AFAP ISSUE UPDATE BOOK

Active Issues

April 2016

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

#	Issue Title	Status	Subject area	Entered
679	Creditable Civil Service Career Tenure Requirements for Federally Employed Spouses of Service Members and Federal Employees	Active	Employment	Feb-12
689	Sexual Assault Restricted Reporting Option for Department of Army Civilians	Active	Employment	Apr-14
650	Exceptional Family Member Program Enrollment Eligibility for RC Soldiers	Active	Family Support	Jan-10
690	Army and Local Community Support for Reserve Component, Geographically Dispersed, and Transitioning Soldiers and Families	Active	Family Support	May-15
691	Reserve Component Soldiers and Families Access to Army Community Service Services	Active	Family Support	May-15
614	Comprehensive Behavioral Health Program for Children	Active	Military Health System	Dec-07
641	Over Medication Prevention and Alternative Treatment for Military Healthcare System Beneficiaries	Active	Military Health System	Jan-09
692	Reserve Component Soldiers Behavioral Health Treatment Regardless of Duty or Veteran Status	Active	Military Health System	May-15
596	Convicted Sex Offender Registry OCONUS	Active	Soldier Support	Nov-06
609	Total Army Sponsorship Program	Active	Soldier Support	Nov-06

Issue 596: Convicted Sex Offender Registry
a. Status. Active
b. Entered. HQDA AFAP Conference, 17 Nov 06
c. Final action. No (Updated: 21 Sep 15)
d. Scope. The OCONUS population is not afforded the same information about convicted sex offenders as personnel stationed in CONUS. No OCONUS registry of convicted sex offenders with a Department of Defense Identification/Installation Access Card exists, thereby denying overseas community members the ability to identify a potential risk of harm to the community. Overseas personnel are more vulnerable to potential assaults by convicted sex offenders.
e. AFAP Recommendations.

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

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

f. Progress.

(1) On 2 Sep 12, Army General Council (AGC) and Office of The Judge Advocate General (OTJAG) did not support publishing the names of Army sex offenders on installation web pages - opining "significant policy concerns". Ultimately an Army hosted Registered Sex Offender (RSO) web site duplicate the DoD Law Enforcement (LE) initiative to match the Federal Bureau of Investigation (FBI) National Sex Offender Registry (NSOR) against the Defense Enrollment Eligibility Reporting System (DEERS) identifying any RSOs in DEERS (Service members, military dependents, federal employees, contractors). DoD's actions alleviates the requirement for an Army "stand alone" RSO website.

(2) Army Regulation (AR) 420-1, (Army Facilities Management), requires Soldiers, Family members, DoD civilians, or other civilians, who are required to register as a sex offender, who intend on occupancy of/or overnight visitation to a Family housing dwelling unit, to provide proof of registration at the Provost Marshall's office prior to occupancy or visitation. Failure to do so will result in the host sponsor being evicted from housing.

(3) SecArmy Directive 2013-06 (Providing Specified Law Enforcement Information to Commanders of Newly Assigned Soldiers; 14 Feb 13) authorizes brigade level commanders to receive newly assigned Soldier's criminal history reports. The Army Law Enforcement Report will contain a sex offense reported to Army law enforcement.

(4) SecArmy Directive 2013-21 (Initiating Separation Proceedings and Prohibiting Overseas Assignments for Soldiers Convicted of Sex Offenses, 7 Nov 13) requires commanders to initiate administrative separation of any Soldier convicted of a sex offense. If the separation authority ultimately approves retention, he or she will initiate an action for the exercise of Secretarial plenary separation authority. If a Soldier has already been the subject of an administrative separation action for that conviction and has been retained as a result of that proceeding, the separation authority will initiate a separation action under Secretarial plenary authority. In addition, the directive requires commanders to ensure that Soldiers convicted of a sex offense are not assigned or deployed on a temporary duty assignment, temporary change of station, or permanent change of station status to non-permitted duty stations OCONUS. The only permitted OCONUS locations are Hawaii, Alaska, the Commonwealth of Puerto Rico, or Territories or possessions of the United States. Soldiers currently serving in any non-permitted OCONUS location are ineligible for continued duty at those locations. Accordingly, OCONUS commanders are required to identify such Soldiers in their commands and coordinate for reassignment to CONUS or permitted OCONUS locations.

(5) Published DoD Directive-Type Memorandum (DTM) Draft 15-003 RSO Identification, Notification, and Monitoring (26 Mar 15) provides for the use of National Crime Information Center (NCIC) information retrieved through the Identity Management Capability Enterprise Services Application (IMESA) for DoD identification, notification, and monitoring of RSOs that live or work on DoD installations. The IMESA will identify affiliated personnel through DEERS, the installation local population database, delayed entry population file and the enlisted referral file and match them against the NCIC National Sex Offender Registry (NSOR) file. OSD will share NSOR information with appropriate defense criminal investigative organizations.

(6) Army G-1 Director of Military Personnel Management published a revision to AR 614-30 – Overseas Service (Jan 15) – which prohibits dependents who are RSOs from accompanying Soldiers on OCONUS tours. Soldiers will be required to declare RSO dependents during reassignment processing with the order issuing authority.

(7) Human Resources Command (HRC) tracks Soldier RSOs using the eligibility limiting assignment code of "L8". Updates of Soldiers with a qualifying sexual assault conviction are provided to HRC by the Office of the Deputy Chief of Staff, G-1 Human Resources Policy Directorate, OTJAG, and the OPMG. Soldiers who are convicted sex offenders are notified of the requirement to in- and out-process with the PMO. Additionally, installation PMOs are required to communicate convicted sex offender information between gaining and losing PMOs.

(8) AR 614-200, (Enlisted Assignments and Utilization Management) and AR 27-10, (Military Justice), require Soldiers who are convicted sex offenders to register with the installation PMO. Further, AR 27-10 requires Soldiers convicted of a sex offense in trial by Special or General Court-Martial (that requires sex offender registration and not confinement), be notified of the sex offender registration requirement by using DA Form 7439. A copy of that form is required to be sent to the OTJAG who will notify HRC (using the DA 7439 and other relevant materials) of Soldiers convicted of these non-confining sex offenses.

(9) The Army's in- and out-processing forms (DA Form 137-1 Unit Clearance Record; DA Form 137-2, Installation Clearance Record; DA 5123-1, In-Processing Personnel Record) revised 3QFY10, require Soldiers process through the installation PMO and report if they are required to register as a sex offender.

(10) Publication revised AR 190-45 will require all qualified convicted sex offenders (Family members, Depart-

ment of the Army civilians, and contractors) who reside or are employed on Army installations to register at the installation PMO.

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

g. GOSC review.

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

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

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

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

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

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

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

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

(9) Sep 15. The VCSA declared the issue active pending publication of regulatory guidance.

(10) Apr 16. The VCSA declared the issue active pending publication of regulatory guidance.

h. Lead agency. OPMG

i. Support agency. OUSD-P&R, OTJAG, DAPE-SH, DMPM, HRC, ACSIM

Issue 609: Total Army Sponsorship Program

a. Status. Active

b. Entered. HQDA AFAP Conference, 17 Nov 06

c. Final action. No (Updated: 22 Apr 16)

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

e. AFAP Recommendations.

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

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

f. Progress.

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

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

(3) In Mar 11, OACSIM-ISS requested both the IMCOM IG and Human Resources Command (HRC) to verify if sponsorship is included in Pre-CIP and CIP, and being inspected. According to the IMCOM IG, the CIP has been postponed due to funding shortages. HRC advised sponsorship inspection is not a HRC requirement; their focus is on training S1/G1's on readiness issues such as reducing non-availables, casualty documents,

and personnel systems. In response, in Apr 11, OACSIM-ISS requested Services Infrastructure Core Enterprise (SICE) Board's assistance to help address TASP compliance and enforcement issues across the Army.

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

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

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

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

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

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

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

(11) IMCOM hosted a two day (2-3 Apr 15) ACT Conference with participation from FORSCOM, TRADOC, USAR, HRC, and other key stakeholders across the Army to finalize the verbiage in the ACT Sponsorship Phased Implementation EXORD. Key areas of concern were discussed/mitigated resulting in a consensus by all participating commands, with the exception of HRC. Continued coordination enabled OACSIM to obtain HRC's concurrence after the "No Sponsor – No Orders" tool was removed from the EXORD. All parties agreed to utilize alternative leveraging tools which could both monitor and report sponsorship metrics while holding gaining commands responsible for timely sponsor assignment.

(12) On 5 Jun 15, OACSIM submitted the ACT EXORD for final review and approval. EXORD will be reviewed by Army G3/5/7 and legal prior to being submitted to senior Army leadership (SMA/VCSA) for final review/approval.

(13) IMCOM hosted a three-day (5-8 Jan 16) meeting with FORSCOM, TRADOC, USAR, HRC, NGB, and other key stakeholders across the Army to determine changes needed in the regulation, as well as the accompanying new DA Pam. Policy and procedural changes required by HQDA EXORD 161-15 were also addressed. The group agreed on the following recommendations:

(a) Initial contact with inbound Soldier can be initiated by gaining command or Soldier simultaneously. It is no longer the Soldier's responsibility to reach out first.

(b) Soldier's contact information located in Army Knowledge Online White Pages will auto-populate in ACT Sponsorship module (by Jul 16) to facilitate "two-way communication".

(c) The Sponsor assignment will be made no later than 120 days from report date versus 10 days from receipt of assignment notification.

(d) If Soldier fails to initiate DA Form 5434, the gaining Unit Sponsorship Coordinator will reach out to the Soldier.

(e) Sponsorship training content and procedures will be revised. IMCOM G1/G9 have formed a working group with target date of May 16 for new product.

(14) IMCOM G1 and the TRADOC ACT team completed ACT Sponsorship training via Defense Collaboration Services for all installations listed in Annex A of the HQDA EXORD 161-15 (Army-Wide Implementation of the TASP ACT Sponsorship Module, Active Component) on 26 Jan 16.

(15) Effective 25 Jan 16, battalion CSMs are added to the ACT Sponsorship module's CSM Visibility feature; facilitating a more direct link to the Soldier's chain of command.

(16) As a result of the inspection of the Military Personnel System, the Army IG recommends transfer of TASP proponency to Army G1. All stakeholders have concurred with the recommendation. A briefing to the Secretary of the Army will be conducted in the Mar/Apr 16 timeframe.

(17) ARNG wrote a draft chapter for AR 600-8-8 and is awaiting ARNG leadership approval.

(18) Draft AR 600-8-8 will be staffed Army-wide in 3rd QTR 16.

g. GOSC review.

(1) Jan 10. The GOSC declared the issue active to fast track an approach to sponsorship that can function in the current operational environment. TRADOC stated the

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

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

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

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

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

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

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

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

(9) Sep 15. The FORSCOM CSM expressed concerns with the process. The FORSCOM CSM stated ACT is driving TASP policy rather than TASP policy dictating ACT functions. The VCSA stated sponsorship has been broken throughout his career but the Army should leverage technology to facilitate the sponsorship process. The VCSA tasked G-1 to take the lead on re-shaping the process, and requested FORSCOM and Training and Doctrine Command clearly articulate what TASP policy should include and align ACT to meet the TASP policy. Additionally, the VCSA directed AFAP GOSC members to make TASP a leadership priority. The VCSA directed ACSIM to accelerate the TASP regulation publication. The Installation Services Director stated a draft regulation would be available in FY16. The Director of the Army Staff agreed to accelerate the APD process.

(10) Apr 16. The SMA stated that "no sponsor, no orders" will be implemented Army wide following a successful pilot. Additionally, sponsorship requirements will be tied to the Soldier's risk category. A specialist would be Tier 1 and required to have a sponsor before orders are issued. A colonel would be Tier 3 and would not be required to have a sponsor. Senior commanders also have the discretion to make a geographic area Tier 1 for all personnel based on unique assignments, such as Kwajalein Atoll. The Chief of Chaplains concurred that transition is a risk time. The SMA closed by stating that the ACT now has White Pages where Soldiers can enter their personal cell phone numbers and email addresses so gaining units can reach the Soldiers.

h. Lead agency. OACSIM

i. Support agency. IMHR-M

Issue 614: Comprehensive Behavioral Health Program for Children

a. Status. Active

b. Entered. HQDA AFAP Conference, 4 Dec 07

c. Final action. No (Updated: 22 Apr 16)

d. Scope. Multiple barriers exist in providing timely, convenient and appropriate Behavioral Health Care Services for children of Active Duty Soldiers, Wounded Warriors and Veterans. There is a critical shortage of Behavioral Health Care Child and Adolescent Providers to meet the current demand. Many Behavioral Health providers are unable to dedicate their entire practice to children's therapy due to occupying administrative positions and performing adult behavioral health care. For example, 504 child psychiatric providers were contacted and only 13% stated they were providing full time child

psychiatric services. The difficulty in recruiting and training direct care providers and a lack of a national educational plan to raise awareness in schools and identify treatment needs, further exacerbate the problem. Comprehensive services are not readily available, nor aligned with other ranges of services for military children, thus creating unneeded barriers to quality Behavioral Health Care.

e. AFAP Recommendations.

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

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

f. Progress.

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

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

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

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

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

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

(4) RMCs training for BH care providers in evidence-based psychosocial practices using the train-the trainer program will begin in Aug 15.

(5) Integrating and coordinating BH services for children and Families within the MTF and local Army community, supporting the principles of a public health model of care continues. MEDCOM staff met with the leadership of "Give an Hour" to have a preliminary discussion for collaborating in expanding SBH to off-post schools and in expanding outreach into the civilian community to provide support for Soldiers' Families. Plans are to pilot this collaboration initially at Joint Base Lewis McChord, Ft. Hood and Ft. Bragg. A Memorandum of Understanding is in the final stages of staffing between Give an Hour and MEDCOM. MEDCOM subject matter experts are on the Advisory Boards of the Center for School Mental Health, University of Maryland and Children Overcoming Military-Based Adversities Together, Rutgers Robert Wood Johnson Medical School as well as members of National Committees that impact Army Children and Families.

(6) Outcome Metrics have been developed. As of DEC 15, approximately 71% of the CAFBHS staffing has been hired or re-missioned. In FY15, CAFBHS patient encounters increased by 7% and aggregate productivity increased 14% for Family Members. The Behavioral Health Data Portal for Adolescents is being implemented Army-wide.

g. GOSC review.

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

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

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

(4) Feb 12. The Secretary of the Army (SA) asked what impact CFACs and SBH programs will have on the Army's requirements for BH providers. The Sergeant Major of the Army (SMA) asked if the objective was to expand SBH programs to all Army garrisons and specifically questioned how that would work with local

school districts who have schools on military installations. The VCSA directed OTSG to define the objective and identify the resource requirement to achieve that objective. OTSG will train Primary Care Managers and BH providers; continue to establish and expand CFACs and SBHs to more installations and standardize metrics and data collection.

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

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

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

(8) Feb 15. The VCSA directed OTSG to lay out their child BH integration efforts with community partners particularly at some larger Army installations. The VCSA expressed interested specifically with the nonprofit organization "Give an Hour."

(9) Sep 15. The OTSG representative stated issue closure is contingent on hiring BH providers. OTSG has only been able to hire sixty five percent of the required staff due to a nationwide shortage of BH providers. The DASD MC&FP offered support through Military Family Life Consultants, particularly the specialists in child and youth behavioral areas. The FORSCOM representative requested remote locations such as Fort Irwin and Fort Polk receive implementation priority. The FORSCOM CSM urged increased recruiting of community partners near Army's installations. The VCSA directed OTSG to provide a follow up on BH provider hiring gaps to analyze how the Army can be more competitive in recruiting BH providers.

(10) Apr 16. The G-3 representative asked whether Soldier BH assets could be used for children. The Surgeon General said no because adult BH do not have proper training to work with children. FORSCOM praised the work done and questioned whether having 90 percent of the PCMs BH providers trained would constitute completion. The VCSA directed the OTSG to work with FORSCOM to determine when the metric for access to child BH providers has been met.

h. Lead agency. DASG-HSZ

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

a. Status. Active

b. Entered. HQDA AFAP Conference, 30 Jan 09

c. Final action. No (Updated: 22 Apr 16)

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

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

f. Progress.

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

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

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

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

(a) MEDCOM directed to establish Regional Medical Command Interdisciplinary Pain Management Centers (IPMC) at: FY11 (start) Eisenhower Army Medical Center, Fort Gordon; Madigan Army Medical Center, Joint Base Lewis-McChord; Tripler Army Medical Center, Hawaii; Landstuhl Army Medical Center, Germany. FY12 (start):

Brooke Army Medical Center, Fort Sam Houston; Womack Army Medical Center, Fort Bragg; Darnall Army Medical Center, Fort Hood; Beaumont Army Medical Center, Fort Bliss. IPMCs represent identification/branding of the highest tier of pain management clinics, in effort to standardize personnel, equipment, and services offered. Services offered include acupuncture, bio-feedback, (yoga), and massage therapy to decrease over-reliance on medication-only treatment of pain.

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

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

(6) MEDCOM strategy continues to partner with several other Army initiatives, including Allied Clinical Services (Polypharmacy), Intrepid Spirits, Performance Triad, Army Medical Homes and Behavioral Health.

(7) The prescribing of chronic opioids decreased from 2% to below 1%.

(8) Some integrative modalities of the CPMP are not TRICARE-approved. Presently, IPMCs prioritize AD beneficiaries and see other beneficiaries as space-available. Future opportunities will allow for work through TRICARE to increase network availability.

(9) Standardized drug testing is being addressed through the HEC pain work group.

(10) At the Feb 15 AFAP GOSC, MEDCOM recommended closure of this issue. However, the VSCA expressed concern regarding transparency and information flow with regard to opioid prescriptions. The issue involves:

(a) MTF prescriptions

(b) network prescriptions

(c) self-referrals that elude MHS visibility

(11) CPMP supports initiatives to increase commander visibility in each of these areas; the greatest risk remains in self-referrals, which require additional time and resources to track.

(a) MTF and Network prescriptions: Within service facilities, chronic narcotic prescriptions are tracked through CHUP (Chronic Pain, High Utilizer, Polypharmacy) and Polypharmacy data pulls that provide Brigade/Division Surgeons updated information, ultimately available to the Commanders through eProfile. CPMP has ongoing efforts with OTSG Director of Allied Clinical Services to make polypharmacy information more accessible. The focus is to streamline data availability through use of CHUP/Polypharmacy registries in order to improve communication with primary care providers, pharmacists and Brigade/Division Surgeons then to commanders.

(b) Soldiers not identified either by CHUP or Polypharmacy: CPMP endorses the Medical Readiness Assessment Tool (MRAT). The MRAT is a predictive tool that uses meta data, predictive analytics, and trending to provide decision support in a holistic format. It identifies potentially at-risk Soldiers. Full implementation of MRAT was delayed and is projected for 2016.

(c) Currently in Beta testing, Allied Clinical Services/DEA initiative will utilize state narcotic prescription registries (NARxCHECK). The program can query statewide opioid prescriptions by individual name. This pilot program is pending funding approval and would provide information on whether a Soldier is seeking medication outside the TRICARE system.

(d) Efforts to increase visibility on prescriptions filled outside MHS will require increased support, resourcing, and financing. CPMP recommends:

(1) Department of the Army issues a policy directing Soldiers to inform unit surgeons of all medical care and prescriptions obtained outside TRICARE network (requires DA/G1 support to enforce).

(2) DHA PASS (Pharmacy Analytics Support Section) streamlines pharmacy reporting data by combining Polypharmacy/CHUP reports, increasing the frequency of their distribution and cross-referencing.

(12) During the Sep 15 AFAP General Officer Steering Committee Meeting the VCSA expressed concerns regarding commanders' receiving notification of Soldiers on medical limiting conditions; particularly those with opioid prescriptions. To address this concern, MEDCOM offers the following information and recommendations:

(a) Prescriptions issued through Health Readiness Platform (HRP) and Network are captured and tracked. Within service facilities, chronic narcotic prescriptions are monitored through CHUP (Chronic Pain, High Utilizer, Polypharmacy) data pulls. In accordance with Army Regulation (AR) 40-501 (Standards of Medical Fitness), identified prescriptions and conditions result in an e-Profile, which is made available to the commanders.

(b) E-Profile is an integral tool for documenting Soldiers' medical conditions. In an effort to improve commander-provider communications and reduce unwarranted variance, MEDCOM published OPORD 10-75 (e-Profile Implementation), which ensured commanders had access to Soldiers on profile for limiting medical conditions/prescriptions.

(c) All Army Activities (ALARACT) Message 017/2011 (ALARACT HQDA EXORD 055-11, Army Implementation of Electronic Profile (e-Profile)) provided guidance to Soldiers and unit commanders on registration and access to e-Profile records.

(d) U.S. Army Audit Agency conducted a review of management of the e-Profile process for MEDCOM. The following findings and recommendations are noted:

(1) Initial e-Profile implementation HQDA EXORD only stated that unit commanders or their designee must register with e-Profile. Of 919 identified unit commanders, less than 50% were registered in e-Profile.

(2) MEDCOM to draft an updated ALARACT/ EXORD and synch with revision of AR 40-501 to include Chapter 7 (Profiling) and Chapter 11 (Medical Readiness). The EXORD will clearly direct unit commanders to register in the e-Profile system.

(13) MEDCOM established an enduring strategy for pain management and recommends that the issue close as completed. Proposed measures of effectiveness to track final implementation include the Pain Assessment

Screening Tool and Outcomes Registry (PASTOR), a National Institute of Health collaborative data collection platform that tracks progress of patients with pain. Evaluation will be reported via the Strategic Management System.

g. GOSC review.

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

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

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

(4) Aug 12. Issue remained active.

(5) Jun 13. Issue remained active.

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

(7) Feb 15. The VCSA directed OTSG to look at the transparency of information exchange with civilian healthcare providers to ensure the military healthcare system knows what is being prescribed by civilian providers.

(8) Sep 15. The DHA representative applauded the Army's work as ground breaking not just in DoD but also in the civilian sector. The VCSA directed OTSG to clearly state the metric that will be used to determine successful completion and close the issue.

(9) Apr 16. The Surgeon General stated that the Medical Readiness Assessment Tool will have indicators to generate command reports on Soldiers utilizing opioids. The reports will be distributed to healthcare teams to ensure healthcare teams have visibility on network provider prescriptions. MEDCOM is developing a pilot program to track who buys opioids out of pocket and out of the network to close the loop on those Soldiers using out-of-network civilian providers.

h. Lead agency. DASG-HSZ

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

a. Status. Active

b. Entered. HQDA AFAP Conference, 15 Jan 10

c. Final action. No (Updated: 21 Sep 15)

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

e. Conference Recommendation. Authorize RC Soldiers enrollment in the EFMP.

f. Progress.

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

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

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

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

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

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

(a) Enrollment is voluntary.

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

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

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

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

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

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

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

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

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

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

(12) Aug-Nov 12, Secretary of the Army Directive was formally staffed with key stakeholders and forwarded to

OGC for review. OACSIM-ISS needed final review by OGC prior to forwarding directive for Secretary of the Army signature. Effective date for implementing this policy change may require adjustment due to OGC review and Secretary of the Army approval of policy change.

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

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

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

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

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

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

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

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

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

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

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

(24) Mar-Jun 15, OACSIM initiated request to OSD for respite care authority as a result of OTJAG funding concerns.

(25) 20 Jan 16, OACSIM received notification from OSD supporting the Army's effort to provide EFMP Respite Care programming, and would carefully examine how respite care is formulated into policy.

(26) Feb-Mar 16, OACSIM will meet with USAR and ARNG to further discuss the bill payer for EFMP respite care.

(27) 11 Feb 16, OACSIM met with USAR and ARNG to confirm each component will fund the cost of EFMP respite care. This concurrence was contingent upon the OSD guidance on the OSD memorandum provided the Army authority to use Appropriated Funds.

(28) 17 Feb 16, OACSIM met with Army OTJAG. OTJAG determined that the Office of the Assistant Secretary of Defense memorandum, dated 19 Jan 16 provided authority to use appropriated funds for this purpose. OTJAG further stated that it is acceptable for the Army to proceed with a tailored respite care program that does not duplicate the services of other available sources, e.g. TRICARE Extended Care Health Option.

(29) The next step is to convene an OACSIM, MEDCOM, IMCOM, ARNG, and USAR working group to leverage contract process and funding transfer from RC to IMCOM; and to submit a revised version of the draft EFMP regulation, AR 608-75, to OTJAG for review and issue an interim policy to provide guidance until the regulation is published.

g. GOSC review.

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

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

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

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

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

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

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

(8) Sep 15. The VCSA expressed concern whether the RC has allocated money in their budget to fund the EFMP requirement. The ARNG and USAR representatives both validated they will fund the requirement pending OSD decision for respite care authority to use operations and maintenance funding. The Deputy Assistant Secretary of Defense for Military Community and Family Policy cautioned the RC that personnel requirements and training requirements partner with implementing a program.

h. Lead agency. DAIM-ISS

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

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

a. Status. Active

b. Entered. HQDA AFAP Conference, 2 Mar 12

c. Final action. No (Updated: 22 Apr 16)

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

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

f. Progress.

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

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

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

(4) As an interim measure, DCS G-1 CP will issue a reminder that "Family members with status will be granted a minimum 90 calendar days LWOP when they relocate with the sponsor to a new assignment location. Extensions of this initial grant of 90 days are encouraged for employees who have been unable to find employment." Army Regulation 690-990-2, Hours of Duty, Pay, and Leave, Annotated, Book 630, Subchapter S12, states that normally, an initial grant of LWOP will not exceed one year, and if an extension (rare cases) would cause an absence beyond two years, the employee should be separated and reemployed at the time they become available for duty.

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

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

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

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

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

(4) AG-1 CP has worked with Defense Civilian Personnel Advisory Service and OPM to encourage finalization of Federal Register. Comments are still being reviewed at OPM OGC.

g. GOSC review.

(1) Aug 12. Issue remains active.

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

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

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

(5) Sep 15. The DASD MC&FP asked if legislation could resolve the issue. The G-1 representative stated the issue could only be resolved by OPM. G-1 reiterated that an organization can offer one hundred eighty days of leave without pay as a bridging strategy and hire behind the employee. The FORSCOM CSM concurred this is a problem that was brought up at the September 2015 Fort Benning Congressional Military Family Caucus Summit. The FORSCOM CSM offered that Soldiers are provided more than thirty days to relocate before reporting to their new duty. Soldiers receive fourteen days to clear their current duty station, travel days to the new duty station, and the option of thirty days leave in route. OPM's thirty day policy could be a contributor to the increasing number of geographical bachelor Soldiers. The DASD MC&FP offered to engage the White House on issue resolution and assist the Army with an interim solution. The VCSA directed G-1 to provide an OPM contact the VCSA could speak with to adjudicate the issue.

(6) Apr 16. The Acting Secretary of the Army stated he would contact OPM to request OPM finalize the change to policy in the Federal Register.

h. Lead agency. DAPE-CPP

i. Support agency. ASA (M&RA)

Issue 689: Sexual Assault Restricted Reporting Option for Department of Army Civilians (DACs)

a. Status. Active

b. Entered. Command Focus Group, 21 Apr 14

c. Final action. No (Updated: 22 Apr 16)

d. Scope. DACs are not included in Army Regulation (AR) 600-20 "Army Command Policy" and Department of Defense (DoD) Directive 6495.01 "Sexual Assault Prevention and Response (SAPR) Program" for restricted reporting of sexual assault. Restricted reporting allows the sexual assault victim to obtain counseling, medical care, and victim advocacy without launching a formal investigation. Authorizing restricted reporting of sexual assault empowers DAC victims to decide how they want to report their case, utilize advocacy services, and receive treatment.

e. Recommendation. Authorize restricted reporting of sexual assault for DACs.

f. Progress.

(1) The issue of extending restricted reporting to Army civilians was initially addressed as a request for exception to policy from US Army Europe (USAREUR) dated Sep 09. DoD and Army approved a one year pilot test allowing civilians to file restricted reports of sexual assault. During the pilot, the DoD Office of General Counsel (OGC) opined that restricted reporting for Federal civilians is contradictory to Title VIII of the Civil Rights Act, Federal employee's equal opportunity laws, and mandates to maintain a safe work place.

(2) DoD Instruction 6495.02, *Sexual Assault Prevention and Response (SAPR) Program Procedures* was published in Mar 13, stating that civilian employees are not eligible for restricted reports. The Army may not promulgate policy inconsistent with a DoD regulation without first garnering DoD approval.

(3) The VCSA instructed the issue of civilian restricted reporting be pursued as a legislative revision during the Feb 15 AFAP GOSC. Since the AFAP GOSC, the SHARP office has held many meetings with other offices germane to the subject i.e., Assistant Secretary of the Army (Manpower & Reserve Affairs,

(4) It has been determined that this effort can be accomplished in a manner that would not contradict compliance with Title VII of the Civil Rights Act and Equal Employment Opportunity laws. The Army must continue to exercise reasonable care to correct and prevent sexual harassment (including sexual assault).

(5) The cost benefit analysis (CBA) and unified legislation and budgeting (ULB) proposal was submitted to Office of the Chief Legislative Liaison (OCLL) in Aug 15. The ASA(M&RA) approved the submission in Sep 15. The proposal was forwarded by OCLL to the Office of the Secretary of Defense.

(6) The HQDA submission seeks to authorize DoD Civilians and their adult dependents access to the SHARP Services. Equal Employment Opportunity Office, Army Office of General Counsel, Office of the Judge Advocate General, MEDCOM, USAREUR, etc. Efforts are ongoing to collect and analyze funding, manpower, policy, and procedural impacts. The cost benefit analysis (CBA) and National Defense Authorization Act legislative proposals are due to the Office of the Chief Legislative Liaison in 4th QTR FY15 in order to qualify for FY18 funding.

(7) The Army was advised in early Feb 16 that OSD Personnel and Readiness disapproved the Army's legislative proposal request. The Army is awaiting a response to their request that the disapproval be revised to "deferred" in order to allow the Army to revise and resubmit their proposal for FY19.

(8) An Exception to Policy (ETP) allowing the Army to authorize DACs with access to RR, SARCs, and VAs was submitted to DoD SAPR Office on 12 Jan 16. In anticipation of approval of the ETP, implementing policy and procedures are staffed for Secretary of the Army signature and release to the field when appropriate.

g. GOSC Review.

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

(2) Sep 15. The VCSA directed G-1 to contact the Air Force so the Army can duplicate their civilian exception to policy.

(3) Apr 16. The Army submitted a legislative proposal not supported by the Navy and the Air Force. The sister services are concerned about liability. The VCSA questioned the difference between Soldier and DACs restricted reports. The Acting Secretary of the Army stated the Feres Doctrine bars claims against the federal government by members of the Armed Forces and their Families for injuries to a member arising from or in the course of activity incident to military service. Actions by DACs are not protected by the Feres Doctrine. The OTJAG stated DACs electing a restricted report, under

the pilot, will complete a waiver form. The DAC restricted report concern is that Army supervisors will not be able to take Title 7 mandated corrective action because the Army will not be aware if there is a hostile work environment. The Inspector General questioned whether the Army is liable if the offender assaults someone else. OTJAG stated that the liability would be no different than the current situation when a Soldier makes a restricted report. The VCSA directed G-1 to obtain an OSD deferred versus denied status on the legislative proposal. Additionally, the VCSA directed the Provost Marshal General to discuss the issue with his service counterparts to determine if they would support a future legislative proposal.

h. Lead agency. DAPE-SH

i. Support Agency. ASA(M&RA), OTJAG, OCLL

Issue 690: Army and Local Community Support for Reserve Component (RC), Geographically Dispersed (GD), and Transitioning Soldiers and Families

a. Status. Active

b. Entered. Ready and Resilient Campaign GOSC, 19 May 15

c. Final action. No (Updated: 22 Apr 16)

d. Scope: The Army does not synchronize Army provided and local community support for RC, GD, and transitioning Soldiers and Families. Many Army efforts, such as Army OneSource, Soldier For Life, Army Wounded Warrior Community Support Network, Community Covenant, and Joining Community Forces inspire local community action but often communities struggle to connect with RC, GD, or transitioning Soldiers and Families in need. Constrained resources highlight the need to synchronize existing Army and local community support to provide a warm hand off to ensure RC, GD, and transitioning Soldiers and Families are connected to trusted, available local support.

e. AFAP Recommendation: Establish a process to connect RC, GD, and transitioning Soldiers and Families to local community support.

f. Progress.

(1) Reconvened working group and agreed existing policy is adequate to implement.

(2) Identified applicable information and referral capabilities as FACs, Army Strong Community Centers, and Fort Family Outreach and Support Center online/phone number.

(3) The ARNG and USAR have shared information and referral resources for a decade. Additionally, the identified resources have been supporting all geographically dispersed military Families.

(4) Received an OSD (Personnel & Readiness) Joining Community Forces (JCF) brief. JCF seeks to increase awareness of and access to existing military and community resources by leveraging existing Service resources to better connect all service members and Families to critical resources.

(5) Working group is analyzing JCF and courses of action. Initial analysis and discussion focused on piloting JCF in eight states and assessing outcomes.

g. GOSC Review.

(1) Sep 15. The VCSA directed a common operating system where a Soldier can look at a map and know what resources are available.

(2) Apr 16. TRADOC and USAR requested to be included in working group discussions.

h. Lead agency. DAIM-ISS

i. Support Agency. ARNG, USAR and IMCOM

Issue 691: Reserve Component (RC) Soldiers and Families Access to Army Community Services (ACS) Service

a. Status. Active

b. Entered. Ready and Resilient Campaign GOSC, 19 May 15

c. Final action. No (Updated: 22 Apr 16)

d. Scope: RC Soldiers and Families cannot access ACS services if they are past the one year post mobilization window. Army Regulation (AR) 608-1 (Army Community Service) states members of the Army National Guard (ARNG), US Army Reserve (USAR) and their Families are eligible for ACS programs and services while on active duty and during post deployment, not to exceed one year after deployment. Key ACS services enhance and support RC Soldier and Family readiness. By not authorizing RC Soldiers and Families access to ACS services beyond the one year post mobilization window, the Army does not validate that readiness support is unending.

e. AFAP Recommendation: Eliminate the one year post mobilization restriction for RC Soldiers and Families to access ACS services.

f. Progress.

(1) The issue evolved from the 2008 Manpower & Reserve Affairs Geographically Dispersed Task Force and the Aug 13 CSA request for active component services to be fully supportive of the RC. The CSA request became the work of an R2C subgroup until the VCSA approved the issue as a part of the AFAP process in May 15.

(2) Sep 14 OTJAG opined that there is no legal objection to the proposed policy change, to be accomplished through a change to AR 608-1.

(3) Initial analysis showed that there are approximately 68,000 RC Soldiers and Family members residing within a 40 mile radius of Army installations.

(4) RC use of ACS services averages 12%, a fraction of the total RC population that would be eligible with a policy change.

(5) In FY14, the ACS annual report revealed 13% of Soldiers and less than 1% of Family members accessed ACS centers for services.

(6) The FY15 ACS annual report revealed that less than 1% of Family members' accessed ACS centers for services. No data was available to determine what ACS services were provided.

(7) OACSIM, continues coordination with Installation Management Command to determine if ACS Services requires additional ACS funding and staffing.

(8) 11 Feb 16, OACSIM met with the ARNG and USAR POCs to discuss potential users of ACS services by RC members located within 40 miles of Army installations, fiscal constraints, partnership opportunities, and types of ACS services that may be utilized.

(9) With potential closures of ACS facilities with populations under 500 Soldiers, reduced ACS staffing, a

site by site analysis needs to be conducted to determine feasibility of extending ACS services to RC members for an undermined time period between deployments. A working group will meet bi-weekly to conduct further analysis to determine a way ahead and whether this recommendation can be adopted within fiscal constraints.

g. GOSC Review.

(1) Sep 15. The ACSIM stressed the importance of capturing workload and requirements to prevent compromising resources. The DASD MC&FP stressed ARNG and USAR Soldiers and Families are eligible for Military One Source (MOS) regardless of activation status. MOS provides resources and twelve no cost non-medical counseling visits per person per issue. DoD OGC gave OSD permission to engage in paid digital strategies since eighty-five percent of the DoD community is online. The G-6 representative expressed concern for how Army recruiters and their Families receive services. The Installation Services Director said the concern is addressed in Issue 690 which targets the GD. The VCSA directed ACSIM to examine systems being employed to capture how ACS resources are used and how the Army will program for the resources in the future. If the Army offers the resource to the RC, the Army must fund it.

(2) Apr 16. OACSIM will submit a Secretary of the Army directive to eliminate the one-year post-mobilization restriction for RC Soldier and Family access to ACS services and authorize service on a space available basis.

h. Lead agency. DAIM-ISS

i. Support Agency. IMCOM**,** ARNG and USAR

Issue 692: Reserve Component (RC) Soldiers Behavioral Health (BH) Treatment Regardless of Duty or Veteran Status

a. Status. Active

b. Entered. Ready and Resilient Campaign GOSC, 19 May 15

c. Final action. No (Updated: 22 Apr 16)

d. Scope: RC Soldiers regardless of duty and Veteran status are not guaranteed BH treatment. RC Soldiers are not mandated to have health insurance. RC Soldiers who have health insurance may be uninsured or underinsured and may be unable to afford the costs of BH treatment deductibles or copayments. BH issues do not begin and end upon demobilization. BH issues may persist well past the 180 day Transitional Assistance Management Program window or may be a result of non-combat related issues. Not guaranteeing BH treatment regardless of RC Soldier duty or veteran status may cause a readiness issue that left unchecked can lead to RC Soldier non-availability.

e. AFAP Recommendation: Provide BH treatment to uninsured or underinsured RC Soldiers regardless of duty and Veteran status.

f. Progress.

(1) In order to provide BH treatment to uninsured or underinsured RC Soldiers regardless of duty and Veteran status the ARNG determined that a ULB proposal is required to fund a BH voucher pilot for treatment.

(2) The ULB proposal requests legislation to authorize a pilot for vouchers to pay existing BH care providers in the Soldiers or Veterans communities.

(3) The vouchers would be funded by Operations & Maintenance (O&M) funds. Use of O&M funds will negate inclusion of TRICARE in issue resolution.

(4) The ARNG, US Army Reserve, Office of the Secretary of Defense, and Office of the Surgeon General are working on the cost benefit analysis portion of the ULB proposal. There is concern that the program could cost more. Therefore a pilot program with comparison and control groups is proposed and supported by sister services for ARNG and Air National Guard only.

(5) The ULB is targeted for the FY18 submission cycle.

(6) The Centers for Disease Control and Prevention estimates that 20% of people ages 18-65 are uninsured. The majority of ARNG Soldiers are civilians 28 days per month. At least one state has confirmed 20% of their Soldiers have no insurance.

(7) ARNG unemployment rates can be as high as one to three percent above the civilian population, according to the Bureau of Labor and Statistics. Many ARNG Soldiers do not qualify as a veteran, as defined by the Veteran's Affairs (VA), and therefore employers are not offered the same incentives to hire.

(8) Medicaid provides health care for individuals when the total annual income for parents is less than 30% Federal Poverty level (~$6K) with some States increasing this income eligibility to 133% Federal Poverty level (~$16K). Unemployed ARNG Soldiers who earn above this amount due to Guard Drill pays would not be eligible for Medicaid medical care services.

(9) Connecticut has a best practice for Behavioral Health Care coverage. The Military Support Program is funded by the State of Connecticut as part of the Department of Medicaid Assistance Services and allows for ARNG Soldiers, who are not classified as a Veteran, or are without insurance coverage, to receive a maximum of 15 out-patient mental health sessions. This excludes in-patient care and substance abuse treatment.

(10) Virginia Veteran and Family Support Services will cover Soldiers for PTSD/TBI deployment related injuries up to three months to include Family support services at no cost. Virginia's definition of a veteran is a broad interpretation, and is not the same definition as the VA. Virginia provides BH care for all members of the National Guard. In cases of substance abuse, service is provided on a case by case basis.

g. GOSC Review.

(1) Sep 15. The VCSA queried if ARNG needed assistance with the cost benefit analysis required for the legislative proposal. ARNG stated no assistance was needed. The OCLL representative reminded members that sister service support is necessary for the legislative proposal. The DASD MC&FP offered MFLC service as a bridge until legislation is passed. The ASA M&RA Congressional Affairs Contact Officer (CACO) stated that the sister services do not support the proposal and recommended a BH voucher pilot to build support for the initiative. In the interim, the ASA M&RA CACO will attend separate working group meetings with the sister services

who have new BH delivery systems in place. The DHA representative requested inclusion in the issue resolution process to evaluate how DHA could interface. VCSA expressed concern that the ARNG stated the issue evolved because DHA could not meet the need. DHA countered that DHA is lifting and shifting managed care support contracts to cover issues where service is required. The VCSA directed the ARNG to share the potential BH voucher pilot with the sister services to build support. The VCSA also directed the ARNG to develop mitigating strategies to resolve BH treatment until the legislative proposal can move forward.

(2) Apr 16. The VCSA deferred discussion on the issue. The VCSA is working with the Acting Secretary of the Army and the Director, ARNG to mature senior leaders' understanding of the issue and the correct approach to resolution.

h. Lead agency. ARNG

i. Support Agency. OTSG, DHA, USAR, OSD-RA, OCLL