REPORT TO CONGRESS

ON

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

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Office of the Under Secretary of Defense
Personnel and Readiness

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Data in Response to (b) (1)

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

Warrior Transition (WT) and Non-WT Soldiers in the PDES - Total # of Cases

Injury	Component	WT Current	Non –WT	MEB TOTAL
Battle Injury	AC	318	80	398
Battle Injury	RC	36	12	48
Non Battle	AC	1,537	2,804	4,341
Non Battle	RC	750	747	1,497
Sub Total		2,641	3,643	6,284

Warrior Transition Soldiers Pending* the PDES

Component	WT Soldiers Not in the MEB or PEB
AC	3,878
RC	2,937
Sub Total	6,815

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

	WT Soldiers Not in the MEB or PEB
WT non PDES	6,815
WT in PDES	2,641
WT Total	9,456

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

Number of Soldiers in a "hold" Status by Days

PDES Status	Injury	Compo	1 – 100	101 - 200	201 - 300	> 301	Total
PDES WT	BI	AC	133	90	49	29	301
		RC	6	10	9	4	29
	NON BI	AC	701	481	190	201	1,573
		RC	289	173	95	44	601
PDES Non WT	BI	AC	47	19	6	8	80
		RC	5	4	1	2	12
	NON BI	AC	1,746	765	186	106	2, 803
		RC	318	196	128	105	747
Total			3,245	1,738	664	499	6,146

Data in Response to (b) (2)

The matrices enclosed with this report contain implementation comments for respective recommendations of the three reports as required by NDAA FY08, Section 1645. There has been much progress in implementing the recommendations of the various task forces and study groups, but much work remains to be done. Additionally, as discussed in the June 2008 Report, the Department is currently testing a Disability Evaluation System Pilot in several locations to include the National Capitol Region.

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

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

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

The matrices enclosed contain numerous references to aspects of the DES Pilot. A complete review of the DES Pilot establishment and criteria for expansion are contained in separate reports to Congress in compliance with sections 1611(a), 1612(c), 1615(a) and 1644 of the National Defense Authorization Act (NDAA) for Fiscal Year 2008 (FY08), Pub. L. 110-181. A final report on the DES Pilot will be submitted to Congress in August 2009, with an analysis, findings and SOC expansion decision.

Conclusion

The Department has made progress in improving the many complex processes of the DES. It is important to appreciate, however, that the ongoing DES Pilot serves to test and implement process changes intended to significantly improve DES timeliness, effectiveness, simplicity, and resource utilization and to serve as a bridge to evolve the DES. The Department anticipates significant improvements in these areas

given that the DES Pilot integrates DoD and VA processes, minimizes duplication, and improves case management practices. The DES Pilot currently includes disability cases originating from 21 locations nationwide, including Alaska. The Department anticipates making a decision on whether and how to expand the DES Pilot by the end of fiscal year 2009.

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

Data gathering and analysis are ongoing to support delivery of a report to Congress in August 2009, as required by NDAA 2008, Section 1644(g)(3), that will support a SOC decision regarding the future of the DES Pilot. Reports previously delivered to Congress include:

- Feasibility of combining DoD and VA Disability Evaluation Systems (NDAA 2008, Sec. 1612)
- Report on rating reductions after Physical Evaluation Board appeals (NDAA 08, Sec. 1615(e))
- Initial and Interim Status reports on the Disability Evaluation System Pilot (NDAA 2008, Sec. 1644)
- Initial Report on Army Medical Action Plan action to improve Army Disability Evaluation System (NDAA 08 Sec. 1645)
- Report on the continuing utility of the Temporary Disability Retirement List (NDAA 2008, Sec 1647)

The DES Pilot provides one possible solution for a DoD and VA Disability Evaluation System using one integrated disability rating system. As previously mentioned, this system has several key features: simplicity; non-adversarial processes; single-source medical exam and disability ratings (eliminating duplication); seamless transition to veteran status; and strong case management advocacy. The system must remain flexible to evolve and update as trends in injuries and supporting medical documentation and treatment necessitates. The Department has continued to make constructive steps forward in regard to the Disability Evaluation System, to include the Pilot's expansion, the Expedited Disability Evaluation System, and the Physical Disability Board of Review. However, it is time for a national dialogue on how America supports its wounded, ill and injured. We need to break down barriers to

trust and transparency, and support recovery, rehabilitation and where appropriate the transition of our Service members to veteran status. The DES Pilot is simply a bridge to an evolved DES System.

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

Enclosures:

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

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

Enclosure 1 - Recommendations and Actions Taken - Independent Review Group

Item Reference #	Reference	Recommendation	Implementation Actions	Previous Status	Current Status
P-1	VA TF on Returning GWOT Heroes	Develop a Joint Process for Disability Determinations Develop in-depth plan for VA/DoD collaboration in MEB/PEB process.	The Departments implemented in November of 2007, a DES Pilot program for disability cases originating at the three military treatment facilities in the National Capital Region. The vision for the DES Pilot is a service member-centric, seamless and transparent DES, administered jointly by DoD and VA. The Departments set the following objectives: evaluate the DES Pilot, refine the mechanisms in the DES Pilot, identify training requirements, test improved case management procedures, and identify legal and policy issues to improve the DES. The DoD published these objectives in the November 21, 2007, DES Pilot Directive Type Memorandum (DTM). Key features of the DES Pilot include integrating the Departments' systems so they run concurrently instead of sequentially. Both Departments agreed to use a single medical examination and single source disability rating to determine a Service member's outcome. To ensure a seamless transition of WII Service members from the care, benefits, and services of DoD to the VA, the Pilot is testing enhanced case management practices.	The DoD and VA are developing options for expanding the DES Pilot to additional locations. The DES Pilot evaluation plan includes extensive quantitative and qualitative performance measures. The Departments will analyze and report the data from the Pilot to inform expansion decisions. The DoD and VA are defining criteria to assess the readiness of a site to implement the DES Pilot. The anticipated criteria will include: physical and human resources, IT architecture development and fielding, case management procedures, training, and costs. The Departments are prepared to train the personnel who would implement the Pilot at expansion sites. Although the primary case managers involved in the DES Pilot are PEBLOs and MSCs, the Departments are preparing plans to train other personnel who process DES Pilot cases.	On August 12, 2008, the DES Pilot Support team presented the Senior Oversight Committee a slate of potential expansion sites beyond the National Capital Region. The expansion sites were approve and an additional 18 sites have implemented the DES Pilot as of May 31, 2009. An interim report on the status of the DES Pilot was submitted to Congress was submitted on November 20, 2008. A final report to Congress is to be submitted by August 31, 2009, with a complete analysis of the DES Pilot and the efficiency and effectiveness of the processes. The Departments have developed training guidance for personnel who are implementing the DES Pilot at the respective sites. Four Navy expansion sites joined the Pilot: NMC San Diego and NHs Bremerton, Camp Lejeune and Camp Pendleton. One MTF (NH Jacksonville) was cancelled for impact of MILCON delays on the required space availability.
9.9	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Expand the Disability Advisory Council (DAC).	The Disability Advisory Council (DAC) charter was formally updated to include a more rigorous oversight role and defined membership with additional membership from the Veterans Benefits Administration (VBA) and inclusion of the OASD(RA) included as an advisory members. To support and complement DES Pilot efforts, DoD is in the process of another revision of the charter for the DAC to add participation from the Veterans Health Administration (VHA). The Charter will also included formal collaborative processes for DoD to provide input to the changes to the VA Schedule for Rating Disabilities (VASRD) process and the addition of a post Physical Evaluation Board (PEB) Quality Control (QC) Process Review.	The revisions to expand the DAC membership to the VHA along with the expanded role on DoD's input to the VASRD updates and a post-PEB QC Process Review will be made not later than August 1, 2008.	The DAC has been expanded to include the VHA. The DAC has also created working groups to identify solutions to issues related to the DES system, such as the VASRD. Navy Surgeon General Representative was assigned to the DAC VASRD Working Group, chartered February 13, 2009. The working group met to identify issues and proposed solutions, to improve consistency of the application of VASRD disability ratings to Military members, and to identify updates to VASRD.

Item Reference #	Reference	Recommendation	Implementation Actions	Previous Status	Current Status
8.2	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	SecDef should request the Secretary of VA to update the Code of Federal Regulations, Title 38, Part IV to account for the unique disabilities and needs of traumatic amputees and burn victims, focused on a loss of function and post-service needs. This requires an expedited process for publishing change.	The Departments are working together through the Senior Oversight Committee on the Wounded, Ill and Injured to address unique disabilities. The VA proposed new ratings of (Traumatic Brian Injury) TBI and Burns in the Federal Register on January 3, 2008. They are addressing the public comments at this time. For burns, the schedule proposes to revise 38 CFR 4.118 so that it defines VA's policies concerning the evaluation of scars, including multiple scars. VA proposes to incorporate, "burn scars," into the title of the diagnostic codes most appropriate for evaluating scars. Previously burn scars were generally rated only if they impacted motion and mobility. For TBI, the schedule proposes to revise 38 CFR 4.124a, diagnostic code 8045, to provide updated medical criteria for evaluating residuals of TBI. VA has proposed to change the title, provide guidance for the evaluation of the cognitive, emotional/behavioral, and physical residuals of TBI, and direct raters to consider special monthly compensation.	Ongoing	On January 6, 2009 the Department of Defense in collaboration with the Department of Veterans Affairs (VA), implemented a process designed to expedite a member through the Disability Evaluation System (DES) to veteran status. This process enables the VA to identify the full range of benefits, compensation and specialty care offered by the VA. To qualify, a service member's condition must be designated as "catastrophic" and the injuries must have been incurred in the line of duty as a direct result of armed conflict. A catastrophic injury or illness is a permanent, severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living to such a degree that a service member or veteran requires personal or mechanical assistance to leave home or bed, or requires constant supervision to avoid physical harm to self or others.

Item Reference #	Reference	Recommendation	Implementation Actions	Previous Status	Current Status
9	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Completely overhaul the DES to include changes in US Code, DoD policies, and Service regulations to implement one DoD level Physical Evaluation Board/Appeals Review Commission with equitable Service representation Goal = one integrated solution	During August 2007, the Departments collaboratively evaluated alternative DES processes. Over 40 DES experts from the DoD and VA reviewed previously adjudicated disability cases using five alternatives. The following alternative DES processes were tested: a sequential Mil Dept and VA evaluation with duplicate disability examinations and ratings; Joint Disability Evaluation Board (JDEB) Baseline: The Mil Depts and VA conduct independent disability examinations, the VA provides ratings, and a joint board determines fitness for duty; Dole-Shalala Variation: a single physical exam, the VA provides ratings, and the Mil Dept PEB determines fitness for duty; JDEB Quality Control Alternative: The Mil Depts conduct disability examinations, the VA provides a single rating, the Mil Dept PEB determines fitness, and a JDEB with a review function; and the JDEB Appellate Review Alternative: The Mil Dept conducts disability examinations, the VA provides a single rating, the Mil Dept PEB determines fitness, and a JDEB is an appellate body. Based on an analysis it was recommended that the Departments implement a DES pilot based on the modified Dole-Shalala Variation.	Same as P-1	Same as P-1
9.2	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Review the 1998 MOU between DoD and VA, implement a common physical for use by the Services and the VA for those service members in the physical DES, and allow flexibility in the timelines test or procedures that would eliminate redundant efforts (as identified in GAO Report 2004)	See P-1 DES Pilot and Expansion Plan. The DES Pilot is testing a common physical that is acceptable to VA for rating of disabilities and the DoD for use in determining fitness and medical requirements for transition physicals. The DES Pilot also has a rigorous evaluation methodology and customer satisfaction program to identify redundancies to ensure seamless transition.	Same as P-1	Same as P-1
9.3	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Joint VA/DoD DES. Establish one solution. Utilize one disability rating system that remains flexible to evolve and be updated as trends in injuries and support medical documentation/treatment necessitate.	See P-1 DES Pilot and Expansion Plan. The DES Pilot utilizes the VA Rating Panel and requires the Military Departments to accept the ratings for fitness decisions and ratings.	Same as P-1	Same as P-1

Item Reference #	Reference	Recommendation	Implementation Actions	Previous Status	Current Status
9.5	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Quickly promulgate regulatory guidelines and policies to the Service Secretaries as soon as changes to the US Code are published.	To complement DES Pilot efforts, we have revised DES policies, refined reporting mechanisms, and collaborated with VA in providing input to the VA Schedule for Rating Disabilities process. The system of continuous improvement implemented last year allows for rapid publication of revisions as the Department learns from studies and the DES Pilot. To date, the Department has issued policy guidance for the DES which established standards, metrics, and reporting requirements to DoD; issued new policy and procedures for the DES Pilot which established the DES Pilot as a test program; issued new policy for standards determining unfitness due to non-deployability as it relates to the performance of duty in regards to a member's grade or rank; issued policy to comply with statute for disability-related provisions of NDAA 2008 – enhanced disability severance pay; and, issued policy in July 2008 to address MEB Appeal, impartial medical advisor, and standards for legal assistance. Additionally, the Department published two reports on attainment of standards: Disability Annual Report (DAR) and the Disability Quarterly Report (DQR).	1) DoD directive memorandum dated November 21, 2007,and accompanying DVA "Fast Letter dated November 27, 2007, provides implementing guidance for the joint DoD/DVA pilot. 2) The Department published policy guidance on March 13, 2008, to implement recent NDAA 2008 modifications to the DES. Another policy change memorandum was published in July 2008 that further promulgates changes to the DES. Implementation guidance for the Disability Evaluation System Pilot was communicated in advance to each planned expansion site. Issued preliminary policy guidance to comply with statute for disability-related provisions of NDAA 2008 -MEB rebuttal, impartial medical advisor. BUMED policy in draft.	Since 2007, the Department, with VA coordination, has published 7 policy updates. The Department will continue to refine the DES until a national reform is complete.
9.6	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Ensure implementation of recommendations made in the Army Inspector General report on the Army physical disability system and the resulting Army Action Plan on WRAMC outpatient care. Follow-up action by the Deputy Chief of Staff, Personnel must be undertaken to ensure this timeline is met and effectiveness of the changes adopted should be measured by September 30, 2007 and adjustments made accordingly.	The recommendations of the Department of the Army Inspector General Report on the Army Physical Disability Evaluation System Inspection and Follow-up Actions on the Army DES are being monitored by the Senior Oversight Committee (SOC) staff.		The Army Deputy Chief of Staff for Personnel will provide an update by September 30, 2009.

Item Reference #	Reference	Recommendation	Implementation Actions	Previous Status	Current Status
9.7	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	The Secretary of Defense, in conjunction with the Secretary of Veterans Affairs, should direct the transition process be streamlined for the service member separating from the DoD to the Dept. of VA.	Elimination of redundancies in the DES is occurring throughout the Military Departments. Each Military Department is applying Lean Six Sigma techniques to improve processes that fall short of goals as well as identification of redundancies and gaps. Also, streamlining the process across the Departments of Defense and VA is a primary goal of the DES Pilot as directed by the SOC. In the Pilot, if a Service member is found unfit, a DoD disposition is made (separate with or without benefits, placed on the temporary disability retirement list (TDRL), or permanent disability retirement list (PDRL)) and the member is given 45 days to transition. During this time, the VA claim is adjudicated and awarded so that the claim is paid within 30 days from the date of separation. The concurrent application of DoD and VA benefits is transparent and greatly streamlines the process.	Same as P-1	Same as P-1
10.5	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Review and update applicable directives to ensure there is no distinction in the care management and disability processing of Active Component and Reserve Component Service members	A comprehensive review of all Department of Defense issuances pertaining to the Disability Evaluation System was completed. Directives were updated where necessary to reflect compliance with NDAA 2008. In addition, a senior member of the Assistant Secretary of Defense for Reserve Affairs was added as a permanent member to the Disability Advisory Council (DAC).	Completed	Completed
8.1	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	SecDef should review the Physical Evaluation Board determinations of all burn cases, dating back to 2001, within one year after the update to US Code 38	The Department of the VA is currently updating CFR 38, Part 4-VA Schedule for Rating Disabilities (VASRD) with new criteria for rating Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD), and updated criteria for rating burns. Once the new rating criteria are established in CFR, DoD will publicize and solicit that those with burn case injuries request their case be reviewed by the newly established Physical Disability Board of Review.	In Process. The regulation updating the schedule for burns was sent to OMB as a final rule on June 20, 2008. OMB's 90-day review period expires on September 22, 2008, unless cleared earlier than that, we anticipate the final rule being published in late September.	After Sep 11, 2001 (until 31 Dec 2009) those individuals who received burns and were subsequently found unfit and rated at 20% or less disabled fall in the category of covered individuals (CIs) by the Physical Disability Board of Review (PDBR). These CIs may apply to the PDBR. In compliance with DODI 6040.44, the PDBR will establish administrative and operational relationships to publicize the board's charter stressing the eligibility criteria to apply to the board.

Enclosure 1 - Recommendations and Actions Taken - Independent Review Group

Item Reference #	Reference	Recommendation	Implementation Actions	Previous Status	Current Status
9.8	IRG on Rehab Care and Admin Processes at WRAMC and NNMC	Conduct a quality assurance review all DES (Army, AF, Navy, Marines) decisions of 0, 10 or 20 percent disability and Existed Prior to Service (EPTS) cases since 2001 to ensure consistency, fairness, and compliance with applicable regulations.	Section 1643 of Pub. L. 110-181added section 1554a to chapter 79 of title 10, United States Code, requiring that the Secretary of Defense establish a board to be known as the Physical Disability Board of Review (PDBR). The purpose of the PDBR shall be to reassess the accuracy and fairness of the ratings of Service members who were discharged as unfit by the Military Departments with a disability rating of 20% or less and were not found to be eligible for retirement. To that end, the PDBR shall review the disability ratings for unfitness determinations by the Military Department Physical Evaluation Boards, and where appropriate, recommend that the Military Departments correct discrepancies and errors in such determinations. The Department designated the Department of the Air Force as the Lead DoD Component for the establishment, operation, and management of the PDBR for the DoD. The PDBR operates under guidelines established in this new issuance in order to comply with statute. The Air Force is required to provide reports to the Secretary of Defense.	The PDBR was established by Department of Defense Instruction, entitled: Lead Component for the Physical Disability Board of Review in June 2008. The Air Force is establishing further procedural and operational instructions for the conduct of the board. The Department anticipates receiving cases by August 2008.	On June 27, 2008, the Department published DoD Instruction 6040.44, “Lead DoD Component for the Physical Disability Board of Review (PDBR).” The PDBR Process began accepting applications using DD Form 294 on January 9, 2009.

Department of the Army Inspector General Corrective Actions Matrix

Type Finding/ Tracking #	Finding	Corrective Action	Previous Status	Current Status
MEB 1	There is a need for (PEB Liaison Officer) PEBLO Training.	Establish PEBLO Training and Certification Policy.	Completed - July 2007, OTSG/MEDCOM Policy 07-029, Physical Evaluation Board Liaison Officer (PEBLO) Training and Certification. Requires PEBLOs complete standard training and certification via distance learning, resident course (held 3 times per year), or PEBLO Conference (held every 2 years). Annual recertification is required. Certification is required within 180 days as a condition of employment for new hires / appointments.	Completed - July 2007
MEB 2	Problem with timeliness of MEB processing stemming from excessive PEBLO workload.	Evaluate and standardize PEBLO to workload ratio	Completed - June 2007, Ratio established as 1:30 based on Lean Six Sigma study of WRAMC workload. Additional PEBLO resources were and continue to be added. Current PEBLO to caseload ratio for 2nd QTR 08 is 1:34.	Completed - June 2007
MEB 3	Inadequate management and oversight for Soldiers undergoing MEBs.	Assign dedicated MEB Physicians at the rate of 1 for every 200 MEB cases at all locations that process MEBs.	Completed - June 2007, Established MEB Physician ratio of 1:200 MEB cases. Currently re-evaluating standards with a proposal to lower it to 1:120.	Completed - June 2007
MEB 3a	Inadequate management and oversight for Soldiers undergoing MEBs.	Establish mechanisms for weekly management and oversight of Soldiers going through the MEB process.	Completed - September 2007, OTSGMEDCOM Policy 07-040, Metrics and Continuous Process Improvements for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing.	Completed - September 2007
MEB 4	Need to reduce return rate of MEBs from the PEB.	Implement Office of the Surgeon General (OTSG) tracking and oversight of returned MEBs.	Completed - September 2007, OTSGMEDCOM Policy 07-040, Metrics and Continuous Process Improvements for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing.	Completed - September 2007
MEB 5	Inadequate monitoring of process and timeliness in MEB processing.	Establish Medical Treatment Facilities (MTF) centralized processing center to oversee all support requirements for MEB processing.	Completed - September 2007, OTSGMEDCOM Policy 07-040, Metrics and Continuous Process Improvements for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing.	Completed - September 2007
MEB 5a	Inadequate monitoring of process and timeliness in MEB processing.	Implement mandatory use of MEB tracking application by PEBLOs.	Completed -September 2007, OTSGMEDCOM Policy 07-040, Metrics and Continuous Process Improvements for Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing.	Completed - September 2007
MEB 6	Knowledge deficit for providers responsible for contributing to MEB process.	Conduct MEB training and education for Providers contributing to MEB process	Initiated July 2007, ongoing. Developed a Provider distance learning module with an anticipated launch in 4th QTR, FY 08.	Distance Learning for provider was completed May 2008. Distance Learning update is scheduled for completion in July 2009.
MEB 7	Inadequate knowledge-base for Soldiers going through MEB process. Need to improve and expedite MEB management.	Implement additional training and education for Soldiers, to include: a. initi standardized briefing; b. creation and distribution of Physical Disability Evaluation System (PDES) pocket handbooks; and c. creation of AKO-based "MyMEB/MyPEB" where Soldiers can monitor progress.	a. Completed - June 2007, Initial standardardized MEB Soldier Brief. b. Completed - May 2007, PDES Pocket Handbook. c. Completed - July 2007, MyMEB.	a. Completed - June 2007, Initial standardardized MEB Soldier Brief. b. Completed - May 2007, PDES Pocket Handbook. c. Completed - July 2007, MyMEB.
MEB 8	Need to improve soldier understanding of MEB and PEB processes.	Develop and administer post-counseling surveys with feedback monitored b US Army Medical Command (MEDCOM) Public Affairs Detachment and routed to PEBLOs at the MTFs.	Initiated June 2007. Ongoing.	Initial Operational Capability (IOC) completed November 2008. Advanced Operating Capability scheduled for July 2009. Full Operational Capability (FOC) scheduled for August 2009. Annual Operational Capability (AOC) testing commences August 2009.
MEB 9	Need to reduce administrative and clinical documents required for the MEB.	Develop processes to reduce and streamline documentation required for the MEB	Completed. Reduced required documentation from 38 items to 19 items.	Lean Six Sigma (LSS) project was completed on March 2008, reducing the number of forms from 38 items to 19 items.
MEB 10	MEB process should be automated to facilitate efficiency and timeliness.	Evaluate and Identify MEB processes that can be automated.	Underway. Projected implementation January 2009.	Initial Operational Capability (IOC) completed November 30, 2008. Advanced Operating Capability scheduled for July 2009. Full Operational Capability (FOC)scheduled for August 2009. Annual Operational Capability (AOC) testing commences August 2009.
PEB 1	ARs 10-59 and 635-40 are not consistent with other Army ARs nor with DoD and VA policy.	a. Rescind AR 10-59. b. Revise 635-40	a. AR 10-59 rescinded. b. A rapid action revision (RAR) to AR 635-40 was staffed in November 2007 and reworked in Mar 08 due to provisions of NDAA 08. OTJAG non-concurred with portions of the RAR and it is being further developed for resubmission to the Office of The Judge Advocate General (OTJAG).	Ongoing. Office of The Judge Advocate General (OTJAG) has concurred with the revised Army Regulation (AR 635-40). The projected target date for submission to Army Publications is June 2009.
PEB 2	PDA uses an insufficient data management program (PDCAPS) to manage PEB cases.	a. Migrate current MEB Internal Tracking Tool (MEBITT system) to Forms Content Management system as the automated MEB for MEDCOM. b. Implement improvements to PDCAPS (PDCAPS 2). Write fielding plan to reflect concurrent development operation with MEDCOM as they build the automated MEB.	a. April 1, 2008, began initial testing of automated MEB at Brooke Army Medical Center. Initia operational capability (IOC) expected in September 2008, with full operational capability in February 2009. b. August 2007, User-testing for PDCAPS 2 failed, requiring removal of contractor. Second fielding of User-testing for PDCAPS 2 to launch concurrently with automated MEB, with an IOC in October 2008. PDCAPS 2 development is contingent upon funding.	Ongoing - a. Initial Operational Capability (IOC) completed November 30, 2008. b. Annual Operational Capability (AOC) August 2009. Awaiting funding for contract to develop replacement system for Physical Disability Case Processing System II (PDCAPS II).

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

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PEB 3	PDA does not consistently meet the DoDI 1332.38 40-day standard for the processing time for a final disability determination	The DAIG determined that the processing time standard of 40 days was not realistic due to due-process requirements for Soldiers. Recommendation wa to change the standard in the DoDI 1332.38 to reflect the potential time necessary for all levels of Soldier appeals.	Completed. Presented the issue to the Disability Advisory Counsel (DAC) shortly after release of the DAIG report. In response, DoD modified the processing time standard via a Directive Type Memorandum (DTM) issued May 3 2007, stating that the processing time goal of 40 days should be met 80% of the time. The 40-day processing time standard is also more fully defined to exclude appellate review. Every level of appellate review after the Formal PEB now has a separate 30-day standard.	Completed May 2007 with issuance of DoD DTM. Army presented the issue to DoD via the Disability Advisory Council and DoD modified the process time standard to a goal of 40 days, which stated that the standard should be met 80% of the time.Also the 40- days processing time are to exclude the appellate review time which have a separate 30-day standard.
PEB 4	Processing Continuation on Active Duty (COAD) and Continuation on Active Reserve (COAR) requests resulted in additional time beyond the DODI 40-day standard in which Soldiers are in the Army PDES.	The DAIG recommended that processing time for COAD and COAR requests not be counted against the DoDI 40-day standard.	Completed. The processing time standard in the DTM excludes time spent processing COAD/COAR requests. The DTM did not set a processing time standard for this type of action.	Completed - May 2007 with issuance of DoD DTM. Actions taken to accomplish this are as stated in prevous status - Army presented the issue to DoD via the Disability Advisory Council and DoD modified the standard.
PEB 5	The US Army Personnel Disability Agency (USAPDA) quality assurance program does not conform to DoD and Army policy.	Develop and implement a quality assurance program that conforms to DoD and Army policy.	Completed. The Center for Army Analysis (CAA) provided assistance with instituting a new QA program, effective 1 Oct 07, that targets quality reviews to specific, relevant ratings disparities t determine cause — guidance, policy, training, population, etc. The CAA will provide another complete analysis in October 2008.	Completed - April 2009 - PDA has taken numerous steps to improve quality of MEBs, thus improving consistency of ratings across PEBs. A follow-up to the CAA analysis of 2007 is planned for 2009 to assess current consistency.
PEB 6	The training of personnel working in the PEB process does not meet the standards as specified in DoDI 1332.38, AR 635-40, and USAPDA SOP.	Develop and implement an on-going training program for personnel involved in the PEB process that meets the standards as specified in DoDI 1332.38, AR 635-40, and USAPDA SOP; and conduct regular staff assistance visits (SAV) by the PDA Headquarters and PEB staffs.	Updated and revamped Adjudicator training program. In addition to the existing requirement for completion of the one week Senior Adjudicator Course, PDA instituted an annual 3-day intensive refresher training program and monthly 2-hour VTC sustainment training sessions for all adjudicators. The first refresher training session was held on 18-20 Sep 07 with upcoming training scheduled for 8-12 Sep 08. The PDA conducted its most recent Senior Adjudicator Course in April 08, with 28 participants from all the Services. In addition, PDA provides annual training to Judge Advocates, military and civilian, who represent Soldiers appearing before the PEB. HQ staff members have conducted multiple SAVs to all three PEBs during FY08. Since the release of the DAIG report, PEBs have participated in 24 SAVs to MTFs, and 15 more SAVs are scheduled during 2008.	Ongoing. USAPDA continues to conduct one-week SAC for all newly assigned adjudicators. All adjudicators attended a three-day refresher training seminar in September 2008, with monthly-2-hour sustainment training for all adjudicators. Future adjudicators training is schedule for September 2009. USAPDA is in the process of submitting the adjudicator training and certification program to TRADOC with a goal of receiving TRADOC certification in the first quarter of FY10. SAVs to MTFs have been discontinued and replaced by targeted training conducted by MEDCOM for their MEB physicians that covers the same material previously addressed by SAVs. In addition, MEB physicians are attending the PDA Senior Adjudicator Course to enhance their understanding of the PDES.
PEB 7	Some Soldiers do not return for their required periodic examinations while in a Temporary Disability Retirement List Status.	Review policies and procedures regarding the tracking of Soldiers who are required to have periodic examinations while in a TDRL status.	Completed. Soldiers who fail to complete required periodic medical examinations are notified of pending retired pay termination unless they comply. Action is taken within 30 days unless Soldiers provide a reasonable explanation for failure to make re-examination appointments. If pay is suspended, it is reinstated only after a Soldier completes the re-examination.	Completed - spring 2007.
PEB 8	PDA and the PEBs recognized the need for additional personnel to process the increased caseload as a result of GWOT and have made some progress.	Evaluate DES manpower to identify additional requirements as result of increased GWOT; include these increased requirements in updated authorization documents; and obtain the necessary resources to complete disability cases within processing time standards.	Ongoing. The PDA developed increased staffing requirements in April 2007 to include increases to the PDA base authorization documents. Army is currently working the requests for authorization increases. The Human Resource Command (HRC) 2009 authorization document includes requirements, but not authorizations, for additional resources for the Agency and the three PEBs. The HRC 2010 document does include these authorizations. HRC has advised that we can request fill against our 2009 requirements and they will work to fill. Current resourcing adequate to meet all Agency requirements other than PEB physicians. The PDA has adequate authorizations, but is having difficulty finding and hiring qualified medical officers. However, current manning has enabled the Agency to continue to meet processing time requirements.	Completed - April 2009 - Current manning has been sufficient to ensure Physical Disability Agency (PDA) can process all disability cases in a timely manner. Each Physical Evaluation Board (PEB) now has four physicians and at least six non-medical adjudicators, the highest staffing in the past 20 years.
PEB 9	The Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) does not accurately reflect the medical conditions and ratings in today's environment.	The Department of Defense is working with the Department of Veterans Affairs on updates to the VASRD. DoD comments and inputs to the VASRD process are now worked through the DoD Disability Advisory Council.	The Office of the Assistant Secretary of Defense for Health Affairs (OASD (HA)) is the proponent for DoD change requests to the VASRD. Following the VA SME's review, the DoD sends the package to the requestor and places the issue on the DAC agenda for review prior to submission to the joint DoD – VA Benefits Executive Committee (BEC).	Ongoing - April 2009 USAPDA SMEs participate as voting members of VASRD workgroup chaired by OASD (HA). Workgroup meets month and reports to the DAC. Working group facilitates Military Departmen and VA collaboration / application of the VASRD.

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PEB 10	Some medical hold and medical holdover personnel in the PDES process do not understand their rights and separation entitlements.	Evaluate policies, procedures and communication tools used to counsel medical holdover personnel on the PDES process and rights and separation entitlements.	PDA reviewed the counseling requirements in AR 635-40 and determined that the information is adequate. The information was not reaching the intended audience. The following documents address that issue. PDA published the PDES Handbook in April 2007. Under AMAP, MEDCOM developed a standard PEBLO briefing and a PEBLO Training Handbook. PDA had major input to both. (Army Medical Action Plan) AMAP Survey will address this finding.	Completed . In addition to the PDES handbook that was published in April 2007, the Soldier receives standardized briefings and has access to Soldier Counsel throughout the entire MEB and PEB process. A survey has been developed by MEDCOM Decision Support Center to determine Soldier satisfaction and will be fielded soon.
PEB 11	A few installations inspected had Americans with Disabilities Act (ADA) violations affecting disabled Soldier's access to facilities.	AMAP to task IMCOM (task 3C2G5A) to ensure accessibility for Warriors in Transition to all facilities they frequent.	Installation Management Command (IMCOM) reports a status of Green for this task. Two PEBs were inspected this year, and only minor ADA deficiencies were noted. The DC PEB main ADA deficiency (front door handicap accessibility) is resolved. Both Fort Sam Houston and Fort Lew Washington PEBs are scheduled to have new PEB buildings built in 2008/9. Fort Sam Houston PEB is on course for a 3QFY09 completion of their new facility. Fort Lewis is also well on trac for a 4QFY08 completion.	Completed - April 2009 New, fully Americans with Disabilities Act (ADA) compliant, Physical Evaluation Board (PEB) facilities have been occupied at our Fort Lewis, Washington and Fort Sam Houston - San Antonio Texas Physical Evaluation Board (PEB) locations. The Washington, DC PEB facility has no ADA deficiencies.
PEB 12	PEB personnel perceive the MOS Medical Retention Board (MMRB) is under used resulting in some Soldiers separating through the PDES unnecessarily.	Evaluate perception of MOS Medical Retention Board being under-utilized resulting in some Soldiers separating through the PDES unnecessarily.	Further discussion on this issue resulted in an G1/AMAP conclusion that having the PEB refer Soldiers to the MMRB is not appropriate or efficient. Training physicians to make the proper recommendation of MMRB vs. MEB is the best approach and MEDCOM has an AMAP task to do so. Therefore, there are no plans to revise AR 635-40 to include a PEB referral to an MMRB	Completed. There is no indication this perception remains within the PEBs. In addition, MEDCOM is building logic into an electronic profile form that should be fielded by the end of F 09 and will determine recommendation for MEB vice MMRB. Currently, the MEB Physician Course has a profile module that is being revised to provide additional education about MMRB/MEB decisions.
PEB 13	Most installation transition centers have additional personnel to handle the increased transition processing workload created by the GWOT in order to meet the Army (transition) time standards.	Establish and implement guidelines to eliminate errors in placing Soldiers on wrong installation transition processing notification lists.	Completed - Spring 2007, Developed a change to the Soldier election form that includes specific entries for desired transition point, as well as, contact information for the Soldier, and Unit chain of command. PDA now enters the TC reflected on the election form even if it is different from t MTF that conducted the MEB. Assignment of Soldiers to Warrior Transition Units (WTU) is also helping eliminate this problem. Staffing of transition centers has not been an issue.	The new Soldier election form was fielded May 2007.
WCTO 1	Clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Medical Holdover Units on active duty installations is needed.	Installation Management Command, in coordination with Assistant Secretar of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Medical Holdover Units on active duty installations.	Completed - December 2007, WTU Consolidated Guidance developed and updated on a regular basis by DA G-1 with input from AMAP stakeholders. Guidance available on the Army G-1 website for ease of access.	Completed - December 2007.
WCTO 2	Department of the Army Medical Holdover Consolidated Guidance needs to specify the command and control, and organizational structure of reserve component Soldiers assigned to Community Based Healthcare Organizations.	US Army Medical Command, in coordination with Assistant Secretary of th Army for Manpower and Reserve Affairs and Deputy Chief of Staff G1, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Community Based Healthcare Organizations.	Completed - June 2007, Merged legacy Medical Hold and Medical Readiness Processing Units into 35 all Component WTUs.	Completed - June 2007. There currently are 36 Warrior Transition Units (WTUs) and 9 Community Based Warrior Transition Units (CBWTUs).
WCTO 3	Standing operating procedures for Medical Holdover Operations, specifically for Medical Retention Processing Units, is needed.	Installation Management Command, in coordination with Assistant Secretar of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, develop and implement standing operatir procedures for Medical Holdover Operations, specifically for Medical Retention Processing Units.	Completed - December 2007, MEDCOM Warrior Transition Office (WTO) is the proponent for developing and implementing SOPs for WTUs.	Completed - December 2007. Warrior Transition Office (WTO) incorporated as part of Warrior Transition Command (WTC) on 1 Apr 09. Overarching policy is now developed by the WTC Planning and Policy Branch with local policy and standard operating procedure (SOP) the responsibility of the local Warrior Transition Unit / Community Based Warrior Transition Unit (WTU / CBWTU) Commander.

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WCTO 4	Development and implementation of the Medical Holdover Operations Systems Analysis and Review checklist to include by-item definitions and supporting standards of performance is needed.	Installation Management Command, with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, complete development and implement the Medical Holdover Operations Systems Analysis and Review checklist to include by-item definitions and supporting standards of performance.	Completed - September 2007, As part of the AMAP, Army created a comprehensive review checklist for all WTU operating systems which was utilized by teams of subject matter experts conducting Staff Assistance Visits to WTUs to measure progress. Currently, WTU Commanders prepare and submit to leadership monthly Unit Status Reports which utilize a robust set of metrics to track and determine operational readiness, a subset of key metrics are briefed monthly to SA as part of the Medical SRG, Senior Commanders conduct periodic Town Hall Meetings with WTs and Families and act on identified concerns, MTF Commanders brief VCSA quarterly on the status of WTUs, WTU Commanders conduct Quarterly Training Briefs and RMC Commanders provide QTBs semi-annually to the MEDCOM CG. The metrics utilized for all reporting requirements cover all WTU operations systems.	Completed - September 2007. Now that Warrior Transition Units (WTUs) and Community Based Warrior Transition Units (CBWTUs) have matured in their operation, the Staff Assistance Visit (SAV) Program has been replaced by the Operational Inspection Program (OIP), which inspects WTUs and CBWTUs for progress and compliance with established policy as well as identifying best practices and areas requiring improvement.
WCTO 5	Training criteria for Medical Holding Unit (MHU) cadre is needed.	The Office of the Surgeon General develop training criteria for Medical Holding Unit (MHU) cadre.	Completed - July 2007, AMEDD Center and School has developed a certification training course for all WTU cadre. Originally a distance learning application, mobile medical training teams have been established that bring the training to WTU cadre on-sight, a resident course is being developed and will be implemented in FY 09.	Completed - July 2007. The resident course for Squad Leaders, Nurse Case Managers, and Platoon Sergeants has been operational since 1 Oct 08 with (4) classes conducted to date, training approximately 387 Warrio Transition Unit (WTU) staff. There are (4) more classes programmed for FY09. This course wi be enduring year-to-year to train new WTU cadre as they are assigned. The Primary Care Manager (PCM) training is currently under redesign and will come back on line later in FY09.
WCTO 6	A by-position targeted training program for all Medical Holdover organization command and control and medical management cadre is needed.	Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Office of the Surgeon General, the Installation Management Command (IMCOM) and US Army Medical Command, complete a by-position targeted training program for all Medical Holdover organization command and control and medical management cadre.	Completed - September 2007, Position-specific training has been developed and implemented for all WTU positions.	See WCTO 5
WCTO 7	Medical holdover Soldiers who are able to work should have duties within the limits of their profiles.	Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations (CBHCO) continue ensuring medical hold and medical holdover Soldiers who are able to work have duties within the limits of their profiles.	Completed - June 2007, The Comprehensive Transition Plan (CTP) developed jointly by the Warrior in Transition, the members of his/her care management, and support staff Triad was developed to assist Warriors in Transition to reset and either return to duty or transition to civilia life. The CTP establishes accountability to ensure WTs engage in cognitive enhancing activities, e.g., military education distance learning courses, college courses, and foreign language study, as well as work reintegration or vocational training.	Completed - June 2007. The Warrior Transition Command (WTC) is currently developing a robust training and employment capability to ensure Warriors in Transition are trained and experienced when they transition either back to duty or to productive civilian careers.
WCTO 8	Installation support agreements to ensure the Physical Evaluation Board facilities are in compliance with Americans with Disabilities standards are needed.	US Army Physical Disability Agency, in coordination with host installation develop installation support agreements to ensure the Physical Evaluation Board facilities are in compliance with Americans with Disabilities standards.	Completed interim renovation effort and priority housing policy. Army policy memorandum dat June 18, 2007 as an AMAP quick win directs Army garrisons to use existing authorities to assig WTs with dependents to housing on a priority basis that is on par with that afforded key and essential personnel. In FY 07, $56M in remodeling and renovation efforts were completed to include numerous interim changes to accommodate the accessibility requirements of WTs. Effo are ongoing to fund and complete MILCON and renovations to create Warrior Transition Complexes to include barracks, WTU administrative facilities, and Soldier Family Assistance Centers all of which are accessible and located in close proximity to MTFs.	Completed - June 2007. All Warrior Transition Unit (WTU) barracks have been inspected under the interim housing standards established in 2007 and found adequate. Currently approved are permanent housing standards for WTU Soldiers that exceed the requirements of the Americans with Disabilities Act. (ADA). Construction and funding have begun to flow to develop Warrior Transition Complexes to provide campus near Military Treatment Facilities (MTFs) dedicated to Warriors in Transition and their Families. Currently funded and / or under construction are nine projects to build all or a portion of the structures comprising these complexes. Recommendation has been made to Congress for an additional $425M as part of the FY09 Supplemental Funding request, with the remainder of the projects to be constructed incorporated into the Program Operating Memorandum (POM) for FY10-15.

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WCTO 9	Medical Retention Processing Unit facilities need to be in compliance with Americans with Disabilities standards.	Installation Management Command ensure Medical Retention Processing Unit facilities are in compliance with Americans with Disabilities standards.	Completed - December 2007, MEDCOM completed assessment of all WTU related facilities and housing. ACSIM has completed Military Construction Project Data assessments (DD Form 1391C) for all required WTU facilities. Ongoing inspections of facilities will be conducted by MEDCOM in coordination with (Installation Management Command) IMCOM.	See as WCTO 8
WCTO 10	Medical Retention Processing Units, and Community Based Healthcare Organizations would benefit from increased personnel.	Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, examine the possibility of increasing the personnel manning of Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations.	Completed - May 2008, Authorization for 2,434 WTU cadre positions with an additional 416 positions approved by the VCSA.	Completed - May 2008. Currently there are 3,600 cadre assigned to the 36 Warrior Transition Units (WTUs) at or beyond, in nearly all cases, the established ratios of Warriors in Transition to particular a staff professional. RDAs are augmented over time to ensure adequate types and numbers of personnel.
WCTO 11	Medical Holding Unit and Medical Retention Processing Unit personnel structures would benefit from having Behavioral Health Specialists assigned.	Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, consider providing a Behavioral Health Specialist to the Medical Holding Unit and Medical Retention Processing Unit personnel structures.	Completed - January 2008, WTU staffing includes clinical social workers assigned at the battalion level who are trained in behavioral health management, to include having completed standardized certification training in behavioral health management.	Completed - January 2008. Aggregate strength in Warrior Transition Unit (WTU) Behavioral Health Specialists is currently staffed at 133%,
WCTO 12	Unnecessary layers of Command and Control (C2) in Communit Based Healthcare Initiative Transition Plan	US Army MEDCOM, in coordination with ASA (M&RA), IMCOM, NGB and Chief, Army Reserve, review the Community Based Healthcare Initiative Transition Plan and eliminate unnecessary layers to command and control.	Completed - June 2007, WTUs established to replace Medical Hold (MH) and Medical Readines Processing Units and to provide C2 for all Warriors in Transition, to include CBHCOs.	Completed - June 2007. WTU command and control capabilities continue to demonstrate the importance of strong leadership. Third party satisfaction surveys are echoing this with the 84% overall satisfaction rate reported by Warriors in Transition and their Families.
WCTO 13	Standardized Regional Medical Command organizational structure needed to provide required functions for Community Based Healthcare Organizations.	US Army MEDCOM develop a standardized Regional Medical Command organizational structure to provide required functions for Community Based Healthcare Organizations.	Completed - 2005, Each Regional Medical Command with one or more CBHCOs within their area of responsibility has an established CBHCO command.	Completed - December 2005. The formation of the Warrior Transition Command (WTC) provides a focus on Warrior Transition Unit (WTU) and Community Based Warrior Transition Unit (CBWTU) operations and further enhances the coordination and direction they receive.
WCTO 14	A policy outlining the assignment criteria for command and control support cadre to Medical Retention Processing Units and Community Based Healthcare Organizations is needed.	Deputy Chief of Staff, G-1, in coordination with Human Resources Command, Installation Management Command, and US Army Medical Command create policy outlining the assignment criteria for command and control support cadre to Medical Retention Processing Units and Communit Based Healthcare Organizations.	Implementation in 2007 of the Army Medical Action Plan included the conducting of an assignment board for C2 positions for all 35 WTUs. Commanders, Command Sergeants Major, and First Sergeants were selected based on the criteria of having combat experience, demonstrate leadership ability, and the compassion and dedication required to care for the Army's wounded, i and injured. Although not a requirement, in many instances those chosen had been wounded in combat themselves. These criteria will continue to be key in future selection of WTU C2 personnel.	Completed - December 2007. The qualification criteria and preferences established for Warrior Transition Unit (WTU) cadre and leadership has generated a corps of proven and often combat sharpened leaders for WTUs. Special Duty Assignment Pay (SDAP) is available at the Drill Sergeant-level for Squad Leaders and Platoon Sergeants who complete WTU training and possess the requisite leadership experience.
WCTO 15	Job descriptions for Medical Retention Processing Unit comman and control cadre are needed.	Installation Management Command, in coordination with the US Army Medical Command, develop job descriptions for Medical Retention Processing Unit command and control cadre.	Completed - January 2008, All WTU TDA positions have current position descriptions and standards of practice developed.	Completed - January 2008.
WCTO 16	Job descriptions for Community Based Healthcare Organizations (CBHCO) command and control cadre are needed.	US Army Medical Command, in coordination with the Installation Management Command, complete the development of job descriptions for Community Based Healthcare Organizations (CBHCO) command and control cadre.	Job descriptions have been completed and are in effect for all C2 cadre of WTUs and CBHCOs. Currently pending approval is a TDA structure for CBHCOs that reflects their being company size elements of Warrior Transition Battalions, thus, further establishing the C2 structure for these units.	Completed - April 2009. Table for Distribution and Allowances (TDA) structure for Community Based Warrior Transition Units (CBWTUs) has been approved and is in place.

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WCTO 17	Integrating MH (AC) operations with MH (RC) operations is needed.	Installation Management Command in coordination with OTSG and FORSCOM review the feasibility of integrating MH (AC) operations with MHO (RC) operations.	Completed - June 2007, WTUs have been established to replace all legacy MH and MHO operations. IMCOM supports WTUs with Soldier Family Assistance Centers, transportation resources, housing support. Senior Commanders are actively engaged in ensuring WTUs are ful supported.	Completed - June 2007.
WCTO 18	Standardization of infrastructure to support an Installation Garrison Command in the absorption of select Soldiers in the Army Physical Disability Evaluation System (APDES) is needed.	Installation Management Command in coordination with OTSG, Deputy Chief of Staff G1 and HRC develop a standardized infrastructure to support an Installation Garrison Command in the absorption of select Soldiers in the Army Physical Disability Evaluation System (APDES).	Completed - February 2008, IMCOM has established Soldier Family Assistance Centers at installations with WTUs to provide consolidated assistance and support to WTs and their Families.	Completed - February 2008.
WCTO 19	C2, personnel, training and transportation for select Soldiers in the Army physical Disability Evaluation System (APDES) is needed.	Installation Management Command (IMCOM) provide the C2, personnel, training and transportation for select Soldiers in the Army physical Disability Evaluation System (APDES).	Completed - June 2007, WTUs provide C2, personnel, training, and transportation for WTs undergoing MEBs/PEBs. IMCOM has provided transportation assets.	Completed - June 2007. Soldier Family Assistance Centers (SFACs) have proven to be an extraordinary component of the Warrior Care and Transition Program (WCTP). Warriors in Transition and their Families find understanding, support, and services they require to make their lives more manageable.
WCTO 20	Policy is needed that projects, on a regional basis, the assignment of C2 support cadre to Community Based Healthcare Organizations (CBHCO) and Medical Retention Processing Units (MRPU) to match the mobilization and demobilization requirements of RC Soldiers.	Deputy Chief of Staff, G-3,in coordination with Human Resources Command, Installation Management Command, and US Army Medical Command develop policy that projects, on a regional basis, the assignment of C2 support cadre to Community Based Healthcare Organizations (CBHCO) and Medical Retention Processing Units (MRPU) to match the mobilization and demobilization requirements of RC Soldiers.	Completed - July 2007, WTU TDA for 2,434 positions approved. An additional 416 positions approved in May 2008 (effective date of change is 15 October 2008). Currently, further expansion of WTU TDAs is being developed to establish the capability of providing C2, care, and support for 12,000 Warriors in Transition and medical case management for an additional 8,000 Soldiers whose condition enables them to remain assigned to their regular units while recovering. All CBHCO Warriors in Transition are assigned to WTUs. Pending is approval of CBHCO TDAs establishing them as company sized elements of battalion level WTUs.	Completed - July 2007 - Currently there are 3,600 cadre assigned to 36 Warrior Transition Units (WTUs) at or beyond, in nearly all cases, the established ratios of Warriors in Transition to particular staff professional. Additionally, establishing the Community Based Warrior Transition Unit (CBWTU) structure to be similar to a company size operation has further improved the command and control as well as the level of mission execution the reserve component Soldiers assigned as cadre both require and deserve.
WCTO 21	Training to educate commanders and leaders on the importance of completing Line of Duty (LOD) investigations in accordance with the required regulations/policies is needed.	US Army commands conduct training to educate commanders and leaders on the importance of completing Line of Duty (LOD) investigations in accordance with the required regulations/policies.	HRC published a policy memorandum June 13, 2007 providing clarification of the requirement for LOC investigations for Soldiers being referred into the PDES. PDA transmitted this policy to MEDCOM June 14, 2007 as an exception establishing a presumptive line-of-duty for disability cases of Soldiers on Active Duty (includes RC on AD) without requiring a form or statement.	Completed - April 2009. All Warrior Transition Unit / Community Based Warrior Transition Unit (WTU / CBWTU) personnel receive considerable training and refresher training in the identification and initiation of Line of Duty (LODs). Adequacy of execution is measured in regular Operational Inspection Program (OIP) investigations with corrective action taken if necessary.
WCTO 22	Improved screening procedures at Military Treatment Facilities (MTF) to ensure identification of wounded or injured Soldiers requiring LODs is needed.	US Army Medical Command review screening procedures at Military Treatment Facilities (MTF) to ensure identification of wounded or injured Soldiers requiring LODs.	HRC published a policy memorandum June 13, 2007 providing clarification of the requirement for Line of Duty (LOD) investigations for Soldiers being referred into the PDES. PDA transmitted this policy to MEDCOM June 14, 2007 as an exception establishing a presumptive line-of-duty for disability cases of Soldiers on Active Duty (includes RC on AD) without requiring a form or statement.	Completed - April 2009. All Warrior Transition Unit / Community Based Warrior Transition Unit (WTU / CBWTU) personnel receive considerable training and refresher training in the identification and initiation of Line of Duty (LODs). Adequacy of execution is measured in regular Operational Inspection Program (OIP) investigations with corrective action taken if necessary.
WCTO 23	Regulatory guidance regarding the transfer of medical documentation needs enforcement.	US Army Medical Command (MEDCOM) enforce regulatory guidance regarding the transfer of medical documentation.	MEDCOM published a policy memorandum on June 15, 2007 delineating procedures for the safeguarding and transfer of medical records when WTs transfer from 1 WTU to another, including guidance on entering such information in AHLTA so the receiving WTU/MTF would have access to such information. Additionally, MEDCOM published a policy memorandum October 9, 2007 citing a JAG interpretation that Soldier medical records may be released to the VA. Also, ALARACT 034-2008 was published February 19, 2008 which further clarified procedures for transfer of medical records to the VA that essentially follows the policy published by MEDCOM in the June 15, 2007 policy memorandum mentioned above.	Ongoing. Warrior Transition Command (WTC) continues to work with Assistant Secretary of th Army for Manpower and Reserve Affairs (ASA M&RA), Office of the Under Secretary of Defense (OUSD), and the Department of Veterans Affairs (VA) to enhance the ability to share medical information. Improvements include the development of an electronic Medical Evaluation Board (MEB) capability. Currently undergoing development is the ability to connect applications with the Wounded Warrior Accountability System (WWAS) which will greatly enhance the ability to have comprehensive and up-to-date information available on Warriors in Transition.

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WCTO 24	Fielding of Armed Forces Health Longitudinal Technology Application (AHLTA) should be supported.	US Army Medical Command continue the fielding of Armed Forces Health Longitudinal Technology Application (AHLTA).	In addition to continuing to field AHLTA, DoD and the VA continue to evaluate the ability to electronically share medical information between Vista and AHLTA. On May 26, 2008, TSG announced DoD wide utilization of MC4. As an AMAP initiative, the Joint Patient Tracking Application (JPTA) is now required to track all wounded, ill, or injured Soldiers. VA has developed the same system which it calls the Veteran Tracking Application that operates in the same manner as JPTA. With the Medical Communications for Combat Casualty Care (MC4) capability, both DoD and VA have the capability to access medical information from the site of injury, through AHLTA or Vista to accomplish a more comprehensive medical picture of Soldiers or Veterans.	Ongoing. Efforts to further field Armed Forces Health Longitudinal Technology Application (AHLTA) have been ongoing, most notably the MOA between OTSG, the Army Reserve, and the Army National Guard which is to be briefed imminently to the CAR to complete the approval process by all parties. This agreement will over time result in AHLTA connectivity by selected AR and ARNG activities. It is significant to note recent concern expressed by both DoD and the VA about the performance and capabilities of AHLTA to contribute effectively in the development of an electronic medical record that can be readily accessed and shared.
WCTO 25	Subordinate commanders compliance with AR 735-5 and Department of the Army All Army Activities 139/2006 P210236Z July 2006 Message, Policies and Procedures for Handling Personal Effects and Government Property needs improvement.	US Army Commands ensure subordinate commanders comply with AR 735-5 and Department of the Army All Army Activities 139/2006 P210236Z July 2006 Message, Policies and Procedures for Handling Personal Effects and Government Property.	The WTU Consolidated Guidance, last updated December 2007, includes guidance on the proper handling of personal effects and government property.	Completed - December 2007. Although monitoring is ongoing as part of Warrior Transition Command's multi-disciplinary annual Organizational Inspection Program of Warrior Transition Units , the presence of guidance in handling personal effects and government property has provided a standard both for compliance and for inspection.
WCTO 26	Medical Holding Units and Medical Retention Processing Units should include a briefing during in processing on how to file claims with the Installation Claims Office for lost personally owned property.	US Army MEDCOM and Installation Management Command ensure Medical Holding Units and Medical Retention Processing Units include a briefing during in processing on how to file claims with the Installation Claims Office for lost personally owned property.	Ongoing efforts with assistance from the Warrior Transition Office. 3.C.1.H.29.A. (U) Task: Draft a Standard Operating Procedure (SOP) to govern operations of Warrior Transition Units and conduct an orientation for new WTU Commanders at the June AUSA Medical Symposium.	Ongoing. Warrior Transition Command (WTC) has established, as part of its Planning and Policy Division policy writing capabilities that have as a priority, the developing of overarching standards and procedures. While this document is still being staffed, the current target date for distribution to the field is August 31, 2009. Operational Inspection Program (OIP) inspections a currently ongoing to identify best practices to be included in the standard document. Military Treatment Facilities (MTFs) and Warrior Transition Units (WTUs) are provided considerable opportunity to develop installation and unit specific standard operating procedures (SOPs). All WTU Commanders are required to attend either the Fort Leavenworth or AMEDD Pre-command course prior to taking command. Upon assignment, WTU Commanders round out their training and orientation by completing the Distance Learning Cadre Certification Course.
WCTO 27	Physicians should be trained and understand when a Soldier should be referred to an Military Occupational Specialty (MOS) /Medical Retention Board versus Medical Evaluation Board.	US Army Medical Command ensure physicians are trained and understand when a Soldier should be referred to an MOS/Medical Retention Board versus Medical Evaluation Board.	Completed - January 2008, The AMAP established MEB physicians who are experienced in knowing when to refer Soldiers for an (MOS Medical Retention Board (MMRB) and when to initiate a MEB. Standardized training has been developed for these MEB physicians who assist in assuring MEB actions are initiated, conducted, and decisions made in accordance with applicable regulations, e.g., AR 40-501 standards and AR 40-400 patient administration requirements.	Completed - January 2008
WCTO 28	Procedures for screening permanent profiles to determine whether to refer a Soldier to an MOS/Medical Retention Board versus Medical Evaluation Board are needed for Commands and units with MOS/Medical Retention Board convening authority.	Commands and units with MOS/Medical Retention Board convening authority establish procedures for screening permanent profiles to determine whether to refer a Soldier to an MOS/Medical Retention Board versus Medical Evaluation Board.	Completed, January 2008 The AMAP established MEB physicians who are experienced in knowing when to refer Soldiers for an MMRB and when to initiate a MEB. Standardized trainin has been developed for these MEB physicians who assist in assuring MEB actions are initiated, conducted, and decisions made in accordance with applicable regulations, e.g., AR 40-501 standards and AR 40-400 patient administration requirements.	Completed - January 2008. The success of the Medical Evaluation Board (MEB) Physician role continues to be demonstrated. Recent efforts at developing an electronic profiling capability wil further enhance the ability to manage and track permanent profiles.
WCTO 29	Biannual medical holdover training for Medical Retention Processing Units and Community Based Healthcare Organizations is needed.	Installation Management Command in coordination with US Army Medical Command (MEDCOM), and Human Resources Command (HRC) continue the current implementation plan to conduct biannual medical holdover training for Medical Retention Processing Units and Community Based Healthcare Organizations.	Completed - February 2008, The AMAP established Soldier Family Assistance Centers (SFAC) under IMCOM to support WTUs. Each WT receives all necessary counseling through this arrangement.	Completed - February 2008. Education and training capabilities and requirements continue to be greatly increased with a commitment to provide on-going training to continually enhance the ski and performance of Warrior Transition Unit / Community Based Warrior Transition Unit (WTU/ CBWTU) staff.

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Type Finding/ Tracking #	Finding	Corrective Action	Previous Status	Current Status
WCTO 30	Authorization for data input fields in Medical Operational Data System is needed.	US Army Medical Command, in coordination with Human Resources Command- Alexandria complete authorization for data input fields in Medical Operational Data System.	Development of the Soldier Patient Tracking System (SPTS) was recently completed and is currently being fielded to Army units. Required additional data fields necessary for patient tracking as part of the Joint Patient Tracking Application (JPTA), SPT, and other applications have been developed. As required by the AMAP, all Army activities utilize the JPTA.	Completed - April 21, 2009. Considerable enhancements to Medical Operational Data System (MODS) capabilities continue to be made as the integrity and availability of information to manage Warriors in Transition continues to expand. The development of the Soldier Patient Tracker and the Warrior in Transition module to track Soldiers through the WTU system represent key enhancements to date. Future enhancements will be made on an ongoing basis as additional requirements are identified.
WCTO 31	Funding for installation transition centers to ensure timely discharge, release from active duty, and retirement orders publishing and disability separation processing is needed.	Installation Management Command continue to fund installation transition centers to ensure timely discharge, release from active duty, and retirement orders publishing and disability separation processing.	Completed - February 2008,Through coordination and support to WTUs, IMCOM operated SFACs accomplish, IAW the AMAP and utilizing on-site VA representatives, complete transition and benefits processing for WTs. This arrangement includes targeting the 90 day period prior to anticipated separation to complete all transition processing to ensure Soldiers are approved and will receive all benefits and payments to which they are entitled.	Completed - February 2008.
WCTO 32	Army Physical Disability Evaluation System (PDES) training is needed in the brigade and battalion pre-command courses and the sergeants major course.	Training and Doctrine Command (TRADOC) include Army Physical Disability Evaluation System (PDES) training in the brigade and battalion pre-command courses and the sergeants major course.	Completed - January 2008 - As part of the AMAP, TRADOC was tasked to complete this requirement and has successfully taken on this responsibility.	Completed - January 2008.
WCTO 33	Army Physical Disability Evaluation System training is needed in company commander and first sergeant courses that includes the unit's role and responsibilities.	Army Commands include Army Physical Disability Evaluation System training in their company commander and first sergeant courses that includes the unit's role and responsibilities.	Completed - January 1, 2008 - As part of the AMAP, TRADOC was tasked to complete this requirement and has successfully taken on this responsibility.	Completed - January 2008.The current resident training courses for Warrior Transition Unit (WTU) cadre provide significant training to ensure understanding of the Army Physical Disabilit Evaluation System (APDES). By Jul 09, the Joint DoD / VA Disability Evaluation System (DES) Pilot will have expanded to include between 65% and 75% of Army Warriors in Transition. DES Pilot training includes ensuring understanding of the DES processes by both Warriors in Transition, their Families, and WTU cadre.
WCTO 34	Training materials and programs to educate unit leaders on all aspects of the Army Physical Disability Evaluation System to include their responsibilities is needed.	Office of the Surgeon General develop training materials and programs to educate unit leaders on all aspects of the Army Physical Disability Evaluation System to include their responsibilities.	Completed - January 1, 2008 - The AMEDD Center and School has developed a training package in coordination with PDA and the Training Doctrine Command (TRADOC) to be used to train unit leaders on the PDES. This training is also utilized as part of the training for WTU cadre.	Completed - January 2008.
WCTO 35	A personnel system that allows Reserve Component commanders to track their mobilized Soldiers and those subsequently assigned to Medical Holdover status is needed.	Deputy Chief of Staff, G1 complete development of a personnel system that allows Reserve Component commanders to track their mobilized Soldiers and subsequently assigned to Medical Holdover status.	Completed - January 1, 2008 - The AMAP established the requirement to utilize the Joint Patient Tracking Application to track Warriors in Transition through the medical care chain beginning at the point of injury through recovery and disposition.	Completed - January 2008.
WCTO 36	Procedures to enable and require Commanders to contact Soldiers and their families while in Medical Holdover status are needed for the US Army Reserve.	US Army Reserve Command develop procedures to enable and require Commanders to contact Soldiers and their families while in Medical Holdover status.	Army is currently deploying the Soldier Patient Tracking System which provides AC and RC commanders the ability to stay in touch with their Soldiers.	Completed - April 2009. Numerous and highly successful capabilities have been put in place, along with all Army Components, not just Warrior Transition Unit (WTU) cadres. They are aware of how to establish communication between Units, Families, and Warriors in Transition. Receiving facilities like Walter Reed Army Medical Center have the Warrior Care and Transition Program (WCTP) requirement to ensure communication with both the forward and rear Headquarters of each incoming Warrior in Transition's parent Unit.
WCTO 37	Procedures to enable and require Commanders to contact Soldiers and their families while in Medical Holdover status are needed for the National Guard.	National Guard Bureau develop procedures to enable and require commanders to contact Soldiers and their families while in Medical Holdover status.	Army is currently deploying the Soldier Patient Tracking System which provides AC and RC commanders the ability to stay in touch with their Soldiers.	Completed - April 2009. The National Guard Bureau (NGB) and the Army National Guard (ARNG) have established dedicated assets and liaison positions to ensure contact is made with Warriors in Transition while they are recovering.

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WCTO 38	TRICARE Management Agency (TMA) review its policy regarding reimbursement of those civilian providers authorized to provide medical treatment to DoD beneficiaries.	TRICARE Management Agency (TMA) review its policy regarding reimbursement of those civilian providers authorized to provide medical treatment to DoD beneficiaries.	TRICARE Management Agency (TMA) has implemented measures to increase access to care. The future of such initiatives is no doubt dependent upon the outcome of congressional action and administration response to whether or not the FY 09 Emergency Supplemental will or will not include provider payment cuts required as a result of MEDICARE related action to cut such payments. VA is also taking action to increase access to providers through arrangements with civilian providers.	Ongoing. Efforts which continue to ensure TRICARE Management Agency (TMA) Provider reimbursement is sufficient to recruit and retain medical professionals. It is anticipated that effort in this area will be required for the foreseeable future. Warrior Transition Command (WTC) applauds the related efforts of Department of Veterans Affairs (VA) to expand rural and under-served areas with the development of Community-Based Outpatient Clinics (CBOCs), expanding community provider agreements, and an aggressive recruitment and retention program which includes development of VA programs to educate and prepare nurses, behavioral care providers, and others to meet the ever expanding demand.
WCTO 39	TRICARE Management Agency review or revise criteria used to certify physicians in remote locations in order to provide care for Soldiers residing there.	TRICARE Management Agency review or revise criteria used to certify physicians in remote locations in order to provide care for Soldiers residing there.	TMA has implemented measures to increase access to care. The future of such initiatives is not doubt dependent upon the outcome of congressional action and administration response to whether or not the FY 09 Emergency Supplemental will or will not include provider payment cuts required as a result of MEDICARE related action to cut such payments. VA is also taking action to increase access to providers through arrangements with civilian providers.	Ongoing. Warrior Transition Command (WTC) and the Warrior Care and Transition Program (WCTP) will continue to work with TRICARE Management Agency (TMA) to develop and successfully implement programs of recruitment, retention, and agreements to share or contract resources and services. WTC interest concerns the impact on provider availability in light of cost cutting measures, e.g., the TRICARE Outpatient Prospective Payment System which, as of May 19, 2009 is projected to save $458M. As part of the development of the Education, Employment, and Internship (EEI) program for Warriors in Transition, WTC is also working with Operation War fighter to prepare and channel Warriors in Transition to civilian positions which at least in part include staffing requirements for WTUs. The structure currently being developed for the EE program represents a cooperative effort between WTC, OSD, VA, DoE, and DoL.

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