will meet to finalize these decision points: define terms for enrollment versus registration; develop criteria for database; discuss resolution for privacy issues and finalize interim solution for data base; define who will receive and track RC DD2792 forms; how will enrollment records be maintained; and resource requirements (respite care, staffing, database).

(8) On 1 Dec 10, recommendations will be briefed to LTG Stultz, USAR and MG Carpenter, ARNG.

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

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

**i. Support agency:** IMWR-FP

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 29 Nov 10)

**d. Subject area.** Family Support

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

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

**g. Progress.**

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

(2) OTJAG concluded that resolving this issue would require change to OPM and/or Federal Ethics Regulation and potentially have legislative impacts. OTJAG suggested FRGs may fundraise on installations; however, Reserve Component FRGs would be limited to AFRCs or

Armories. OTJAG indicated that 501-3c (tax-exempt, nonprofit) status and then fundraise externally.

(3) Family, Morale and Welfare and Recreation Command (FMWRC) Family Programs reiterated similar recommendations.

(4) Reviewed issue with FMWRC SJA. FMWRC SJA will coordinate with OTJAG and provide an opinion on issue resolution and suggested language.

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

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

(7) FMWRC action officer and OACSIM action officer met to examine the current FRG fundraising strategy. The recommended course of action is to curtail FRG fundraising and explore options for funding FRGs. Recommendations include: (1) \$500 cap for "Cup and Flower Fund" (not lower than company/battery level); (2) Commanders have a brigade level mechanism and an SOP to accept donations; (3) Examine option to fund FRGs based on a Dollar to Soldier Ratio and (4) FRGs have the option to establish a 501-3-c, Private Organization, if they desire to fundraise.

(8) Recommendations were coordinated with USAR and ARNG Family Points of Contact.

(9) DAIM-IS was briefed on above recommendations. Guidance was to further develop recommendations and provide an update Oct 10.

(10) ACSIM coordinated a teleconference with, FMWRC and Reserve Component Family Programs Points of Contact to further review and revise FRG Holistic Funding strategies. Revised recommendations include: (1) Examine option to develop dollar ratio for FRGs (similar to unit MWR funds) to fund non mission essential activities; (2) Recommend a \$1000 cap on Informal Funds; (3) Recommend Informal Funds to be established not lower than the company/battery level; (4) Develop an FRG survey tool/questionnaire to ascertain what FRG tasks are not currently being met via funding options (APF, Informal, and Supplemental); (5) Develop a standard budget template for Commanders for FRG mission essential tasks; (6) Reinforce training for Commanders and FRG members on FRG mission essential tasks; and (7) Review recommendations with Senior Spouses and/or FRG Leaders.

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

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

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

**i. Support agency.** IMWR-FP, OTJAG

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 29 Oct 10)

**d. Subject area.** Force Support

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

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

**g. Progress.**

(1) Since February 2010 the Behavioral Health Division has made three site visits to local programs who train service dogs that assist disabled Service members and veterans.

(2) In February 2010 OTSG developed an Animal Assisted Therapy/Animal Assisted Activities policy letter/memorandum for the Regional Medical Commanders.

(3) On 6 June 2010 the Behavioral Health Division provided a pre brief to TSG informing him of the approximate cost of contracting with local nongovernmental organizations to provide service dogs to Wounded Warriors.

(4) In September 2010 the Behavioral Health Division developed a MEDCOM policy for use of canines and other service animals in Army medicine. The policy specifically addresses use of service dogs with Wounded Warriors (WW)/Warriors in Transition (WT) who are in the critical phase of their rehabilitation program where both significant progress and sometimes setbacks occur. Through this policy, standards are established for authorized use of service dogs at Military Treatment Facilities (MTF). This policy is currently being staffed.

(5) Behavior Health Division engaged OTSG Resource Management beginning September 2010 to explore funding options to support an Army service dog program. Two funding options exist. One will be to pursue joint incentive funds and leverage the Veterans Administration as it recently received Congressional funding to start a VA service dog program. Second, OTSG will submit an unfunded requirement (UFER) to MEDCOM and Army to compete for funding.

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

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

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

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 29 Oct 10)

**d. Subject area.** Entitlements

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

**f. Conference Recommendation.**

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

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

**g. Progress.**

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

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

b. PL 111-84. The DoD Office of Wounded Warrior Care and Transition Policy (OWWCTP) continues to develop a USD (P&R) Directive Type Memorandum to implement Section 603 of PL 111-84 to establish a caregiver stipend for catastrophically injured Service Members. Currently, progress is limited due to a pending decision by DEPSECDEF concerning the population eligible for receipt of the stipend. The issue is whether all catastrophically injured Service Members would qualify or only those wounded or injured in a theater of war or, alternatively, only those who would qualify for Combat-Related Special Compensation.

c. The DoD Senior Oversight Council (SOC) approved a stipend of \$2,983 per month paid to all Service Members who are catastrophically injured in the line of duty and require the assistance of a caregiver to avoid placement in an institution. Note: S. 3454 (NDAA 11) Section 632 seeks to clarify that the stipend amount will match the amount specified in 38 USC Section 1720g, which currently is the \$2,983 per month amount mentioned above. The already passed House version of NDAA 11 (HR 5136) does not contain any such provision. S. 3453 would also require DoD to report to Congress on the implementation of appropriate training programs for

caregivers of active duty service members eligible for caregiver compensation under 37 USC Section 439.

d. PL 111-163. Title I of PL 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010 calls for the Department of Veterans Affairs (VA) to establish a training, support, care, and stipend program for family member primary caregivers of Veterans who require assistance with Activities of Daily Living. Payment will vary by location, nature, and frequency of care provided and payment will be made directly to caregiver. A VA work group is currently developing implementation guidance for the management of the stipend program. OWWCTP is sitting in on the work group sessions to ensure coordination of the DoD NDAA 10 Caregiver Stipend program with the VA program.

(2) PL 111-84 and PL 111-163 provide for caregiver stipends, training, and other considerations based on the degree and amount of care a Soldier/Veteran requires, thereby negating any requirement for lump sum payments from TSGLI.

**h. Lead Agency:** WTC

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

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 12 Jan 11)

**d. Subject area.** Entitlements

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

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

**g. Progress.**

(1) Section 631 of the NDAA for FY08 amended title 37 United States Code to provide authority for reimbursement of travel expenses of up to \$300 per round trip for certain RC Soldiers who are: (1) qualified in a skill designated as critical; (2) assigned to a unit or in a reserve pay grade with a critical manpower shortage; or (3) assigned to a unit or position that is disestablished or relocated due to defense base closure or realignment or other force structure reallocation and the member is required to commute outside the local commuting distance. ALARACT 249/2008 further defined the normal commuting distance to be within 150 miles.

(2) DoD Manual 4165.63-M "DoD Housing Management (Sep 93) authorizes "Reserve

Component personnel to occupy transient Unaccompanied Personnel Housing (UPH) during periods of scheduled inactive duty training at an installation.

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

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

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

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

(7) GOSC Review. The Feb 11 GOSC declared the issue as originally written unattainable because the other Services do not support changing the JFTR to provide a general "residence to duty to residence" compensation entitlement for RC IDT travel. Issue will be recrafted by the Army Reserve. The FY08 NDAA authorizes reimbursement (up to \$300 per round trip) for RC Soldiers: (1) qualified in a critical skill; (2) assigned to a unit or in a reserve pay grade with a critical manpower shortage; or (3) assigned to a unit or position that is disestablished or relocated due to BRAC or force structure reallocation and the member is required to commute outside the local commuting distance. The Chief, Army Reserve said that he recognizes the burden on Soldiers in some cases to travel and pay out of pocket for hotel or gas, especially junior enlisted Soldiers. He recognized that the other Services do not support a change to the JFTR. He explained that the Army Reserve received authority to contract lodging, and where possible, are contracting hotel rooms near the Reserve Centers, with priority to junior enlisted first. The Army Reserve is also exploring a possible offset to travel expenses. The Army National Guard representative added that, even though the Guard is state centric, there could be a 400-mile distance between duty location and residence, which can be a very serious issue, particularly for junior enlisted Soldiers. The FMWRC Commander stated that the Lodging Success Program might be able to assist in hard-to-get-at spots and realize some savings.

**h. Lead agency.** USAR

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

**a. Status.** Active

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

**c. Final action.** No (Updated: 18 Nov 10)

**d. Subject area.** Medical

**e. Scope.** When the TRICARE beneficiary chooses an upgraded/deluxe DME, the beneficiary must pay full cost out-of-pocket with no reimbursement for the TRICARE allowable charge. DME providers are limited to accepting the TRICARE allowable charge as payment in full for the medically necessary standard DME. Purchasing the upgraded/deluxe DME could improve patient compliance, quality of life, comfort, or function. Reimbursement of the TRICARE allowable charge offsets the increased cost of the upgraded/deluxe DME incurred by the TRICARE beneficiary.

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

**g. Progress.**

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

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

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

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

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

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

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

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

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

(6) OTSG coordinated with TMA to see if beneficiaries can be authorized reimbursement of the TRICARE allowable charge for the standard DME when a patient chooses an upgraded/deluxe DME at their own expense. OTSG sent a formal request, asking TMA to assess the feasibility of this option to meet the intent of this AFAP recommendation. In their response, TMA agreed having such an option would offset the cost and would improve patient quality of life, comfort and function. TMA stated they would support our submission of a Unified Legislation and Budgeting proposal to modify Title 10. Cost estimates will be determined following the OTSG and TMA's assessment of a way ahead.

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

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Force Support

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

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Family Support

**e. Scope.** The unremarried former spouses of Soldiers who retired under Temporary Early Retirement Authority (TERA) are not entitled to benefits under the 1982 Uniformed Services Former Spouses' Protection Act (USFSPA). The TERA allowed Servicemembers (SM) to receive retirement benefits at fewer than 20 years however it did not protect unremarried former spouses. Minimum eligibility requirements for full benefits currently include 20 years of marriage, 20 years of credible service and 20 years of overlap. The minimum eligibility requirements under the USFSPA were not updated to reflect the TERA. For example, a SM and spouse who were married for 18 years while SM served 18 years of credible service and the SM retired with full benefits at 18 years. When they divorced, the SM retains full benefits but the spouse does not. Unremarried former spouses of a SM who retired under TERA deserve full retention of benefits.

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Force Support

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

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Family Support

**e. Scope.** There is no formal standardized training for Designated Caregivers of Wounded Warriors on self-care, stress reduction, burnout and prevention of abuse/neglect. A November 2010 study *Caregivers of Veterans- Serving on the Homefront* showed, "Providing care to a veteran (under the age of 65) with a service-related condition has widespread impacts on the caregiver's health." This study also reported increased stress or an-

xiety (88%) or sleep-deprivation (77%) among Caregivers. The Department of Veteran Affairs recognizes this issue and is developing training for Family Caregivers of Wounded Warrior Veterans. Designated Caregivers with no formal training experience stress, anxiety, and burnout, which may lead to Wounded Warriors abuse/neglect.

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

**h. Lead agency.** OTSG

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Medical

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

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Family Support

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

are caused undue emotional stress when they must justify their survivor status.

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

**h. Lead agency.** AHRC

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Medical

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

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

**h. Lead agency.** OTSG

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Force Support

**e. Scope.** RC Soldiers can only apply for MRP2 within six months from their date of release from active duty (REFRAD). Warrior Transition Unit Consolidated Guidance (WTUCG 20 March 2009) states the MRP2 program is designed to return Soldiers back to active duty for the purpose of evaluation, treatment, and/or physical disability evaluation system (PDES) processing. Examples of conditions that might not manifest within six months include Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and recurring orthopedic injuries. Extending the MRP2 time restriction to five years would allow RC Soldiers to receive proper medical treatment in

order to identify and resolve contingency related medical and behavioral health conditions.

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Entitlements

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

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Child Care

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

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Youth

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

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Family Support

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

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Employment

**e. Scope.** Department of Army Civilians (DACs) are not authorized to utilize the Strong Bonds program. DACs are being deployed into Overseas Contingency Operations (OCO) and combat zones. As a result, deployed

DACs and their Families undergo many of the same stresses and have similar relationship issues related to long-term separations and difficult experiences as Soldiers and their Families. Permitting the use of the Strong Bonds program will allow deployed civilians and their Families the benefits of creating strong support groups, building resilient relationships, and promoting healthy Families.

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

**h. Lead agency.** OCCH

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Medical

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

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

**h. Lead agency.** OTSG

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Medical

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

gibility or through a family member." A contracted cadet and their dependents have many of the same health challenges as a Selected Reserve and their dependents. A medical health care entitlement, similar to TRS, for contracted Cadets and their dependents will help to ease a financial burden.

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

**h. Lead agency.** OTSG

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

**a. Status.** Active

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

**c. Final action.** No

**d. Subject area.** Employment

**e. Scope.** Because DACs retiring OCONUS do not receive locality pay, their retirement annuity is less than the annuity of a DAC of comparable grade who retires from a CONUS location. When calculating "annuity pay" for a DAC employee located in CONUS, base pay plus the locality pay is used. When calculating "annuity pay" for a DAC employee located OCONUS, only base pay is used. The purpose of "Virtual" Locality Pay is to achieve equity of retirement pay of CONUS and OCONUS employees at the end of the employees' career. "Virtual" Locality Pay would enable overseas employees to have their annuity benefits calculated as if they received CONUS based locality pay in the computation for their "high three years" of average salary.

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

**g. Progress.** Progress on resolving this issue will be reported in the Summer 2011 Issue Update Book.

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