SECRETARY OF THE ARMY
WASHINGTON

DEC 14 2012

MEMORANDUM FOR RECORD

SUBJECT: Report on Inspection of the Behavioral Health (BH) Process, Disability Evaluation System (DES) and Integrated Disability Evaluation System (IDES)

In accordance with my Title 10 responsibilities as Secretary of the Army, this memorandum serves as my review of the recommendations as set forth by The Inspector General (TIG) in the above-entitled inspection report. The Director of the Army Staff will task appropriate Army officials to implement each approved recommendation. The Inspector General will continue to monitor implementation and provide me with interim progress reports, as appropriate. My review of these recommendations is enclosed.

RELEASE AUTHORIZATION: I hereby authorize this report and associated recommendations to be posted to the Inspector General Network.

John M. McHugh

Encl

John M. McHugh

SUBJECT: Enclosure (SecArmy Recommendation Review) to SecArmy, Subject: Report on Inspection of the Behavioral Health (BH) Process, Disability Evaluation System (DES) and Integrated Disability Evaluation System (IDES)

1. Commander, United States Army Medical Command (MEDCOM).

a. Conduct re-training and re-validation of all Medical Evaluation Board (MEB) sites incorporating and ensuring compliance with current implementation guidance.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

b. In coordination with DCS, G-3/5/7, create standardized training requirements regarding the completion of DA Form 7652 (Commander's Performance and Functional Statement) during installation Company Commander / First Sergeant Courses.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

c. In coordination with DCS, G-1, standardize IDES reception, education and process integration for all IDES personnel and all stakeholders involved; include specific training for Soldiers, leaders, Physical Evaluation Board Liaison Officers (PEBLO), Soldier Medical Evaluation Board Counsels (SMEBC), MEB Doctors, BH Professionals and other involved IDES associates.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

d. Ensure compliance and reinforce implementation of Office of The Surgeon General (OTSG) / MEDCOM Annex O (MEB Phase Implementation Guidance to Operations Order (OPORD) 12-31).

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

e. Ensure Soldiers' appeals and Impartial Medical Reviews (IMR) are conducted by a provider independent of the MEB process for Service Members (SM) that they have provided a Narrative Summary (NARSUM) for (no same physician diagnosis and review).

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

f. Develop utilization guidance for PEBLOs and Contact Representatives to facilitate effective communication, responsibility management and cross-organizational coordination.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

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g. Explore expansion of the resident PEBLO training program and update the online training.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

h. Clarify MEDCOM Policy 12-035 for providers to decrease the perceived conflict between the policy and the current American Psychological Association (APA) guidelines and standards.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

i. Conduct a cost benefit analysis of the methods to expand SMEBC program.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

j. Encourage Family member participation in IDES.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

2. Deputy Chief of Staff, G-1.

a. In coordination with CDR MEDCOM, explore expansion of Physical Evaluation Boards (PEB) and / or modification of current authorities within IDES (i.e. increase number of PEBs, increase current PEB / MEB capabilities or expand current site authorities).

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

b. In coordination with Director, United States Army Physical Disability Agency (PDA) and CDR, MEDCOM, conduct periodic certification and audit process for sites conducting MEBs and PEBs.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

c. Develop a credible proponent / office of primary responsibility for the IDES process.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

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d. In coordination with CDR, MEDCOM, establish a forum or method for routine discussion of IDES-related policies to synchronize the implementation of regulatory changes across all Army installations and address any emerging issues or concerns.

SA Review: Approve JMC **Disapprove** ____ **See Me** ____

e. Align Outside the Continental United States (OCONUS) IDES process to support Soldier and Continental United States (CONUS) installation requirements.

SA Review: Approve JMC **Disapprove** ____ **See Me** ____

f. In coordination with Chief Information Officer (CIO) / G-6, establish a single tracking application for the IDES process that includes multi-organizational and Soldier access to allow for a common operating picture.

SA Review: Approve JMC **Disapprove** ____ **See Me** ____

g. Update DA Form 7652 (Commander's Performance and Functional Statement) to include the requirement for a second signature from the next higher commander to increase accountability for thorough completion of the form.

SA Review: Approve JMC **Disapprove** ____ **See Me** ____

h. In coordination with Office of the Judge Advocate General (OTJAG), clarify and issue updated policy regarding the rights and responsibilities of commanders to administratively separate Soldiers and to administer punishment under the Uniform Code of Military Justice (UCMJ) to Soldiers in the IDES process.

SA Review: Approve JMC **Disapprove** ____ **See Me** ____

i. In coordination with CDR, MEDCOM, establish a standard vetting process for all IDES training material.

SA Review: Approve JMC **Disapprove** ____ **See Me** ____

j. Update DA Form 3947 (Medical Evaluation Board Proceedings) to include the IMR election.

SA Review: Approve JMC **Disapprove** ____ **See Me** ____

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k. In coordination with CDR, MEDCOM, enforce standardization of Warrior Transition Unit (WTU) acceptance criteria.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

3. Deputy Chief of Staff, G-3/5/7 in coordination with DCS, G-1 and CDR, MEDCOM review all relevant training and establish an Army-wide, standardized teaching program for IDES to ensure baseline knowledge for leaders, Soldiers and Families.

SA Review: Approve ✓ **Disapprove** ____ **See Me** ____

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A

Inspection Summary:
Inspection of the Behavioral Health (BH) Process, Disability Evaluation System (DES) and Integrated Disability Evaluation System (IDES)

What We Did:

The DAIG conducted an inspection of the BH, DES and IDES. There are 19 findings and 22 recommendations from this inspection, key highlights are listed below.

What We Found:

- Non-compliance with Army standard for processing IDES Service Members (SM).
- Challenges exist in harmonizing, synchronizing and resolving IDES process issues.
- Knowledge about the IDES process is uneven and incomplete across all echelons of the Army.
- Multiple IDES tracking systems provide limited visibility while increasing workload and confusion for all participants and leaders concerned with the IDES process.
- There was poor or inconsistent organizational understanding of the role and requirements of DA Form 7652 (Commander's Performance and Functional Statement).
- The IDES reception and integration process for Soldiers, leaders and BH providers is not standardized and varies considerably across sites and roles.
- Medical Treatment Facilities (MTF) not in compliance with MEDCOM Operations Orders (OPORD).

What We Recommend:

- Conduct retraining and revalidation of all Medical Evaluation Board (MEB) sites incorporating new implementation guidance.
- Create standardized training requirements regarding the completion of DA Form 7652 (Commander's Performance and Functional Statement).
- Standardize IDES reception, education and process integration for all IDES personnel and all stakeholders involved.
- Ensure compliance and reinforce implementation of Annex O (MEB Phase Implementation Guidance to OPORD 12-31).
- Conduct periodic certification and audits for sites conducting MEBs and Physical Evaluation Boards (PEB).
- Align Outside Continental United States (OCONUS) IDES process to support SM and Continental United States (CONUS) installation requirements.
- View all relevant training and establish an Army-wide chain teaching program for IDES.

DEPARTMENT OF THE ARMY
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WASHINGTON DC 20310-1700

SAIG-ID

DEC 07 2012

MEMORANDUM FOR SECRETARY OF THE ARMY

SUBJECT: Inspection of Behavioral Health (BH) Evaluations and Diagnoses in the Context of the U.S. Army Disability Evaluation System (DES) and Integrated Disability Evaluation System (IDES)

1. **Purpose.** From 15 May 2012 – 30 October 2012, the Department of the Army Inspector General (DAIG) conducted a comprehensive inspection of BH evaluations and diagnoses in the context of the DES and IDES. This memorandum provides an executive summary of the inspection results.

2. **Background.**

a. In November 2007, the Department of Defense (DoD) launched the DES Pilot Program, integrating aspects of the DoD and Department of Veterans Affairs (VA) disability evaluation systems to run concurrently rather than sequentially. The initiative was intended to be service member (SM) centric and focused on eliminating duplicative, time consuming and often-confusing elements of the two Departments' processes. The DES Pilot Program was centered in the National Capital Region (NCR) and was implemented at one Army (Walter Reed Army Medical Center), one Navy (Bethesda Naval Hospital) and one Air Force (Malcolm Grow Medical Center) Medical Treatment Facility (MTF). A DoD and VA review of the Program's first operational year deemed the Pilot successful enough to justify its extension beyond the NCR. On 1 June 2009, the DoD and VA DES Pilot Program expanded to other locations, was designated the IDES and became the model for DoD-wide implementation. The Army's IDES Program completed its final phase of implementation in October 2011.

b. Before 2008, the Army used the DES process to maintain a fit and ready force. The legacy DES evaluated only those medical conditions that called into question a Soldier's ability to continue to serve in the military. Disability compensation was awarded through two separate and sequential processes: the first process, conducted by the Army and the second, and subsequent process executed by the VA. As to the Army process, upon receiving a level 3 or 4 permanent profile (P3 or P4), a Soldier was referred for a medical evaluation by an Army medical department for a Medical Evaluation Board (MEB) and subsequently assigned a disability rating by an Army Physical Evaluation Board (PEB) as to those medical conditions rendering the Soldier unfit for continued service. Soldiers were accorded many opportunities for appellate reviews throughout the MEB and PEB processes pending a final disability determination

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resulting in: the Soldier's medical separation and receipt of severance pay; medical retirement and award of disability retired pay; or return to duty.

c. Once a Soldier attained Veteran status, the VA prepared a claim to identify the medical conditions to be evaluated as part of the VA Compensation and Pension (C&P) examination. The VA conducted the C&P examination, evaluated the results and provided the Veteran a disability rating for all service connected conditions (not only those conditions rendering the Soldier unfit for further service in the Army). On average, it took 6 – 9 months after a Soldier received Veteran status before the Soldier began receiving VA benefits.

d. Beginning in 2007, the DoD and VA worked together to upgrade and simplify the disability evaluation and compensation system. The resultant process was the IDES. IDES integrated DoD and VA processes by initiating VA claim development while the Soldier was still a SM and by supplanting the Army's medical evaluation with the VA's C&P examination. Under the IDES, the DoD accepted the VA's C&P examination as the medical examination of record and directed the Army to use the results of the VA C&P examination as the basis for its determination as to whether a SM met or failed to meet retention standards. The VA C&P examination continued to be used by the VA as the basis for determining a Veteran's total disability compensation.

3. **Inspection Objectives.** In a 15 May 2012 directive, the Secretary of the Army (SecArmy) enumerated four objectives for the DAIG inspection:

a. (Knowledge) *Assess whether commanders, Soldiers and other participants in DES / IDES are sufficiently informed about, and understand, their respective roles; their rights and duties; and the sources of information and assistance available to them; all with a view to optimizing their participation in, and the overall effectiveness of, DES / IDES processes.* In general, the Inspection Team found major gaps in education and understanding of all participants in the IDES process, which limited their effective participation in the process. This lack of education was a common thread throughout the deficiencies identified in this report.

b. (Process) *Review the effect of the Army's implementation of IDES on the diagnosis and evaluation of behavioral health conditions.* There was overall weak implementation of Army IDES policy which resulted in additional BH exams and sometimes led to changed BH diagnoses.

c. (Appeal) *Review and evaluation of the sufficiency of appeal procedures available to Soldiers participating in the DES / IDES processes.* There are ample appeal,

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reconsideration and similar opportunities in the IDES process; however, care provider interpretation of appeal procedures sometimes disadvantage SMs.

d. (Non-Medical) *To the extent arising from tasks outlined in this directive, collect and report to the Under Secretary of the Army (USA) and the Vice Chief of Staff, Army (VCSA) any observations that command climate or other non-medical factor affected behavioral health diagnoses and evaluations.* While the Inspection Team found command-climate related non-medical factors affecting Soldiers in the IDES process, (*e.g.*, Co Cdr's not submitting DA Form 7652 Commander's Performance and Functional Statement) they did not find significant non-medical factors directly affecting BH diagnoses and evaluations.

e. In addition, the inspection was intended to provide a factual baseline for all key organizations with responsibilities in the IDES BH process. All results were provided to the Army Behavioral Health Task Force, U.S. Army Medical Command (MEDCOM) and the Deputy Chief of Staff (DCS), G-1 for corrective action planning.

4. **Process Map.** Analysis of data accumulated from over 6,400 individuals across the 46 sites inspected resulted in findings that correspond to three primary areas of concern: Goverance / Process Oversight; Synchronization Concerns; and Execution Shortfalls as illustrated in Figure 1.

- The Governance / Process Oversight area reports on information associated with the Knowledge, Process, Appeals and Non-Medical objectives.

- The Synchronization Concerns area reports on data primarily derived from the Knowledge and Non-Medical objectives.

- The Execution Shortfalls area reports information associated with the Knowledge, Process and Appeals objectives.

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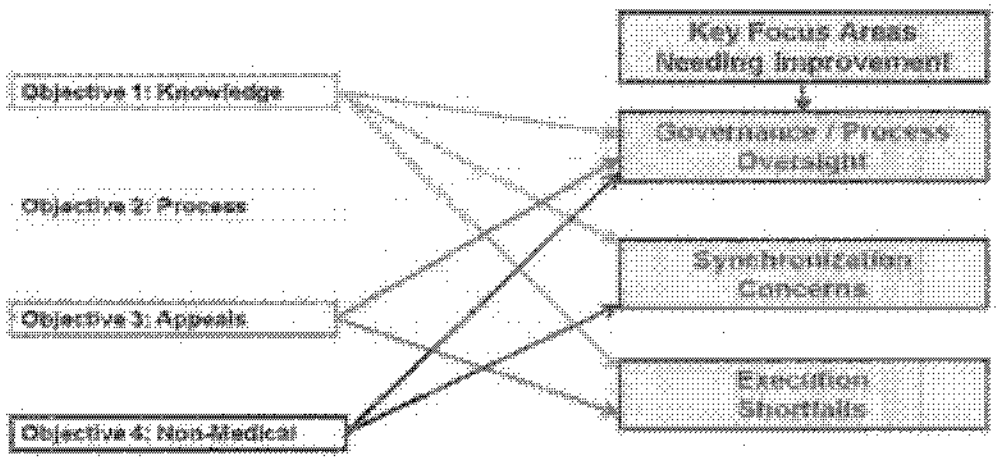
(Figure 1) **Recommendation Process Map**



5. **Inspection Methodology.**

a. Preparation Phase. To prepare for this inspection, the Inspection Team received training on the IDES process, integrated 47 subject matter experts with the Team, interviewed senior Army officials associated with MEDCOM and DCS, G-1 and conducted extensive review of documented policies and procedures believed to govern the DoD and VA disability processes. Additionally, the Inspection Team conducted pre-inspection visits of the Physical Disability Agency (PDA) and a MTF responsible for conducting MEBs to validate inspection tools and establish a baseline understanding of MEDCOM and VA internal organization and structure, policies, processes and procedures.

b. Execution Phase. Beginning in July 2012, the Inspection Team conducted site visits, including 32 MTFs, 15 Warrior Transition Units (WTUs), eight Community-Based Warrior Transition Units (CBWTUs), an MEB processing site, five pre-MEB sites and three PEB sites. The Inspection Team conducted over 750 interviews, 80 sensing sessions and contacted 6,418 Soldiers, Family Members and civilian contractors. DAIG surveyed 2,472 leaders, Soldiers and BH professionals. Finally, the Inspection Team conducted an analysis of IDES-related regulations, forms and procedures to evaluate the efficiency of the current process.

c. Descriptive Percentages. For purposes of this report, data is presented using the following descriptive percentage ranges: Nearly all (90 – 99%), Most (76-89%), Majority (51 – 75%), Half (50%), Some (26 – 49%) and Few (1 – 25%).

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6. **Inspection Summary.**

a. The Inspection Team found that the MEDCOM's execution of the IDES process was inefficient and contributed to the Army's inability to ensure SM completion of the process within the DoD-established goal of 295 days. This, coupled with the lack of an effective Army proponent to develop and disseminate IDES policies and processes across the Army, hindered the timely implementation and execution of IDES. These findings are best illustrated by the MTFs' unwillingness to follow published guidance or the common MTF practice of minimally instituting new guidance so as not to disrupt current activities, even though the new guidance was specifically intended to change drastically those very activities. The DAIG Inspection Team attributed much of this ineffectiveness to the medical profession's primary focus on so-called "clinical prerogatives" in lieu of enforcing organizational discipline and compliance. For example, notwithstanding that DoD Directive Type Memorandum (DTM) 11-015 prescribes a single medical examination, to be conducted by the VA (the VA Compensation and Pension (C&P) Examination), as the basis for all IDES processing, doctors assigned to conduct MEBs continued to assert that they were serving in a clinical role rather than in the administrative role assigned to them as part of the MEB process. Given their clinical role, as they perceived it, these doctors believed they had an ethical obligation to question and confirm the veracity of the VA medical examination. SMs were then subjected to additional testing, medical file reviews, re-writes of the Commander's Performance and Functional Statements and numerous other post-VA C&P examination events. The conduct of these follow-on reviews and events contravened the processes and procedures at the heart of the new IDES, as established by DoD DTM 11-015 and unduly extended IDES processing times. SM faith in, and understanding of, IDES was low; the post-VA C&P examination tests and reviews performed by the Army directly contradicted what Physical Evaluation Board Liaison Officers (PEBLOs) had told Soldiers about the new IDES.

b. The Inspection Team found that MEDCOM understood the issues that MTFs were having with compliance to IDES implementation. As a result of DA and MEDCOM IG feedback, on 16 July 2012, MEDCOM issued guidance in the form of Annex O to MEDCOM Operations Order (OPORD) 12-31 (Implementation of the IDES). Annex O further amplified the DTM 11-015 "single medical examination" requirement as applied to Army MTFs. Annex O required MTFs to accept the VA C&P Exam as the exam of record, eliminating the need for MEB doctors to conduct additional clinical diagnostic re-evaluation, although it allowed physicians some discretion. IAW the DTM, Annex O stipulated that an MEB examiner's sole duty was to conduct an administrative review of SM records to ensure compliance with established protocols. Although there was cultural resistance to this guidance at many MTFs, MEDCOM has shown a commitment to enforcing the "single medical exam" mandate to ensure a more streamlined and

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efficient IDES process for SMs. MEDCOM IGs are now assessing compliance with the "single medical exam" requirement as part of The Surgeon General's IDES Corrective Action Plan (CAP).

c. The Inspection Team isolated four overarching factors for non-compliance with IDES policy and procedures as set forth in DoD DTM 11-015 and Headquarters Department of the Army (HQDA) Execution Order (EXORD) 080-12, which implemented the DTM for the Army:

(1) *Inadequate resourcing of the IDES process.* IDES sites are inadequately resourced to handle the increasing numbers of SMs entering into the process. For example, less than 20% of the Soldiers completing IDES in September 2012 executed the process within the DTM's Active Component (AC) goal of 295 days or the Reserve Component (RC) goal of 305 days.

(2) *Lack of recurring certification, continuous process improvement and audit and inspection capability.* The Inspection Team found a lack of oversight at MEB / PEB sites. No Army official or organization undertook to conduct, or to ensure the conduct of, recurring certification, continuous process improvement, audits or inspections of MEB / PEB sites.

(3) *MTFs are improperly implementing proponent requirements.* MTFs routinely interpret and implement policies locally. In some instances, a facility will implement the policy change in a way that causes the least disruption to its existing processes, even if the policy was intended to cause a drastic change to those processes. Culture and individual personalities play a large role in how medical professionals and MTFs implement policies. This was evident with MTF interpretations of the "single medical exam" requirement, the ineffective transfer of OCONUS SMs to CONUS MTFs, improper withholding of second profile signatures and inappropriate MTF interpretations of the MEB appeals process.

(4) *Lack of Internal Controls.* The Inspection Team found that MEDCOM lacked internal controls. For example, the process for disseminating Annex O, which implemented the critical "single medical exam" requirement set forth in DTM 11-015 from MEDCOM through Regional Medical Commands (RMC) to MTF leadership was ineffective as many BH providers and other personnel involved in the IDES process did not receive the Annex and thus were unaware of this important change in MEDCOM policy.

7. **Key Findings.** There are 19 findings in this inspection report. A summary of the key findings follows:

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a. **Governance / Process Oversight:**

(1) *Non-compliance with Army standard for processing IDES SMs.* During Fiscal Year (FY) 2012, the Army averaged 396 days for an AC SM to complete the IDES process versus the DoD DTM 11-015 goal of 295 days. According to the September 2012 IDES Monthly Report, during the final six months of Fiscal Year (FY) 2012, the Army averaged 386 days for AC and 366 days for RC to complete the IDES process. This is far short from the DTM 11-015 goal of 295 days for AC and 305 days for RC Soldiers.

Choke points in the IDES process indentified during the past three months included the MEB stage (average 91 days versus 35 day goal), the PEB stage (average 19 days versus 15 day goal), the Disposition stage (average 88 days versus 35 day goal) and the Transition Stage (average 83 days versus 30 day goal). The sheer volume of SMs participating in IDES and the organizational structure required to support IDES far exceeded capacity, resulting in an inability to meet established timelines across the IDES process. Without improvements, SMs continued to languish in the system, which at times, exacerbated SMs' BH symptoms and led to an increase in friction and disciplinary problems within the units to which SMs were assigned.

(2) *Challenges exist in harmonizing, synchronizing and resolving IDES process issues.* There was no single overarching IDES policy. The IDES process proponent lacked the capability to effectively meet all regulatory roles and responsibilities. IDES was one of 155 programs managed by The Adjutant General, U.S. Army Human Resources Command (HRC). Proponency for IDES was not well known, nor were roles and responsibilities understood. Different commands directed and managed different principal parts of the IDES. For instance, HRC exercises operational control over the IDES process. The PDA, a subordinate organization of HRC, is delegated authority as the IDES operator and MEDCOM is the IDES operator for Army medical assets involved in the IDES process. This approach made communication of the various IDES policies, procedures and personnel processes tenuous and consistent oversight challenging.

(3) *Knowledge about the IDES process is inconsistent and incomplete across all echelons of the Army.* Training on IDES is inadequate, not standardized and in some cases conflicts with current standards. IDES represented a fundamental change to the Army's disability process. However, at the outset, neither DCS, G-1 nor MEDCOM issued overarching implementation policy guidance or training for Soldiers, leaders or personnel involved in the IDES process. The lack of detailed policy reduced the likelihood of standardization, synchronization and a clear understanding of expectations for all actors in the IDES process.

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To combat this lack of universal knowledge MEDCOM has developed and issued an IDES guide. This guide is a partial solution that provides health care personnel a reference, but still falls short of the comprehensive training that is required to establish an Army-wide baseline understanding of the IDES. During the course of the inspection, teams found sporadic instances of IDES professionals (i.e. PEBLOs, BH and MEB Doctors) propagating inaccurate information on the IDES process. Future training must ensure there are no misperceptions among leadership and command messages are consistent with current official guidance.

b. **Synchronization Concerns:**

(1) *Multiple IDES tracking systems provide limited visibility while increasing workload and confusion.* Inspectors identified the use of multiple tracking systems (e.g., Veterans Tracking Application [VTA], Automated eDES, spread sheets, eMEB, ePEB), as well as noting that almost all sites used personally developed / customized local tracking systems to assist in gathering real time data. The use of multiple tracking systems may have been necessary to meet reporting requirements; however, this has resulted in an increased workload for PEBLOs, who must continually update multiple tracking systems. Due to increased workload and inefficiencies, PEBLOs sometimes fail to update the automated systems, resulting in inaccurate or missing data within / between systems.

(2) *There was poor and inconsistent organizational understanding of the role and requirements of DA Form 7652 (Commander's Performance and Functional Statement).* A majority of Soldiers and leaders surveyed (1303 of 2,472 or 53%) assessed themselves as having a poor understanding of the IDES process. Moreover, some leaders (422 of 1,471 or 29%) indicated that they were either unaware of the importance of DA Form 7652, that they had never heard of the form or that the form was not applicable to them in their leadership role. Consequently, many unit commanders provided no direct performance-based observations of the Soldier or assessment of the Soldier's suitability for continued service. Yet, this form—the only non-medical evaluation of a Soldier's performance of duty-related tasks and functions—is of great importance to the IDES process.

(3) *The IDES process for Soldiers is not standardized and varies considerably across sites / roles and inhibits proper understanding of procedural requirements.* Leaders' limited knowledge of the IDES process precluded their ability to positively influence, educate or support SMs undergoing the IDES process. Of leaders surveyed, some (396 of 1,403 or 28%) indicated that they "had never received any information or awareness" regarding the IDES process, and a few (346 of 1,420 or 24%) indicated that they were "not familiar with any" of the primary and integral roles in the IDES.

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Moreover, some leaders (380 of 1,403 or 27%) indicated that they had to get information about the IDES on their own. Of BH providers surveyed, some (168 of 383 or 44%) "somewhat disagreed" to "strongly disagreed" with the statement that Soldiers had a comprehensive understanding of the IDES process. Only a few (10 of 383 or 3%) BH providers surveyed indicated that they "strongly agreed" Soldiers in the IDES had a comprehensive understanding of the process. Regarding BH providers' introduction to, and training in, the IDES system, some (155 of 366 or 42%) indicated that they procured information on their own or that they had never received any training in the IDES process.

(4) *Administrative Separation procedures for Soldiers in the IDES process.* Many commanders and enlisted leaders indicated a belief that Soldiers often seek refuge in the IDES process, particularly seeking BH services, after committing offenses that would subject them to punishment under the UCMJ. However, this action would not prohibit a commander from taking the appropriate administrative action against a Soldier in the IDES process, whether in the form of an Article 15 or by initiating an administrative separation action. Enlisted leaders indicated significant frustrations because of commanders' hesitation to apply administrative and / or disciplinary actions to Soldiers in the IDES process. Commanders reportedly direct enlisted leaders to counsel Soldiers in writing about offenses, but enlisted leaders perceive these efforts as futile when commanders do not follow-up with appropriate corrective actions or punishment, when warranted.

c. **Execution Shortfalls:**

(1) *MTFs not in compliance with MEDCOM OPORDs implementing established DoD and Army Policy.* Half (16 of 32 or 50%) of MTFs were not in full compliance with critical components of Office of The Surgeon General (OTSG) / MEDCOM Annex O to Fragmentary Order (FRAGO) 1 OPORD 12-31 that implemented DTM 11-015 and HQDA EXORD 080-12 requirements. These MTFs continued to conduct post VA C&P examination reviews even after the publication of a FRAGO that explicitly directed that no such exams take place. The post C&P exams included BH evaluations and provider assessments of SMs diagnosed with BH related issues by VA providers.

(2) *Appeals and Impartial Medical Reviews (IMR) not conducted by an independent provider.* During the course of this inspection, inspectors found some (14 of 32 or 44%) MEB sites where MEB physicians or BH providers who originally wrote the Narrative Summary (NARSUM) also conducted IMRs of the same Soldier's NARSUM. This practice led Soldiers to perceive both a lack of impartiality and that IMRs were not being conducted according to regulatory guidance (DTM 11-015) Appendix 4. DTM 11-015 states, "a Soldier has the right to an IMR, when requested, to

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serve as an independent source for review of the findings and recommendations of the MEB..." ANNEX O to OPORD 12-31 implements this DoD requirement for the Army, stating "the IMR reviewer(s) cannot be one of the signature authorities for the Soldier's MEB, and / or NARSUM process."

(3) *Utilization and training of PEBLOs and Contact Representatives (PEBLO assistants) is inconsistent.* PEBLOs, in effect, are the face of IDES and are involved in every administrative action associated with the process. The Inspection Team found that the current utilization guidance at MTFs overtasked PEBLOs and relied on them for any new requirements as well as substantive MEB actions. However, there was no published utilization and training guidance for PEBLOs and Contact Representatives. The online PEBLO training course was outdated with the legacy DES information. In addition, PEBLOs were not equipped with the necessary initial training, command support and uniform guidance to effectively perform their duties. The inspection also identified that some PEBLOs and Contact Representatives were certified for duty without obtaining a thorough and standardized IDES knowledge base. The issues raised may indicate a possible inappropriate grade designation and need for a position description review based on the duties PEBLOs actually peform.

(4) *Shortage of Soldier Medical Evaluation Board Counsels (SMEBC).* SMEBCs are the only legal representatives in the Army that serve IDES Soldiers as a client. Despite the criticality of these personnel, there were insufficient SMEBCs to serve Soldiers in the IDES program. Inspectors noted that some sites (15 of 32 or 47%) did not have SMEBCs located on the installation and were supported by other installations. Installations without a SMEBC presented Soldiers with transportation and timeline challenges. Soldiers were either forced to commute longer distances to receive SMEBC services or SMEBCs were forced to commute to provide services to Soldiers. The shortages of SMEBCs also negatively affected the five-day timeline for a Soldier to request an IMR and / or appeal. Soldiers' timelines included non-duty days, which led to challenges receiving timely legal assistance. For example, if a Soldier received his or her MEB results on a Thursday and the five-day suspense to file an appeal included non-duty days (the weekend), the Soldier may not have had an opportunity to receive adequate counsel.

(5) *DA Form 3947 (Medical Evaluation Board Proceedings) contains no provision for a Soldier to elect an IMR.* The DA Form 3947 does not include an option for a Soldier to request an IMR. Instead, a Soldier must submit a memorandum in order to request an IMR. This requirement for a Soldier to initiate separate correspondence to request an IMR places an unnecessary burden on the Soldier, prolongs the IDES timeline and does not facilitate automated document processing.

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8. **Key Recommendations.** There are 22 recommendations in this inspection report. Key recommendations are presented below:

a. **Commander (CDR), MEDCOM.**

(1) Conduct re-training and re-validation of all Medical Evaluation Board (MEB) sites incorporating and ensuring compliance with current DoD, Army and other applicable implementation guidance.

(2) In Coordination With (ICW) DCS, G-3/5/7 and CDR, TRADOC create standardized training requirements for inclusion in installation Company Commander / First Sergeant Courses regarding the completion of the Commander's Performance and Functional Statement (DA Form 7652).

(3) ICW DCS, G-1, standardize IDES reception, education and process integration for all IDES personnel and all stakeholders involved; include specific training for Soldiers, leaders, PEBLOs, SMEBCs, MEB Doctors, BH Professionals and other involved IDES personnel.

(4) Ensure compliance and reinforce implementation of OTSG / MEDCOM Annex O (MEB Phase Implementation Guidance to OPORD 12-31), to the extent it implements DoD and Army policy.

b. **DCS, G-1.**

(1) ICW PDA and CDR, MEDCOM, conduct periodic certification and audits for sites conducting MEBs and PEBs.

(2) Develop a credible proponent / office of primary responsibility for the IDES process.

(3) ICW CDR, MEDCOM, establish a forum or method for routine discussion of IDES-related policies to synchronize the implementation of regulatory changes across all Army installations and address any emerging issues or concerns.

(4) Align Outside Continental United States (OCONUS) IDES process to support SM and Continental United States (CONUS) installation requirements.

c. **DCS, G-3/5/7.** ICW DCS, G-1 and CDR, MEDCOM review all relevant training and establish an Army-wide, standardized teaching program for IDES to ensure baseline knowledge for leaders, Soldiers and Families.

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9. **Ongoing Corrective Actions.** Upon completion of the execution phase of this inspection, the Inspection Team provided all stakeholders a briefing detailing findings and recommendations. In response to this briefing, the DCS, G1 and CDR, MEDCOM have already initiated the following key corrective actions (all ongoing corrective actions are listed in Enclosure 11 Appendix 4):

a. DCS, G-1 has—

(1) Designated a Brigadier General to serve as the IDES process "Champion."

(2) Together with the Chief Information Officer (CIO) / G-6, established a contract for an end-to-end Information Technology (IT) solution that allows for a common operating picture based on the needs of the IDES participant (SM, MTF Cdr, Co Cdr, etc.).

(3) Initiated the development of, and will subsequently staff and disseminate a single, updated, consolidated and comprehensive regulation for IDES, as directed by HQDA EXORD 080-12.

(4) Through the PDA, implemented a recent SecArmy directive authorizing PEBs to reduce Informal PEB (IPEB) staffing from three to two board members. The results of these actions improved the process minimally in September 2012, but long-term should significantly contribute to reduced IDES processing times.

b. CDR, MEDCOM recently—

(1) Established two additional MEB Remote Operating Cells (MEBROC) at Joint Base Lewis-McChord (JBLM) and Fort Carson and is evaluating the need for more cells.

(2) Directed the inspection of one–half of all IDES sites to assess compliance with authorized policies and procedures.

(3) Issued FRAGO 3 (OPORD 12-31) which directed the alignment of PEBLOs to supported units.

10. **Verification.** The 19 findings and 22 recommendations from this report were coordinated with and briefed to, each organization with equities in this inspection for verification and comments. All organizations concurred with the findings and recommendations of this report.

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11. **Recommendation Follow-up.** Stakeholders identified in Enclosure 1 (Verification Matrix), will receive a copy of the inspection report and a HQDA, tasking requiring them to develop a corrective action plan to address their assigned recommendations and provide a copy of their plan to the DAIG Analysis and Inspection Follow-up Office (SAIG-AI / [redacted]) NLT 30 days after receipt of the HQDA tasking.

Encl
as

PETER M. VANGJEL
Lieutenant General, USA
The Inspector General

CF:
UNDER SECRETARY OF THE ARMY
ASSISTANT SECRETARY OF THE ARMY, MANPOWER AND RESERVE AFFAIRS
CHIEF OF STAFF, ARMY
VICE CHIEF OF STAFF, ARMY
CIO / G-6
DEPUTY CHIEF OF STAFF, G-1
DEPUTY CHIEF OF STAFF, G-3
COMMANDER, UNITED STATES ARMY MEDICAL COMMAND
DIRECTOR, ARMY BEHAVIORAL HEALTH TASK FORCE

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SAIG-ID
SUBJECT: Enclosure 1 (Verification Matrix) to Memorandum, Subject: Inspection of the US Army Behavioral Health (BH), Disability Evaluation System (DES) and Integrated Disability Evaluation System (IDES)

1. Verification. The stakeholder organization(s) have been provided a (briefing / copy) of the inspection report findings and recommendations for verification and comment. The intent of this process is to ensure the inspection report is correct and to capture stakeholder's comments in the final report. The enclosure to this memorandum identifies the (stakeholder / responsible entity) and date briefed followed by a matrix containing all observations, findings, recommendations and concurrence or non-concurrence. There are 19 findings and 22 recommendations on the Secretary of the Army memorandum representing all of the findings from the objectives, other matter and positive notes.

2.

Organization	Stakeholder	Briefing Date	Comment
DIR, BHTF	(b)(6)	20121015	Concur
DCS, G-3/5/7		20121015	Concur
CDR, MEDCOM		20121015	Concur
DCS, G-1		20121018	Concur
CIO / G-6		20121101	Concur

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Functional Assessment 1: *Governance / Process Oversight (PO)*

Findings	Recommendation	Stakeholder (s) Brief Date	Comment
PO-1 DEFICIENCY (reference# ID-1205.01): During Fiscal Year (FY) 2012, the Army averaged 396 days for a SM to complete the IDES process versus the Directive Type Memorandum 11-015 goal of 295 days.	**PO-1.1 (reference# ID-1205-01.01):** DCS G-1, in coordination with CDR MEDCOM, explore expansion of Physical Evaluation Boards (PEB) and / or modification of current authorities within IDES (i.e. increase number of PEBs, increase current PEB / MEB capabilities or expand current site authorities).	DCS, G-1 (20121018) MEDCOM (20121015)	Concur Concur
PO-2 DEFICIENCY (reference# ID-1205-02): The IDES process lacks a recurring certification and audit capability for MEB and PEB sites needed to ensure common procedures and a common operating picture for each stakeholder across the enterprise.	**PO-2.1 (reference# ID-1205-02.01):** CDR, MEDCOM, conduct re-training and re-validation of all Medical Evaluation Board (MEB) sites incorporating and ensuring compliance with current implementation guidance.	MEDCOM (20121015)	Concur
	PO-2.2 (reference# ID-1205-02.02): DCS, G-1 ICW Dir, US Army Physical Disability Agency (PDA) and CDR, MEDCOM, conduct periodic certification and audit process for sites conducting MEBs and PEBs.	DCS, G-1 (20121018) MEDCOM (20121015)	Concur Concur
PO-3 OBSERVATION (reference# ID-1205-03): Challenges exist in harmonizing, synchronizing and resolving IDES process issues.	**PO-3.1 (reference# ID-1205-03-01):** DCS G-1, develop a credible proponent / office primary responsibility for the IDES process.	DCS, G-1 (20121018)	Concur

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Findings	Recommendation	Stakeholder(s) Brief Date	Comment
PO-4 OBSERVATION (reference# ID-1205-04): Knowledge about the IDES process is uneven and incomplete across all echelons of the Army.	**PO-4.1 (reference# ID-1205-04.01):** DCS, G-3/5/7 ICW DCS, G-1 and CDR MEDCOM, review all relevant training and establish an Army-wide, standardize teaching program for IDES to ensure baseline knowledge for leaders, Soldiers and Families.	MEDCOM (20121015) DCS, G-1 (20121018) DCS, G-3/5/7 (20121015)	Concur Concur Concur
Functional Assessment 2: *Synchronization Concerns (SC)*			
SC-1 Deficiency (reference# ID-1205-05): MTFs are improperly implementing proponent policies.	**SC-1.1 (reference# ID-1205-05.01):** DCS, G-1, ICW CDR, MEDCOM, establish a forum or method for routine discussion of IDES-related policies to synchronize the implementation of regulatory changes across all Army installations and address any emerging issues or concerns.	MEDCOM (20121015) DCS, G-1 (20121018)	Concur Concur
SC-2 OBSERVATION (reference# ID-1205-06): Inconsistencies exist between IDES processes for Soldiers based in CONUS and OCONUS.	**SC-2.1 (reference# ID-1205-06.01):** DCS, G-1, align OCONUS IDES process to support Soldier and CONUS installation requirements.	DCS, G-1 (20121018)	Concur

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Findings	Recommendation	Stakeholder(s) Brief Date	Comment
SC-3 OBSERVATION (reference# ID-1205-07): Multiple IDES tracking systems provide limited visibility while increasing workload and confusion for all participants and leaders concerned with the IDES process.	**SC-3.1 (Ref #ID-1205-07.01):** DCS, G-1, ICW CIO / G-6, establish a single tracking application for the IDES process that includes multi-organizational and Soldier access to allow for a common operating picture.	DCS, G-1 (20121018) CIO / G-6 (20121030)	Concur Concur
SC-4 OBSERVATION (reference# ID-1205-08): There was poor or inconsistent understanding of the role and requirements of DA Form 7652 (Commander's Performance and Functional Statement).	**SC-4.1 (reference# ID-1205-08.01):** CDR, MEDCOM ICW DCS, G-3/5/7, create standardized training requirements regarding the completion of DA Form 7652 (Commander's Performance and Functional Statement) during installation Commander / First Sergeant Courses.	MEDCOM (20121015) DCS, G-3/5/7 (20121015)	Concur Concur
	SC-4.2 (reference# ID-1205-08.02): DCS, G-1, update DA Form 7652 to include the requirement for a second signature from the next higher commander to increase accountability for thorough completion of the form.	DCS, G-1 (20121018)	Concur
SC-5 OBSERVATION (reference# ID-1205-09): The IDES reception and integration process for Soldiers, leaders and BH providers is not standardized and varies considerably.	**SC-5.1 (reference# ID-1205-09.01):** CDR, MEDCOM ICW DCS G-1, standardize IDES reception, education and process integration for all IDES personnel and all stakeholders involved; include specific training for Soldiers, leaders, Physical Evaluation Board Liaison Officers (PEBLO), Soldier Medical Evaluation Board Counsels (SMEBC), MEB Doctors, BH Professionals and other involved IDES associates.	MEDCOM (20121015) DCS, G-1 (20121018)	Concur Concur

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Findings	Recommendation	Stakeholder(s) Brief Date	Comment
SC-6 OBSERVATION (reference# ID-1205-10): Commanders mistakenly believe that the IDES process shields Soldiers from administrative separation proceedings and from punishment under the Uniform Code of Military Justice (UCMJ).	**SC-6.1 (reference# ID-1205-10.01):** DCS, G-1, ICW Office of the Judge Advocate General (OTJAG), clarify and issue updated policy regarding the rights and responsibilities of commanders to administratively separate Soldiers and to administer punishment under the Uniform Code of Military Justice (UCMJ) to Soldiers in the IDES process.	DCS, G-1 (20121018)	Concur
Functional Assessment 3: *Execution Shortfalls (ES)*			
ES-1 DEFICIENCY (reference# ID-1205.11): Half (16 of 32 or 50%) of MTFs are not in full compliance with OTSG / MEDCOM Annex O to FRAGO 1 OPORD 12-31.	**ES-1.1 (reference# ID-1205.11.01):** CDR, MEDCOM ensure compliance and reinforce implementation of Office of The Surgeon General (OTSG) / MEDCOM Annex O (MEB Phase Implementation Guidance to OPORD 12-31). ***Ongoing Action:*** *OTSG / MEDCOM FRAGO 2 (OPORD 12-31) directed brief-back of Annex O distribution, receipt acknowledgement and confirmation of required guidelines.*	MEDCOM (20121015)	Concur

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Findings	Recommendation	Stakeholder(s) Brief Date	Comment
ES-2 DEFICIENCY (reference# ID-1205.12): At some (14 of 32 or 43%) MEB sites, appeals and IMRs were not conducted by an independent provider.	**ES-2.1 (reference# ID-1205.12.01):** CDR, MEDCOM, ensure Soldiers' appeals and Impartial Medical Reviews (IMR) are conducted by a provider independent of the MEB process for SMs that they have provided a Narrative Summary (NARSUM) for (no same physician diagnosis and review). ***Ongoing Action:*** *IDES Guidebook issued on 1 Oct 12 reinforcing existing regulation that prohibits MEB members from appeal and IMR adjudication.*	MEDCOM (20121015)	Concur
ES-3 OBSERVATION (reference# ID-1205.13): There is no standardized vetting process for IDES training material.	**ES-3.1 (reference# ID-1205.13.01):** DCS, G-1 ICW CDR MEDCOM, establish a standard vetting process for all IDES training material. ***Ongoing Action:*** *WTC in collaboration with MEDCOM Patient Administration Division (PAD), developed standardized familiarization for WTC / CBWTU Soldiers, Families and unit cadre (partial solution).*	MEDCOM (20121015) DCS, G-1 (20121018)	Concur Concur
ES-4 OBSERVATION (reference# ID-1205.14): Utilization and training of PEBLOs and Contact Representatives is inconsistent.	**ES-4.1 (reference# ID-1205.14.01):** CDR, MEDCOM develop utilization guidance for PEBLOs and Contact Representatives to facilitate effective communication, responsibility management and cross-organizational coordination. ***Ongoing Action:*** *OTSG / MEDCOM FRAGO 3 (OPORD 12-31) directed alignment of PEBLOs to supported units. MEDCOM is conducting a review of all PEBLO and support team position descriptions.*	MEDCOM (20121015)	Concur

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Findings	Recommendation	Stakeholder (s) Brief Date	Comment
ES-4 OBSERVATION (reference# ID-1205.14): Cont.	**ES-4.2 (reference# ID-1205.14.02):** CDR, MEDCOM explore expansion of the resident PEBLO training program and update the online training. ***Ongoing Action:*** *PEBLO Mobile Training Teams approved. OTSG improving customer service training across MEDCOM.*	MEDCOM (20121015)	Concur
ES-5 OBSERVATION (reference# ID-1205.15): MEB physicians and BH providers perceived MEDCOM Policy 12-035 as pressuring them to diagnose PTSD.	**ES-5.1 (reference# ID-1205.15.01):** CDR, MEDCOM clarify MEDCOM Policy 12-035 for providers to decrease the perceived conflict between the policy and the current American Psychological Association (APA) guidelines and standards.	MEDCOM (20121015)	Concur
ES-6 OBSERVATION (reference# ID-1205.16): There was a shortage of SMEBCs.	**ES-6.1 (reference# ID-1205.16.01):** CDR MEDCOM, conduct a cost benefit analysis of the methods to expand SMEBC program.	MEDCOM (20121015)	Concur
ES-7 OBSERVATION (reference# ID-1205.17): There was no provision on the DA Form 3947 (Medical Evaluation Board Proceedings) for a Soldier to elect an IMR.	**ES-7.1 (reference# ID-1205.17.01):** DCS G-1, update DA Form 3947 (Medical Evaluation Board Proceedings) to include the Impartial Medical Review election.	DCS, G-1 (20121018)	Concur
ES-8 OBSERVATION (reference# ID-1205.18): Minimal participation of Family members in the IDES process.	**ES-8.1 (reference# ID-1205.18.01):** CDR MEDCOM, encourage Family member participation in IDES.	MEDCOM (20121015)	Concur

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FUNCTIONAL AREA: *Other Matters (OM)*

Findings	Recommendation	Stakeholder (s) Brief Date	Comment
OM-1 DEFICIENCY (reference# ID-1205-19): WTUs have different acceptance criteria for service members.	**OM-1.1 (reference# ID-1205-19.01):** DCS G-1 ICW CDR MEDCOM, enforce standardization of Warrior Transition Unit (WTU) acceptance criteria.	DCS, G-1 (20121018) MEDCOM (20121015)	Concur Concur

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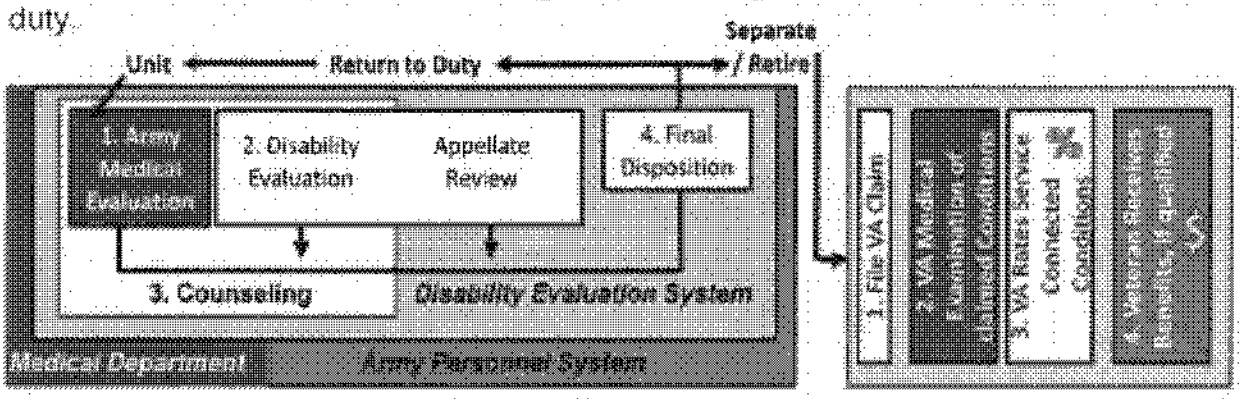
Functional Assessment Area 1: Guidance and Process Oversight (PO).

Background: Before 2008, the Army used the Disability Evaluation System (DES) to maintain a fit and ready force. This legacy system, illustrated below (Figure 2), evaluated Soldiers with conditions that called into question a Soldier's ability to continue to serve in the military through two separate processes conducted by the Army and the VA. Upon receiving a P3 or P4 permanent profile, Soldiers received a medical evaluation by the Army Medical Department and a Disability Evaluation by the Army. Soldiers received multiple opportunities for Appellate Reviews during the process and a final determination was made resulting in medical separation, retirement, or return to duty.



(Figure 2)

Once a Soldier received veteran status, the VA prepared a claim to identify the conditions to evaluate as part of the VA C&P examination. The VA evaluated the results of the C&P Exam and provided disability ratings for all service connected conditions. According to VA testimony to Congress, it took on average 6 – 9 months after the Soldier received Veteran status before they began receiving benefits.

Since 2007, the DoD and the VA worked to update and simplify the disability determination and compensation system. On 1 June 2009, a DoD and VA DES Pilot Program which expanded to other locations as IDES under DoD wide implementation. The Army's IDES Program completed its final implementation phase in October 2011. The resultant IDES process is shown at Figure 3 on page 2-2.

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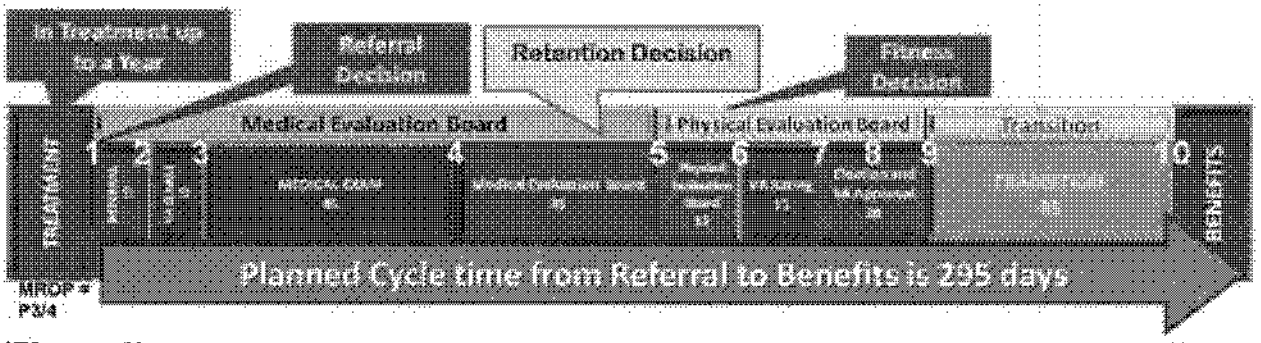

(Figure 3)

The IDES integrates VA and DoD / Army processes by conducting the VA claim development while the Soldier is still a Service Member (SM) and supplants the Service's medical exam with the VA's C&P exam. Under IDES, the DoD directed the Services to use the VA's C&P exam as the medical examination of record and to use the results as the basis for DoD's determination of whether a SM meets or fails retention standards. The VA C&P exam also is the basis for the VA's determination of total disability compensation.

Several concerns were noted in the implementation of the IDES, particularly as it related to Soldiers with BH conditions. Consequently, the Secretary of the Army tasked the Department of the Army Inspector General (DAIG) to inspect Behavioral Health aspects of the Army's IDES Process by focusing on four inspection objectives:

Objective 1 – Knowledge: Assess whether commanders, Soldiers and other participants in DES / IDES are sufficiently informed about, and understand, their respective roles; their rights and duties; and the sources of information and assistance available to them; all with a view to optimizing their participation in, and the overall effectiveness of, DES / IDES processes.

Objective 2 – Process: Review the effect of the Army's implementation of IDES on the diagnosis and evaluation of behavioral health conditions.

Objective 3 – Appeals: Review and evaluation of the sufficiency of appeal procedures available to Soldiers participating in the DES / IDES processes.

Objective 4 – Non-Medical: To the extent arising from tasks outlined in this directive, collect and report to the Under Secretary and the VCSA any observations that command climate or other non-medical factor affected behavioral health diagnoses and evaluations.

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Analysis of data accumulated from over 6,400 individuals across the 46 sites inspected resulted in findings that correspond to three primary areas of concern:

Governance / Process Oversight (PO)	Synchronization Concerns (SC)	Execution Shortfalls (ES)

- The Governance / Process Oversight area reports on information associated with the **Knowledge, Process, Appeals and Non-Medical** objectives.
- The Synchronization Concerns area reports on data primarily derived from the **Knowledge and Appeals** objectives.
- The Execution Shortfalls area reports information associated with the **Knowledge, Process and Appeals** objectives.

SUMMARY OF FINDINGS: In the Guidance / Process Oversight (PO) focus area, the inspection identified two Deficiencies, two Observations and made five Recommendations.

1. **PO-1 DEFICIENCY (reference# ID-1205.01):** During Fiscal Year (FY) 2012, the Army averaged 396 days for a SM to complete the IDES process versus the DTM 11-015 goal of 295 days.

2. **PO-2 DEFICIENCY (reference# ID-1205-02):** The IDES process lacks a recurring certification and audit capability for MEB and PEB sites needed to ensure common procedures and a common operating picture for each stakeholder across the enterprise.

3. **PO-3 OBSERVATION (reference# ID-1205-03):** Challenges exist in harmonizing, synchronizing and resolving IDES process issues.

4. **PO-4 OBSERVATION (reference# ID-1205-04):** Knowledge about the IDES process is uneven and incomplete across all echelons of the Army.

FINDINGS AND RECOMMENDATIONS:

PO-1 DEFICIENCY (reference# ID-1205.01): During FY 2012, the Army averaged 396 days for a SM to complete the IDES process versus the DTM 11-015 goal of 295 days.

ROOT CAUSE: (CAN'T COMPLY) The IDES infrastructure is under resourced.

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DISCUSSION: Less than 20% of AC Soldiers who completed the IDES in August 2012 finished within the goal of 295 days. According to the September 2012 IDES Monthly Report, during the final six months of FY 2012, the Army averaged 386 days for an AC SM and 366 days for a RC Soldiers to complete the IDES process. This is deficient from the DTM 11-015 goal of 295 days for AC Soldiers and 305 days for RC Soldiers.

The Army's established FY 2012 goal was for 60% of AC Soldiers to complete IDES in 295 days. Completion is defined as either returning to duty or receiving VA benefits. During August 2012, 43% of Army Reserve and 39% of Army National Guard members completed IDES within that goal. Choke points in the IDES process identified during the past three months included the MEB stage (91-day average versus 35-day goal), the PEB Stage (19-day average versus 15-day goal), the Disposition Stage (88-day average versus 35-day goal) and the Transition Stage (83-day average versus 30-day goal).

Leaders, Soldiers in the IDES process and Families complained that the process takes too long. Additionally, Soldiers with BH conditions often reported during interviews that their symptoms were exacerbated while in the IDES. Soldiers commonly reported limited access to BH treatment while in the IDES; a perception of a continued negative stigma associated with BH conditions in the Army and the uncertainty about how long the process would take. Soldiers in the Disposition and Transition stage of the IDES reported that they were unable to make definite plans regarding occupational opportunities outside of the Army, make housing arrangements or make financial plans for their future. This was primarily the result of the ambiguity surrounding how long it would take to receive a decision regarding their disposition, when they would be able to transition to Veteran status and the level of compensation they would receive. Moreover, exacerbation of BH symptoms reportedly led to an increase in disciplinary problems within the unit, creating additional challenges for leadership.

In some OCONUS locations, the absence of VA C&P exam capabilities for IDES creates additional timeliness challenges for commands, MTFs and WTUs in CONUS. The majority of OCONUS sites lack an Army or DoD MEB structure, although all OCONUS MTFs have the resources required to field an MEB site. Additionally, these locations lack VA C&P exam support necessary for IDES processing. Consequently, once an OCONUS Soldier receives a second signature on his or her permanent profile establishing their Medical Retention Determination Point (MRDP), per Paragraphs 2 and 3B(1) of All Army Activity (ALARACT) 374-2001, the Soldier "must transfer to a CONUS MTF to complete the IDES process." OCONUS sites reported that it routinely took 90+ days before a Soldier received all documents necessary for a Permanent Change of Station (PCS) to CONUS. As a result, the gaining MTF receives an IDES case that is many times well in excess of 100 days into the IDES process, yet the case has not even made it to the Claim Development Stage of IDES.

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Troop unit and medical unit commanders in Europe and Pacific Regional Medical Commands (RMC) constantly voiced frustrations over the lack of a PEB dedicated to handling their OCONUS IDES cases. Commanders with Soldiers in IDES and leaders responsible for executing the IDES process appealed for the Army to expand the number of PEB sites to include an OCONUS PEB. Many leaders suggested that a PEB at Tripler Army Medical Center would aid in timely processing of OCONUS IDES packets.

DTM 11-015, Attachment 2, paragraph 4a directed Secretaries of the Military Departments to "Establish procedures for their respective Military Departments to ensure IDES site MEBs and Military Department PEBs are staffed and resourced to meet IDES timeliness goals." For OCONUS sites, a significant obstacle is the lack of a local / geographically near MEB and VA C&P exam capability, and a PEB within their region to process IDES cases efficiently.

RECOMMENDATION:

PO-1.1 (reference# ID-1205-01.01): DCS, G-1 ICW CDR, MEDCOM explore expansion of Physical Evaluation Boards (PEB) and / or modification of current authorities within IDES (i.e. increase number of PEBs, increase current PEB / MEB capabilities or expand current site authorities).

ONGOING ACTION: *CDR, MEDCOM recently established two additional MEBROCs at JBLM and Fort Carson and is evaluating the need for further expansion.*

ONGOING ACTION: *PDA recently directed PEB to reduce informal PEB staffing from three to two board members. Formal PEB membership remains unchanged at three members.*

STANDARDS:

DTM 11-015 – Integrated Disability Evaluation System (IDES), Incorporating Change 1, 3 May 2012, Attachment 2, Paragraph 4a;

OTSG / MEDCOM Policy Memo 08-030, Subject: Transfer of Warriors in Transition (WTs) Assigned to Outside Continental United States (OCONUS) Warrior Transition Units (WTUs) to CONUS WTUs, 9 June 2008 (Expired), Paragraph 4;

HQDA ALARACT 374/2011: ALARACT HQDA EXORD 295-11 Implementation of OCONUS (Europe, Japan and Korea) Plan for Soldiers Referred to the Integrated Disability Evaluation System (IDES) dated 1 September 2011, paragraph 2, 3A(1), and 3B(1)(C)(1)(B).

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PO-2 DEFICIENCY (reference# ID-1205-02): The IDES process lacks a recurring certification and audit capability for MEB and PEB sites needed to ensure common procedures and a common operating picture for each stakeholder across the enterprise.

ROOT CAUSE: (DON'T KNOW / WON'T COMPLY) There was a lack of clearly defined oversight for conduct of recurring certification, continuous process improvement and audits.

DISCUSSION: AR 11-2, Managers Internal Control Program, paragraphs 1-7a and b require "Army functional proponents to develop and maintain policies and regulations that include effective internal controls...," and to "develop a method for evaluation and reporting of the key internal controls identified through risk assessment...." The functional proponent for IDES is the Department of Army DCS, G-1. In coordination with US Army MEDCOM, DCS, G-1 developed two OPORD, (MEDCOM OPORDs 09-04 and 11-35) that directed oversight (inspections and audits) of the IDES process. MEDCOM executed neither OPORD.

On 10 April 2012, MEDCOM's Assistant Chief of Staff, Health Policy and Services, Behavioral Health Division (BHD) issued OTSG / MEDCOM Policy Memo 12-035. This memo provides "Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder (PTSD)." Paragraph 5, states, "the availability of consistent evidence-based assessment and treatment services for PTSD is a high priority for the US Army Medical Department...." The policy memo included no internal control plans necessary to provide reasonable assurance that the behavioral health assessment and treatment of PTSD would meet the established measures of success. Although, MEDCOM OPORD 12-31, Section 3, Execution a (1) b and d specifically directed that leaders at all levels to "adhere to and enforce standards and timelines;" "seek ways to minimize variation and increase predictability;" and "measure outputs through the development of standardized metrics." The inspection teams found no such recurring certifications / audits or inspections of MEBs / PEBs

Army Regulation 5-1, Total Army Quality Management, paragraphs 1-4e and f require "heads of field operating agencies and managers at all levels to implement systematic strategic and customer-focused approaches to continuous process improvement; develop and periodically update strategic plans supporting continuous organizational performance improvement;" and "establish goals for continuous improvement of key processes." The inspection teams found no evidence of systematic strategic efforts to continuously assess or improve implementation of the IDES process. There were no recurring certifications / audits or inspections of MEB / PEB sites.

As IDES is currently constructed, it is a bifurcated process. Both DCS, G-1 and MEDCOM have responsibility for managing the processes and personnel in different

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sections of the IDES. Consequently, there is no single Army-element specifically designated to develop controls and to audit or inspect the application of the controls for the IDES process from end to end. DCS, G-1's regulatory guidance and MEDCOM's orders indicate intent to conduct oversight. However, lack of a single designated element responsible for conducting program-wide oversight of the IDES led to inconsistent or absent implementation of quality control measures at the MEB and PEB levels.

RECOMMENDATIONS:

PO-2.1 (reference# ID-1205-02.01): CDR, MEDCOM, conduct re-training and re-validation of all Medical Evaluation Board (MEB) sites incorporating and ensuring compliance with current implementation guidance.

PO-2.2 (reference# ID-1205-02.02): DCS, G-1 ICW Dir., PDA and CDR, MEDCOM, conduct periodic certification and audit process for sites conducting MEBs and PEBs.

ONGOING ACTION: *CDR, MEDCOM has directed MEDCOM IG to conduct a compliance inspection of the requirements of Annex O.*

STANDARDS:

DTM 11-015 – Integrated Disability Evaluation System (IDES), Incorporating Change 1, 3 May 2012;

AR 5-1, Total Army Quality Management, 15 March 2002;

AR 11-2, Managers' Internal Control Program, 4 January 2010;

AR 40–501, Standards of Medical Fitness, 14 December 2007 (Revised 4 August 2011);

AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 February 2006 (Revised 20 March 2012);

HQDA Army Disability Evaluation System (DES) Standardization, DTG: 172003Z Feb EXORD 08042;

OTSG / MEDCOM Policy Memo 12-035, Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder (PTSD), 10 April 2012;
OPORD 09-04 (Disability Evaluation System Pilot Expansion Site Assessment Team), Date/Time Group (DTG) 211200Q October 2008;

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MEDCOM OPORD 11-35 (Phase III Implementation of the Integrated Disability Evaluation System (IDES) in the Army Medical Department (AMEDD), DTG 291500Q April 2011;

MEDCOM OPORD 12-31 (MEDCOM Implementation of The Integrated Disability Evaluation System), DTG 051415Q April 2012.

PO-3 OBSERVATION (reference# ID-1205-03): Challenges exist in harmonizing, synchronizing and resolving IDES process issues.

ROOT CAUSE: (CAN'T COMPLY) The IDES process proponent lacked the capability to effectively meet all regulatory roles and responsibilities.

DISCUSSION: The IDES is an administrative process intended to separate Soldiers from the Army based on the determination by competent medical authority regarding fitness for continued service. The Adjutant General (HRC) is the proponent for IDES; it is one of 155 programs managed by DCS, G-1. Proponency of IDES was not well known, nor were its roles and responsibilities understood. Different commands directed and managed different principal parts of the IDES. The Adjutant General (HRC) exercises operational control over the IDES process. The PDA, a subordinate element of HRC, is delegated authority as the IDES operator, and MEDCOM is the IDES operator for Army medical assets involved in the IDES process. This approach made communication of the various IDES policies, procedures and personnel processes tenuous and consistent oversight challenging. There was no single overarching IDES policy.

Per AR 635-40, Physical Evaluation for Retention, Retirement or Separation, paragraph 2-4b, the PDA's responsibilities extends to developing policies, procedures and programs in IDES. This includes vetting the content of training materials, the oversight of training provided to the field and the uniform interpretation / application of related laws and directives. PDA is currently empowered to "interpret and implement policies coming from higher authority," but not laterally other staff activities such as OTSG or MEDCOM. Consequently, three commands distributed policies, procedures, and orders regarding the implementation of IDES. Due to poor integration of the different commands involved, the guidance issued often was unclear and occasionally contradictory.

A clear illustration of the challenge facing the current proponency structure was the issuance, acceptance and implementation of Annex O. In the four years since the publication of DTM 11-015, the Army published no clear implementation guidance regarding the MEB portion of IDES. Each Army MEB site was left on its own to develop local policies and procedures to meet the perceived intent of the IDES. This inevitably

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led to significant MEB site-to-site variability in the implementation of the MEB portion of the IDES. To address the lack of standardization and to specifically reduce the practice of post-C&P examinations, Commander, MEDCOM issued Annex O (MEB Phase Implementation Guidance) to OPORD 12-31. However, MTFs that had been executing based on their own interpretation of the MEB portion of the IDES for several years were reluctant to modify their local procedures. MEDCOM distributed Annex O to the RMCs with an unspoken expectation that the RMCs would ensure appropriate distribution. There was no requirement to acknowledge receipt of Annex O nor was there follow-up to provide process oversight or validate proper implementation. The team found poor reception and implementation of Annex O across the sites inspected. In fact, half (16 of 32, 50%) of the MTFs inspected continued to perform post-C&P examinations in direct contradiction to Commander, MEDCOM's Annex O instruction.

RECOMMENDATION:

PO-3.1 (reference# ID-1205-03-01): DCS, G-1 develop a credible proponent / office of primary responsibilty for the IDES process.

ONGOING ACTION: *DCS, G-1 has designated a Brigadier General to serve as the IDES process "Champion."*

STANDARDS:
DTM 11-015 – Integrated Disability Evaluation System (IDES), 19 December 2011, Incorporating Change 1, May 3, 2012;

AR 5-1, Total Army Quality Management, 15 March 2002;

AR 11-2, Managers' Internal Control Program, 4 January 2010;

AR 40-400, Patient Administration, 27 January 2010 (Revised 15 September 2011);

AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 February 2006 (Revised 20 March 2012);

OPORD 12-31 MEDCOM OPORD 12-31 (MEDCOM Implementation of The Integrated Disability Evaluation System), DTG 051415Q April 2012;

Annex O (MEB Phase Implementation Guidance) to OPORD 12-31 (MEDCOM Implementation of The Integrated Disability Evaluation System), 16 July 2012.

PO-4 OBSERVATION (reference# ID-1205-04): Knowledge about the IDES process is uneven and incomplete across all echelons of the Army.

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DISCUSSION: Training on IDES is inadequate, not standardized and in some cases conflicts with current standards. IDES represented a fundamental change to the Army's disability process. However, neither DCS, G-1 nor MEDCOM issued overarching implementation policy guidance or training for Soldiers, leaders, or personnel involved in the IDES process. The lack of detailed policy reduced the likelihood of standardization, synchronization or a clear understanding of expectations for all actors in the IDES process.

The average Soldier entering the IDES lacks a medical background, which can make a clear understanding of the medical aspects of the IDES process difficult. Furthermore, many Soldiers in IDES have a BH component to their condition. These BH symptoms affect cognitive faculties such as attention, concentration and memory and often further impact Soldiers' ability to comprehend and manage the IDES process. Unless Soldiers receive a clear presentation and understand of what is to come, the IDES process will simply happen to Soldiers instead of Soldiers acting as informed and contributing participants in their case.

The team noted a recent emphasis on training IDES in Pre-Command Courses (PCC) and local Company Commander / First Sergeant (CO / 1SG) courses, although emphasis on the topic is minimal. Survey data show few leaders (313 of 1332 or 24%) obtained their knowledge about IDES from a pre-command course. A few leaders (273 of 1332 or 21%) indicated that their knowledge of IDES came from routine Medical Information Briefs. However, the majority of leaders surveyed (738 of 1332 or 56%) indicated that they either had to get information about IDES on their own or that they had never received any information about IDES.

Across the sites inspected, there was significant variability in how soldiers, leaders and IDES personnel received training and education regarding the implementation of IDES at their location. Some Soldiers (411 of 952 or 43%) indicated that they received information from routine Medical Information Briefs. A few (188 of 952 or 20%) indicated they received In-Class Training. However, some (353 of 952 or 37%) reported that they had to get the information on their own or they never received information about IDES.

In 2008, MEDCOM issued a DES brief to all MTFs and directed PEBLOs to use it as a base document for IDES initial training. MEDCOM allowed modification if the document to accommodate local needs. However, only a few Soldiers (273 of 1000 or 27%) found the briefing they received to be very informative. MEDCOM has yet to issue a standardized IDES version of the briefing. Unless there is a more formalized process to review plans and materials, information given about the IDES insures variability in the information presented to Soldiers and leaders both across and even within MTFs.

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RECOMMENDATION:

PO-4.1 (reference# ID-1205-04.01): DCS, G-3/5/7 ICW DCS, G-1 and CDR, MEDCOM review all relevant training and establish an Army-wide, standardized teaching program for IDES to ensure baseline knowledge for leaders, Soldiers and Families.

ONGOING ACTION: *MEDCOM IDES Guide issued (partial solution).*

STANDARDS:

ALARACT 152-2010, Disability Evaluation System (DES) Process Improvement Plan EXORD;

ALARACT 148-2011, Overview of the Integrated Disability Evaluation System (IDES) for Installation Company-Detachment Pre-Command Course (PCC) or Orientations, Annex B;

ALARACT 041-2012, HQDA EXORD 093-12, Standardize Company Commander-First Sergeant (CCFSC).

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Functional Assessment Area 2: Synchronization Concerns (SC)

SUMMARY OF FINDINGS: In the Synchronization Concerns area, the inspection identified one Deficiency, five Observations and made seven Recommendations.

1. **SC-1 DEFICIENCY (reference# ID-1205-05):** MTFs are improperly implementing proponent policies.

2. **SC-2 OBSERVATION (reference# ID-1205-06):** Inconsistencies exist between IDES processes for Soldiers based in CONUS and OCONUS.

3. **SC-3 OBSERVATION (reference# ID-1205-07):** Multiple IDES tracking systems provide limited visibility while increasing workload and confusion for all participants and leaders concerned with the IDES process.

4. **SC-4 OBSERVATION (reference# ID-1205-08):** There was poor or inconsistent organizational understanding of the role and requirements of DA Form 7652 (Commander's Performance and Functional Statement).

5. **SC-5 OBSERVATION (reference# ID-1205-09):** The IDES reception and integration process for Soldiers, leaders and BH providers is not standardized and varies considerably.

6. **SC-6 OBSERVATION (reference# ID-1205-10):** Commanders mistakenly believe that the IDES process shields Soldiers from administrative separation proceedings and from punishment under the Uniform Code of Military Justice (UCMJ).

FINDINGS AND RECOMMENDATIONS:

SC-1 DEFICIENCY (reference# ID-1205-05): MTFs are improperly implementing proponent policies.

ROOT CAUSE: (DON'T KNOW / WON'T COMPLY) Local policies and MTF leader personalities are the predominant factors in the MTF organizational culture.

DISCUSSION: The proponent disseminates policies and requirements to facilities that have an active role in the processing of Soldiers in the IDES, but there is no top-down oversight to track the implementation of those policies and requirements. MTFs routinely determine how to interpret and implement policies locally. In some instances, a facility will implement the policy change in a way that causes the least disruption to its existing processes, even if the policy intended a drastic change to those processes.

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The most illustrative example of MTFs improperly implementing proponent policies is the gap between proponent adoption of IDES to MEDCOM publishing FRAGO 1 (Annex O) to MEDCOM OPORD 12-31 (MEDCOM Implementation of the Integrated Disability Evaluation System). Despite the release of FRAGO 1, each MEB site continued to interpret and implement policies and requirements differently to fit their processes rather than changing their processes to conform to the new guidance. Annex O fundamentally changed the conduct of MEBs from a medical examination by Army standards to an administrative function using VA C&P examinations as the examination of record. Despite the release of Annex O, half (16 of 32 or 50%) of all MEB sites inspected continued to conduct post-C&P examinations. According to the IDES, the VA C&P examination serves as the examination of record, yet it took MEDCOM four years to publish specific implementation guidance. Moreover, there was no pressure from DCS, G-1 to publish guidance even though DCS, G-1 was the proponent and had a better understanding of the fundamental process changes required by IDES.

The uneven implementation of and adherence to updated IDES policies across Army installations speaks to the need for a formalized method of clarifying policy questions and overseeing the timely implementation of IDES-related regulatory changes.

RECOMMENDATION:

SC-1.1 (reference# ID-1205-05.01): DCS, G-1, ICW CDR, MEDCOM, establish a forum or method for routine discussion of IDES-related policies to synchronize the implementation of regulatory changes across all Army installations and address any emerging issues or concerns.

ONGOING ACTION: *First info-sharing forum occurred 1st week in October; the focus was institutionalizing processes.*

STANDARDS:

MEDCOM OPORD 12-31 "MEDCOM Implementation of the Integrated Disability Evaluation System," (5 April 2012);

FRAGO 1 (Annex O) to MEDCOM OPORD 12-31 "MEDCOM Implementation of the Integrated Disability Evaluation System," (16 July 2012);

OTSG / MEDCOM Policy Memo 12-035 "Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder (PTSD)," (10 April 2012);

HQDA Executive Order (EXORD) 080-12 "Army DES Standardization," (17 February 2012 (EXPIRED));

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"DTM 11-015 – Integrated Disability Evaluation System (IDES)," (3 May 2012);

Army Regulation 40-400, "Patient Administration," (27 January 2010 (Rapid Action Revision 15 September 2011));

AR 40-501, "Standards of Medical Fitness," (18 January 2007 (Rapid Action Revision 4 August 2011));

AR 635-40, "Physical Evaluation for Retention, Retirement or Separation," (8 February 2006 (Rapid Action Revision 20 March 2012)).

SC-2 OBSERVATION (reference# ID-1205-06): Inconsistencies exist between IDES processes for Soldiers based in CONUS and OCONUS.

ROOT CAUSE: (DON'T KNOW) There was a lack of clearly defined oversight for recurring certification, continuous process improvement and audits.

DISCUSSION: *P3 & P4 Profiles & IDES Restarts.* MTF IDES staff and WTU senior staff state that, in their opinion, as many as 50% of OCONUS Soldier profiles fail to meet P3 requirements or WTU criteria established at the CONUS MTF. However, there was no evidence that MTF IDES staff or WTU staff communicated their concerns to the OCONUS sites or to MEDCOM. To address the perceived deficiencies in the records received, CONUS MTFs and WTUs routinely restarted OCONUS Soldiers' profiles upon arrival at their CONUS locations, thereby prolonging the SM's time in the IDES process. MTF IDES and WTU staff attributed the restarts for two reasons. First, CONUS staff reported insufficiencies in profiles or accompanying medical documentation from OCONUS. Despite this claim, there was no evidence that Soldiers with P3 / P4 profiles from OCONUS sites returned to duty after CONUS staff re-evaluated the cases. A second reason was that MTF staff did not want the days it took the Soldier to transfer from OCONUS to count toward the gaining MTF's processing timeliness. For this reason, Soldiers reported having their permanent profiles rewritten, even if the second signature was on the profile and the Soldier's IDES process had officially begun. Rewriting the P3 / P4 profiles permitted a "restart" of the IDES clock and served as a management tool to facilitate favorable reporting data to higher headquarters.

Medical Records & Diagnosis. The practice of discounting healthcare provider diagnoses, evaluations, profiles and other documentation was pervasive across inspected sites. The practice included BH and healthcare providers within the same MTF, within MEDCOM and external sources. MEB and IDES staff repeatedly stated discontent with not only other healthcare provider assessments, but also with regulatory and directive guidance from senior commands. A few sites (6 of 32 or 19%) indicated active resistance to the guidance set forth in Annex O. When queried if they attempted

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to contact the assessing provider when there was a disagreement about diagnoses, responses included comments of varying rationale such as, "I didn't know I could," "why should I," "I don't know how," and "that's not my job." The inspection revealed these practices occurred across the Army.

WTU Access. Inspection teams reported incidents of local command policies limiting Soldier acceptance into a WTU. This practice occurred across the Army. Other impediments to WTU access included vacating P3 / P4 profiles and a lack of effective file transfer between OCONUS and CONUS locations.

Most other inconsistencies exist due to varying degrees of program implementation, levels of agency integration, lack of program knowledge by leaders and Soldiers and differing resource availability. Most often, inconsistencies proved to be site-specific and did not present as systemic issues during this inspection.

RECOMMENDATION:

SC-2.1 (reference# ID-1205-06.01): DCS, G-1 align OCONUS IDES process to support Soldier and CONUS installation requirements.

ONGOING ACTION: *FRAGO 4 to MEDCOM OPORD 12-31 currently in staffing.*

STANDARDS:

ALARACT 374 / 2011, "ALARACT HQDA EXORD 295-11 Implementation of OCONUS (Europe, Japan and Korea) Plan for Soldiers Referred to the Integrated Disability Evaluation System (IDES)," (1 September 2011);

AR 40-501, "Standards of Medical Fitness," (18 January 2007 (Rapid Action Revision 4 August 2011));

MEDCOM OPORD 12-31 "MEDCOM Implementation of the Integrated Disability Evaluation System," (5 April 2012);

FRAGO 1 to MEDCOM OPORD 12-31 "MEDCOM Implementation of the Integrated Disability Evaluation System," (16 July 2012);

Department of the Army Warrior Transition Unit Consolidated Guidance (Administrative), (20 March 2009);

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FRAGO 4 (OCONUS IDES Processes) to MEDCOM OPORD 12-31 (MEDCOM Implementation of the Integrated Disability Evaluation System), DRAFT XXXXXXQ September 2012 (currently in staffing);

Warrior Transition Battalion-Europe, OPORD 12-017 (Execution of Europe OCONUS IDES, Exception to Policy), 10 July 2012.

SC-3 OBSERVATION (reference# ID-1205-07): Multiple IDES tracking systems provide limited visibility while increasing workload and confusion for all participants and leaders concerned with the IDES process.

ROOT CAUSE: (CAN'T COMPLY) Currently there is not a viable single IT solution servicing all aspects of IDES.

DISCUSSION: Inspectors identified the use of multiple system-sponsored tracking systems (e.g., Veterans Tracking Application (VTA), Automated eDES, eMEB, ePEB, etc.), as well as idiosyncratic local tracking systems to assist in gathering real time data. The use of multiple tracking systems was necessary to meet regular reporting requirements. However, PEBLOs indicated this resulted in an increased workload that detracted from their ability to serve their clients, and that much of the data entry across tracking systems was redundant. Due to the increased workload and inefficiencies of using multiple tracking systems, PEBLOs sometimes failed to update all the systems used, resulting in inaccurate or missing data across the systems. Although Department of the Army (DA) and Congressional-level IDES briefing data is based upon information contained in VTA, local tracking systems appear to provide the most up-to-date IDES information at each site because the local systems are tailored to provide senior commanders with the information they most frequently request. Complicating matters, Soldiers and leaders do not have access to most automated systems and therefore must rely on PEBLOs to get a common operating picture of a Soldier's status in the IDES process.

There is a Congressionally mandated effort to create and field a joint DoD and VA health records system that has the potential to remedy the stated concerns. The effort launched as part of the Presidential Virtual Lifetime Electronic Record initiative in 2009. The DoD / VA effort, named the Integrated Electronic Health Record (iEHR), will be a completely new system as opposed to a fusion of current systems. Currently there is initial operating system testing at multiple sites, and the agencies must demonstrate significant single-site operations by 2014. Entire system fielding is set for 2017. Therefore, it will not be able to address any of the immediate information tracking concerns noted in the IDES.

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RECOMMENDATION:

SC-3.1 (reference# ID-1205-07.01): DCS, G-1 ICW CIO / G-6 establish a single tracking application for the IDES process that includes multi-organizational and Soldier access to allow for a common operating picture.

ONGOING ACTION: *PDA ICW CIO / G-6 have established a contract for an end-to-end IT solution.*

STANDARD: HQDA EXORD 080-12 "Army DES Standardization," (17 February 2012 (expired)).

SC-4 OBSERVATION (reference# ID-1205-08): There was poor or inconsistent understanding of the role and requirements of DA Form 7652 (Commander's Performance and Functional Statement).

ROOT CAUSE: (DON'T KNOW) A majority of Soldiers and leaders surveyed (1303 of 2,472 or 53%) assessed their understanding of the IDES process as poor. Moreover, some leaders (422 of 1,471 or 29%) indicated that they were either unaware of the importance of DA Form 7652, that they had never heard of the form or that the form was not applicable to them in their leadership role.

DISCUSSION: The DA Form 7652 is an integral part of the IDES Case File. In fact, DA Form 7652, a Soldier's treatment records and the VA C&P exam represent the primary documents used to construct a Soldier's Narrative Summary (NARSUM). Moreover, it is a commander's only opportunity to provide direct input on a Soldier's capabilities and limitations for consideration by the MEB.

Despite the importance of DA Form 7652 in the IDES process, there was significant variability regarding the relative weight given the form, primarily due to how thoroughly commanders completed the form. This was a function of a general lack of commanders' education or understanding as to the overall importance of the form itself. Based upon survey data, a substantial portion of Army leaders indicated a poor understanding of the form and its importance in the IDES process. Specifically, few leaders surveyed (148 of 1,471 or 10%) indicated that they 'Somewhat Disagreed' to 'Strongly Disagreed' with the statement that they were familiar with DA Form 7652 and its impact on a Soldier in the IDES process. Moreover, few leaders surveyed (247 of 1,471 or 19%) indicated they either 'did not know' about DA Form 7652, or that the form was not applicable to them in their leadership role. Combined, these results suggest that more than one in four leaders surveyed indicated that they were generally unfamiliar with the role and importance of DA Form 7652.

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The poor understanding of the role and requirements of DA Form 7652 is in part due to inconsistent education and training regarding IDES in general and DA Form 7652 in particular. A majority of leaders surveyed (823 of 1,469 or 56%) rated their familiarity with IDES as being "Aware of the process but not familiar with the details," or worse. A few of the leaders surveyed (294 of 1,469 or 20%) indicated that they were not familiar with the IDES system at all. Moreover, some leaders surveyed (396 of 1,403 or 28%) indicated that they had "never received any information or awareness" of IDES. Ostensibly, as many as one in five commanders' first exposure to DA Form 7652 will come after a formal request to complete the form. Consequently, some commanders must complete a form for which they have received no training or instruction. Their understanding is limited in regards to how the form supports the IDES process or how they can best complete the form to serve the needs of their Soldiers and the MEB / PEB.

Another concern noted by MEB and PEB personnel was that, according to HQDA Letter 635-08-1, the Soldier's current unit commander is responsible for completing DA Form 7652. However, in instances where Soldiers reach MRDP while at the CBWTU, the CBWTU commander may not have any direct performance-based observations of the Soldier to complete the form thoroughly. Additionally, if a Soldier reaches MRDP shortly after a change in leadership in his or her unit, after a recent transfer to a new unit, or following a recent PCS, the new leadership may not have had sufficient opportunity to observe the Soldier's duty performance to the degree necessary to complete the form.

RECOMMENDATIONS:

SC-4.1 (reference# ID-1205-08.01): CDR, MEDCOM ICW DCS, G-3/5/7, create standardized training requirements regarding the completion of DA Form 7652 during installation Commander / First Sergeant Courses.

SC-4.2 (reference#ID-1205-08.02): DCS, G-1 update DA Form 7652 (Commander's Performance and Functional Statement) to include the requirement for a second signature from the next higher commander to increase accountability for thorough completion of the form.

STANDARDS:

HQDA Letter 635-08-1, "SUBJECT: DA Form 7652, Physical Disability Evaluation System (PDES) Commander's Performance and Functional Statement," (8 December 2008 (expired));

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DA Form 7652, "Physical Disability Evaluation System (PDES) Commander's Performance and Functional Statement," (December 2008);
DTM 11-015 – Integrated Disability Evaluation System (IDES), (3 May 2012);

FRAGO 1 (Annex O) to MEDCOM OPORD 12-31 "MEDCOM Implementation of the Integrated Disability Evaluation System," (16 July 2012);

AR 635-40, "Physical Evaluation for Retention, Retirement or Separation," (8 February 2006 (Rapid Action Revision 20 March 2012)).

SC-5 OBSERVATION (reference# ID-1205-09): The IDES reception and integration process for Soldiers, leaders and BH providers is not standardized and varies considerably.

ROOT CAUSE: (DON'T KNOW) A majority of Soldiers and leaders surveyed (1303 of 2,472 or 53%) reported a poor understanding of the IDES process.

DISCUSSION: According to analysis of survey data obtained during the inspection, a majority of leaders surveyed (823 of 1,469 or 56%) indicated that their understanding of the IDES process entailed "being aware of the process, but unfamiliar with details," or worse. Of leaders surveyed, some (396 of 1,403 or 28%) indicated that they "had never received any information or awareness" regarding the IDES process, and a few (346 of 1,420 or 24%) indicated that they were "not familiar with any" of the primary and integral roles in the IDES. Moreover, some leaders (380 of 1,403 or 27%) indicated that they had to get information about the IDES on their own.

Soldiers surveyed in the IDES process demonstrated fairly consistent results compared to leaders. Specifically, some Soldiers surveyed (480 of 1,003 or 48%) indicated that their understanding of the IDES process corresponded to being "aware of the process, but unfamiliar with the details," or worse. Surprisingly, a few of the Soldiers (95 of 952 or 10%) currently in the IDES process indicated that they were "not familiar with the system" at all. When asked how they obtained information about IDES, a majority (599 of 952 or 63%) of Soldiers indicated that they had received some aspect of formal instruction. However, some (353 of 952 or 37%) indicated they either had to get information on their own, or that they had never received any information about IDES. A majority of Soldiers (756 of 1002 or 75%) indicated that they received a formal briefing upon entering the IDES and some (273 of 1000 or 27%) indicated that the briefing was very informative or beneficial.

Of BH providers surveyed, some (168 of 383 or 44%) "somewhat disagreed" to "strongly disagreed" with the statement that Soldiers had a comprehensive understanding of the IDES process. Only a few (10 of 383 or 3%) BH providers surveyed indicated that they

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"strongly agreed" Soldiers in the IDES had a comprehensive understanding of the process. Regarding BH providers' introduction and training in the IDES system, some (155 of 366 or 42%) indicated that they got information on their own or that they had never received any training in the IDES process.

The above data substantiates claims made during the inspection that there is no consistent or clear method for receiving Soldiers into the IDES process or for providing general education about the IDES process to the involved parties.

RECOMMENDATION:

SC-5.1 (reference# ID-1205-09.01): CDR, MEDCOM ICW DCS, G-1 standardize IDES reception, education and process integration for all IDES personnel and all stakeholders involved; include specific training for Soldiers, leaders, PEBLOs, SMEBCs, MEB Doctors, BH Professionals and other involved IDES associates.

STANDARDS:

DTM 11-015 – Integrated Disability Evaluation System (IDES), (3 May 2012);

Appendix 2 (NARSUM Guide Book) to Annex O (MEB Phase Implementation Guidance) to FRAGO 1 to OPORD 12-31;

AR 635-40, "Physical Evaluation for Retention, Retirement or Separation," (8 February 2006 (Rapid Action Revision 20 March 2012));

MEDCOM OPORD 11-35 "Phase III Implementation of the Integrated Disability Evaluation System in the Army Medical Department," (April 2011).

SC-6 OBSERVATION (reference# ID-1205-10): Commanders mistakenly believe that the IDES process shields Soldiers from administrative separation proceedings and from punishment under UCMJ.

ROOT CAUSE: (DON'T KNOW / WON'T COMPLY) Administrative separation and UCMJ procedures for Soldiers in the IDES process are confusing.

DISCUSSION: ALARACT 159 / 2012, "Enlisted Administrative Separation Process – Final Medical Disposition," published on 13 June 2012, clarifies enlisted administrative separation processing for Soldiers identified as not meeting medical retention standards IAW AR 635-40, Physical Evaluation for Retention, Retirement or Separation. ALARACT 159 / 2012 highlights information from AR 625-200, paragraph 5–17a(9).

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ALARACT 159 / 2012, Paragraph 4a states, "Except for separation in lieu of court-martial, final disposition through the Disability Evaluation System (DES) takes precedence over administrative separation processing, regardless of when the medical determination is made (before, during, or after initiation of an administrative separation)." Paragraph 4b(1) to ALARACT 159 / 2012 indicates that "when it is determined that a Soldier does not meet medical retention standards, the separation authority will not take final action on any administrative separation action to which the Soldier may be subject until a final medical retention determination is made." Unless a Soldier is pending administrative separation for fraudulent entry or misconduct, the MEB will refer a soldier to the PEB in accordance with their findings. Paragraph 4b(2) to ALARACT 159 / 2012 continues with the cycle stating, "When the MEB determines referral to a Physical Evaluation Board (PEB) is warranted, Soldiers will be referred to the PEB unless the Soldier is processing for administrative separation for fraudulent entry of misconduct." In those cases, "the General Court-Martial Convening Authority (GCMCA) must direct, in writing, whether to proceed with the IDES process or administrative separation. The GCMCA's written directive must address whether the Soldier's medical condition is the direct or substantial contributing cause of the conduct that led to the recommendation for administrative separation, and / or whether other circumstances of the individual case warrant disability processing instead of further processing for administrative separation."

Senior Mission Commanders (SMC), who are usually General Officers and have GCMCA responsibility, were cognizant of how to process an administrative separation action on a Soldier in the IDES process. Brigade and battalion commanders demonstrated a clear understanding of their rights and responsibilities as well. However, confusion regarding the process was evident in interviewing company commanders, who have the responsibility for initiating administrative separation actions. When interviewed about the process for initiating separation actions for Soldiers in the IDES process, company commanders replied with comments such as, "I'm not allowed to chapter Soldiers," "I didn't know I could initiate chapters," and "an administrative separation would slow down a Soldier's IDES process." In instances where company commanders relegated the authority for initiating administrative separation actions to their first sergeants, the first sergeants interviewed demonstrated similar levels of confusion about the process.

While there are company commanders who are fully aware that they can administer non-judicial punishment to Soldiers in the IDES process and are doing so when the punishment warrants, there are also commanders who are either unaware or are hesitant to punish Soldiers using an Article 15 for a variety of reasons. In some cases, company commanders believe that non-judicial punishment may delay a Soldier's progress in the IDES process, thereby also delaying the unit's receipt of a deployable Soldier to replace the Soldier in the IDES. In other cases, commanders reported that

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they did not want to penalize Soldiers who already have behavioral or emotional concerns in the fear that the punishment would "push them over the edge" and lead to attempted or completed suicide, inflicting injuries upon themselves, abusing their spouses or other Family members, or otherwise exacerbating existing emotional difficulties.

Many commanders and enlisted leaders indicated a belief that Soldiers often seek refuge in the IDES process, particularly seeking BH services, after committing offenses that would subject them to punishment under the UCMJ. However, this action would not prohibit a commander from taking the appropriate administrative action against a Soldier in the IDES process, whether in the form of an Article 15 or by initiating an administrative separation action. Enlisted leaders have indicated significant frustrations because of commanders' hesitation to apply administrative and / or disciplinary actions to Soldiers in the IDES process. Commanders reportedly direct enlisted leaders to counsel Soldiers in writing about offenses, but feel the efforts are futile when commanders do not follow-up with the appropriate corrective actions or punishment, when warranted.

A few installations (5 of 32 or 16%) delayed the second signature on the permanent profile, thereby delaying a Soldier from officially entering the IDES process in order to proceed with administrative separation. This practice subjects Soldiers who should be in the IDES to administrative separation proceedings without the opportunity to simultaneously process through the IDES. The concern is that when the GCMCA receives an administrative separation action for a decision, if the GCMCA is not aware that the Soldier is awaiting entry into the IDES and as a result, there will be no consideration for whether the Soldier's behavioral health difficulties significantly contributed to their misconduct.

Office of The Judge Advocate General (OTJAG) released an Information Paper on 22 August 2012, SUBJECT: Adverse Action Processing While Pending Medical Disposition. This document "provides guidance to commanders on options available in response to misconduct or substandard performance when the Soldier is pending a Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB)."

RECOMMENDATION:

SC-6.1 (reference# ID-1205-10.01): DCS, G-1 ICW OTJAG, clarify and issue updated policy regarding the rights and responsibilities of commanders to administratively separate Soldiers and to administer punishment under the Uniform Code of Military Justice (UCMJ) to Soldiers in the IDES process.

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ONGOING ACTION: *OTJAG published an Information Paper on 22 August 2012, SUBJECT: Adverse Action Processing While Pending Medical Disposition.*

STANDARDS:

ALARACT 159 / 2012, "Enlisted Administrative Separation Process – Final Medical Disposition," (13 June 2012);

AR 635-200, "Active Duty Enlisted Administrative Separations," (6 June 2005 (Rapid Action Revision 6 September 2011));

AR 135-178, "Enlisted Administrative Separations," (13 March 2007 (Rapid Action Revision 13 September 2011));

NGR 600-200, "Enlisted Personnel Management," (31 July 2009);

AR 635-40, "Physical Evaluation for Retention, Retirement or Separation," (8 February 2006 (Rapid Action Revision 20 March 2012));

AR 40-501, "Standards of Medical Fitness," (18 January 2007 (Rapid Action Revision 4 August 2011));

HQDA EXORD 080-12, "Army Disability Evaluation System (DES) Standardization," (17 February 2012 (expired)).

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Functional Assessment Area 3: Execution Shortfall (ES)

SUMMARY OF FINDINGS: Previously identified shortfalls in implementation and process oversight and synchronization concerns led to execution shortfalls that hindered the IDES process. These shortfalls included the following two deficiencies and six observations:

ES-1 DEFICIENCY (reference# ID-1205.11): Half (16 of 32 or 50%) of MTFs are not in full compliance with OTSG / MEDCOM Annex O to FRAGO 1 OPORD 12-31.

ES-2 DEFICIENCY (reference# ID-1205.12): At some (14 of 32 or 43%) MEB sites, appeals and IMRs were not conducted by an independent provider.

ES-3 OBSERVATION (reference# ID-1205.13): There is no standardized vetting process for IDES training material.

ES-4 OBSERVATION (reference# ID-1205.14): Utilization and training of PEBLOs and Contact Representatives is inconsistent.

ES-5 OBSERVATION (reference# ID-1205.15): MEB physicians and BH providers perceived MEDCOM Policy 12-035 as pressuring them to diagnose PTSD.

ES-6 OBSERVATION (reference# ID-1205.16): There was a shortage of SMEBCs.

ES-7 OBSERVATION (reference# ID-1205.17): There was no provision on the DA Form 3947 (Medical Evaluation Board Proceedings) for a Soldier to elect an IMR.

ES-8 OBSERVATION (reference# ID-1205.18): Minimal participation of Family members in the IDES process.

The noted shortfalls impact the IDES timeline, which in most cases negatively affect Soldiers' and leaders' readiness.

FINDINGS AND RECOMMENDATIONS:

ES-1 DEFICIENCY (reference# ID-1205.11): Half (16 of 32 or 50%) of MTFs were not in full compliance with OTSG / MEDCOM Annex O to FRAGO 1 OPORD 12-31.

ROOT CAUSE: (WON'T COMPLY) Half (16 of 32 or 50%) of MTFs were conducting post-C&P examinations.

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DISCUSSION: Annex O provided clarifying guidance on the requirements and procedures for the IDES process. Most notably, Annex O reemphasized the following: the VA C&P exam is the exam of record; the MEB examiner is not required to confirm or validate documented diagnoses through a post-C&P exam; the MEB provider's task is to conduct an administrative review of the records to determine if the Soldier meets or does not meet retention standards; and the IDES process is non-adversarial in nature.

During the inspection, teams observed that the process for disseminating Annex O from MEDCOM through RMCs to MTF leadership. This process was ineffective as many providers and other personnel involved in the MEB / IDES process were unaware of Annex O. Inspection teams observed anecdotal information that Annex O was not received in a timely manner. There were instances where it appeared the inspection teams were the first to provide the MTF with a copy of Annex O. Providers and others involved in the MEB / IDES process expressed a significant concern about Annex O. MEB physicians perceived they were losing their roles as clinicians and simply becoming administrators. Additionally, some providers expressed their belief that the new process marginalized them. This belief compounded the MEB physicians' perception that the VA C&P BH examinations were, at times, of substandard quality. This led to a few (6 of 32 or 19%) MTFs expressing an unwillingness to comply with Annex O. MEB physicians indicated that they would continue to conduct follow up examinations on Soldiers who have completed the VA C&P examination to validate BH diagnoses, which is contrary to Annex O guidance.

RECOMMENDATION:

ES-1.1 (reference# ID-1205.11.01): CDR, MEDCOM ensure compliance and reinforce implementation of OTSG / MEDCOM Annex O (MEB Phase Implementation Guidance to OPORD 12-31).

ONGOING ACTIONS: *OTSG / MEDCOM FRAGO 2 (OPORD 12-31) directed brief-back of Annex O distribution, receipt acknowledgement and confirmation of required guidelines.*

STANDARD: OTSG / MEDCOM Annex O (MEB Phase Implementation Guidance) to FRAGO 1 OPORD 12-31 "MEDCOM Implementation of the Integrated Disability Evaluation System," (16 July 2012).

ES-2 DEFICIENCY (reference# ID-1205.12): At some (14 of 32 or 43%) MEB sites, appeals and IMRs were not conducted by an independent provider.

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ROOT CAUSE: (WON'T COMPLY) Providers felt they were in the best position to review their original decision on a Soldier's MEB results to expedite process.

DISCUSSION: During the course of this inspection, inspectors found some (14 of 32 or 43%) MEB sites where MEB physicians or BH providers who originally wrote the NARSUM also conducted IMRs of the same Soldier's NARSUM. This practice led Soldiers to perceive a lack of impartiality and that IMRs were not conducted according to regulatory guidance (DTM 11-015) Appendix 4. DTM 11-015, Appendix 4, Attachment 4, paragraph 2-j states, "a Soldier has the right to an IMR, when requested, to serve as an independent source for review of the findings and recommendations of the MEB,..." ANNEX O, FRAGO 1 to OPORD 12-31, paragraph 6e-1f states "the IMR reviewer(s) cannot be one of the signature authorities for the Soldier's MEB, and / or NARSUM process".

Soldiers may request an appeal if they disagree with the MEB findings and the recommendations of an IMR. To ensure an independent provider conducts appeals, neither appointing authority nor the approving authority for MEB proceedings may participate in the proceedings. The approving authority may delegate their authority to review and act on the MEBs. The inspection team noted that the approving authority typically delegated this authority to the Deputy of Commander of Clinical Service (DCCS). AR 40-400, paragraph 7-13 states, "the individual to whom this authority is delegated to must not participate in the board proceedings either as a member, witness, consultant or in any other capacity."

RECOMMENDATION:

ES-2.1 (reference# ID-1205.12.01): CDR, MEDCOM ensure Soldiers' appeals and Impartial Medical Reviews (IMR) are conducted by a provider independent of the MEB process for SMs that they have provided a Narrative Summary (NARSUM) for (no same physician diagnosis and review).

ONGOING ACTION: *IDES Guidebook issued on 1 October 2012 reinforcing existing regulation that prohibits MEB members from appeal and IMR adjudication.*

STANDARDS:

OTSG / MEDCOM Annex O (MEB Phase Implementation Guidance) FRAGO 1 to OPORD 12-31 "MEDCOM Implementation of the Integrated Disability Evaluation System," (16 July 2012);

AR 40-400, Patient Administration, (27 January 2010, Rapid Action Revision (RAR) Issue Date: 15 September 2011);

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DTM-11-015; Integrated Disability Evaluation System (IDES), (19 December 2011, Incorporating Change 1, 3 May 2012);

National Defense Authorization Act (NDAA) 2008;

OTSG / MEDCOM Policy 11-46, "MEB Processing Guidance," (10 June 2011, Expires 10 June 2013).

ES-3 OBSERVATION (reference# ID-1205.13): There is no standardized vetting process for IDES training material.

ROOT CAUSE: (CAN'T COMPLY) There is no management oversight to ensure training materials are standardized.

DISCUSSION: IDES training material varied from installation to installation and within installations across various IDES actors. For example, there were training courses that lacked Programs of Instruction (POI) and instead centered around opinions and experiences. Every site had varying degrees of accuracy of their training packages. Many of the observed IDES actors provided outdated and conflicting information. For example, IDES training at one installation covered the legacy DES with presentation times of 30 minute or less. At another installation, the training covered a combination of the DES and IDES with presentation times of two or more hours. There were cases where the IDES training was only a five-minute presentation coupled with outdated handouts. Soldiers and leaders were ultimately the recipients of the non-standardized training provided.

IDES training for local Company Commander / First Sergeant Courses also varied across installations. Company Commanders complete DA Form 7652 for their Soldiers in the MEB process. DA Form 7652 is a significant source document to assist MEB providers with writing NARSUMs. Local Company Commander / First Sergeant Courses rarely covered DA Form 7652 in IDES training.

IDES training materials lacked management oversight to ensure standardization across installations. As a result, IDES trainers often presented unsanctioned versions of IDES.

RECOMMENDATION:

ES-3.1 (reference# ID-1205.13.01): DCS, G-1 ICW CDR, MEDCOM establish a standard vetting process for all IDES training material.

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ONGOING ACTION: *WTC in collaboration with MEDCOM PAD, developed standardized familiarization for WTC / CBWTU Soldiers, Families and unit cadre (partial solution).*

STANDARD: N/A

ES-4 OBSERVATION (reference# ID-1205.14): Utilization and training of PEBLOs and Contact Representatives is inconsistent.

ROOT CAUSE: (DON'T KNOW) There was no published utilization and training guidance for PEBLOs and Contact Representatives. The online PEBLOs training course contained outdated legacy DES information.

DISCUSSION: The PEBLO is integral to the IDES process. PEBLOs provide Soldiers with guidance and information, manage Soldier appointments, transfer IDES records to the appropriate personnel and maintain MEDCOM guidance of a 1:40 PEBLO to Soldier ratio. They also maintain information in online systems and provide updates to commanders on Soldiers in the IDES process as outlined in the DTM 11-015, Appendix 4, Attachment 4.

The inspection revealed that there was no standardized utilization of PEBLOs and Contact Representatives. In addition, they were not equipped with the necessary initial training, command support and uniform guidance to effectively perform their duties.

The inspection also identified that some PEBLOs and Contact Representatives were certified without obtaining a thorough and standardized IDES knowledge base. The resident course at Joint Base San Antonio had insufficient offerings (frequency and classroom capacity) to meet demands and lacked current information on the IDES process. Some PEBLOs interviewed also stated they were denied attendance to the resident training due to a lack of funding. These personnel were then directed to complete the online PEBLO course consisting of 14 modules and 22 training hours. The online course is not consistent with the resident course curriculum.

Current training is not sufficient to educate PEBLOs and Contact Representatives as required to support the IDES process. PEBLOs and Contact Representatives were observed with varying levels of proficiency, with on-the-job training providing the basis for PEBLO and Contact Representatives knowledge. The resident course and online training also did not include training on all required IT systems utilized by PEBLOs and Contact Representatives.

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RECOMMENDATIONS:

ES-4.1 (reference# ID-1205.14.01): CDR, MEDCOM develop utilization guidance for Physical Evaluation Board Liaison Officers (PEBLO) and Contact Representatives to facilitate effective communication, responsibility management and cross-organizational coordination.

ES-4.2 (reference# ID-1205.14.02): CDR, MEDCOM explore expansion of the resident PEBLO training program and update the online training.

ONGOING ACTION: *OTSG / MEDCOM FRAGO 3 to OPORD 12-31 directed alignment of PEBLOs to supported units (partial solution BCTs only).*

ONGOING ACTION: *OTSG improving customer service training across MEDCOM.*

ONGOING ACTION: *MEDCOM is conducting a review of all PEBLO and support team position descriptions.*

ONGOING ACTION: *PEBLO Mobile Training Teams (MTT) approved.*

STANDARDS:

DTM-11-015; Integrated Disability Evaluation System (IDES), (19 December 2011, Incorporating Change 1, May 3, 2012);

National Defense Authorization (NDA) Act 2008;

DoDI 1332-38, "Physical Disability Evaluation," (November 14, 1996, Incorporating Change 1, July 10, 2006);

FRAGO 3, Align PEBLO / PEBLO Leads to Support Units..., to OPORD 12-31 "MEDCOM Implementation of the Integrated Disability Evaluation System," (17 September 2012).

ES-5 OBSERVATION (reference# ID-1205.15): MEB physicians and BH providers perceived MEDCOM Policy 12-035 as pressuring them to diagnose PTSD.

ROOT CAUSE: (WON'T COMPLY) MEB physicians and BH providers expressed the belief that it was unethical to utilize unpublished Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V) criteria to diagnosis PTSD.

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DISCUSSION: Inspection teams observed that providers at most installations (21 of 32 or 66%) reported feeling pressured to diagnose PTSD in response to OTSG / MEDCOM Policy 12-035, published on 10 April 2012. The specific concerns revolved around the perception that the policy strongly encourages utilizing unpublished criteria for PTSD. DSM-V criteria are not anticipated to be published by the American Psychiatric Association (APA) until approximately May 2013. OTSG / MEDCOM Policy 12-035 acknowledges that DSM-IV Text Revision criteria should be followed in diagnosing PTSD. It also states that clinicians should strongly consider making a diagnosis of PTSD, rather than using a more generic diagnosis such as Anxiety Disorder Not Otherwise Specified, even when the currently accepted diagnostic criteria are not met.

The draft DSM-V criteria for PTSD propose elimination of the A2 criterion. The A2 criterion for PTSD states that an individual, in response to the trauma, experienced a feeling of "fear, helplessness, or horror." By recommending that providers strongly consider not using the A2 criterion, some providers reported feeling that the intent of OTSG / MEDCOM Policy 12-035 was to pressure them to make the diagnosis of PTSD utilizing unpublished criteria. The APA explicitly states that clinicians should not utilize the proposed DSM-V criteria until published in May 2013.

RECOMMENDATION:

ES-5.1 (reference# ID-1205.15.01): CDR, MEDCOM clarify MEDCOM Policy 12-035 for providers to decrease the perceived conflict between the policy and the current American Psychological Association (APA) guidelines and standards.

STANDARDS:

OTSG / MEDCOM Policy Memo 12-035, "Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder (PTSD)," (10 April 2012);

Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition Text Revision (DSM-IV TR), (June 2000).

ES-6 OBSERVATION (reference# ID-1205.16): There was a shortage of SMEBCs.

ROOT CAUSE: (CAN'T COMPLY) Some (15 of 32 or 47%) installations were not allocated SMEBCs at their location.

DISCUSSION: There were insufficient SMEBCs to serve Soldiers in the IDES program. Inspectors noted that multiple sites did not have SMEBCs located on the installation and they were supported by other installations. Installations without a SMEBC presented transportation and timeline challenges. Soldiers were forced to commute longer

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distances to receive SMEBC services or SMEBC were forced to commute to provide services to Soldiers. This situation limits Family participation. Other options available such as telephone appointments were used while video telephone conference capabilities were limited.

The shortages of SMEBCs also negatively affected the five-day timeline for a Soldier to request an IMR and / or appeal. Soldiers' timelines included non-duty days, which led to challenges receiving timely legal assistance. For example, if a Soldier received his or her MEB results on a Thursday and the five-day suspense to file an appeal included non-duty days (the weekend), the Soldier may not have had an opportunity to receive adequate counsel. These challenges resulted in requests for extensions. Requests for extensions were routine, obviously impacting the IDES timeline.

RECOMMENDATION:

ES-6.1 (reference# ID-1205.16.01): CDR, MEDCOM conduct a cost benefit analysis of the methods to expand Soldiers' Medical Evaluation Board Counsel (SMEBC) program.

STANDARD: DTM-11-015; Integrated Disability Evaluation System (IDES), (19 December 2011, Incorporating Change 1, 3 May 2012).

ES-7 OBSERVATION (reference# ID-1205.17): There was no provision on the DA Form 3947 (Medical Evaluation Board Proceedings) for a Soldier to elect an IMR.

ROOT CAUSE: (CAN'T COMPLY) The DA Form 3947 does not address IMRs.

DISCUSSION: The DA Form 3947 does not provide an opportunity to request an IMR, which excludes necessary options available to Soldiers. Instead, a Soldier must submit a memorandum in order to request an IMR. This requirement for additional documentation to request an IMR prolongs the IDES timeline.

RECOMMENDATION:

ES-7.1 (reference# ID-1205.17.01): DCS, G-1 update DA Form 3947 (Medical Evaluation Board Proceedings) to include the Impartial Medical Review election.

STANDARDS:

AR 40-400, "Patient Administration," (27 January 2010, Rapid Action Revision (RAR) Issue Date: 15 September 2011);

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OTSG/MEDCOM Policy 11-046, "MEB Processing Guidance," (10 June 2011, Expires 10 June 2013).

ES-8 OBSERVATION (reference# ID-1205.18): Minimal participation of Family members in the IDES process.

ROOT CAUSE: (DON'T KNOW) Family members reported poor understanding of IDES and limited ability to assist with supporting the IDES process.

DISCUSSION: During the inspection, Family members reported a poor understanding of the IDES process. There was no evidence of a systematic method used across Army installations to provide IDES information to Family members, or a way to encourage Family member participation and support of the process. In fact, at one installation an IDES staff member reported that Family members were discouraged from participating in informational briefings about IDES due to the added time it takes to respond to Family member questions. During sensing sessions, Family members indicated that they often felt that they did not have sufficient information to adequately assist in managing the process, understand the SM responsibilities and plan for the Family's future. However, Family members reported that SMs in the IDES process often lack many of the cognitive or physical attributes required to manage the IDES effectively. Because of their disabilities, SMs frequently depend upon Family members for assistance with managing the IDES process. In these instances, Family members reported significant difficulties with obtaining information about the IDES and determining where their family member was in the process.

The lack of information provided to Family members curtailed their ability to assist with the process and occasionally led to an exacerbation of symptoms, missed appointments, or missed IDES deadlines. None of the Family members interviewed during the inspection indicated that they had received a Family member-centric briefing, pamphlet or presentation. Moreover, during Soldier sensing session, Soldiers frequently indicated that providing additional opportunities for Family members to engage in the IDES process would be beneficial. Family members reported that meetings offered occurred during normal business hours, which made attendance difficult due to childcare and work obligations.

Installations where leadership and IDES personnel encouraged Family participation and provided Soldier Family Assistance Centers (SFACs) support generally reported greater SM satisfaction with the IDES process. Specifically, Family members reported that improved communication often helped mitigate negative impact from leave restrictions, improved SM attendance at IDES appointments, and that Soldiers in the IDES with informed Family members were more cognizant of their rights and responsibilities as it related to the process. Finally, commanders reported that well informed Family

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members also assisted with managing expectations in the process, which helped to allay SM concerns about IDES timelines and the transition process.

RECOMMENDATION:

ES-8.1 (reference# ID-1205.18.01): CDR, MEDCOM encourage Family member participation in IDES.

STANDARD: N/A

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Functional Assessment Area: Other Matters

SUMMARY OF FINDINGS: During interviews and sensing sessions, inspectors routinely received feedback from troop units, MTFs and WTUs opining that WTUs apply different acceptance criteria at their installation from that applied by other installations. Per Department of the Army WTU Consolidated Guidance – 20 March 2009, page 21, paragraph 2-3b, [Active Component] "(1) Soldiers with complex medical conditions that require extensive case management qualify for assignment or attachment to the WTU. (2) Soldiers with medical conditions that do not require case management should remain in their units and utilize standard healthcare system and access to care standards." Guidance for installations OCONUS, except for Alaska and Hawaii, differed from all other locations. Beyond policy driven differences, the team identified areas where an individual would be assignable to a WTU whereas simply by consideration of local factors would not be assignable at another WTU. This matter was not within the directed objectives of this inspection and is addressed as an other matter.

OM-1 DEFICIENCY (reference# ID-1205-19): WTUs have different acceptance criteria for service members.

ROOT CAUSE: (DON'T KNOW) Senior Mission Commanders (Installation Commanders) influence acceptance criteria at their locations.

DISCUSSION: Chapter 2 of Department of the Army WTU Consolidated Guidance – 20 March 2009 addresses different acceptance criteria for AC, RC, special cases for COMPOs 1 and 2 / 3, whether the Soldier is stationed Outside CONUS and whether assignment is to a standard WTU versus a Community Based WTU. USAR / ARNG Soldiers and their leaders said their Soldiers with behavioral health issues are having an exceptionally difficult time getting into WTUs.

For OCONUS locations, paragraph 2 of ALARACT 374 / 2011 requires "Soldiers that meet their medical retention determination point (MRDP) to undergo permanent change of station (PCS) to a CONUS WTU to complete IDES." ALARACT 374 / 2011, paragraph 3b(1) requires gaining and losing medical treatment facilities / medical commands / WTUs to take specific actions prior to movement of an OCONUS Warrior in Transition (WT). Cadre associated with OCONUS WTUs coordinating reassignment routinely experienced issues where the WTU to which their Soldier was being considered for reassignment evaluated supporting medical records and medical tests to differing criteria than if the Soldier was to be assigned elsewhere. OCONUS WTU cadre dealt with at least eight CONUS WTUs when coordinating reassignment to a gaining WTU. They have a good basis for insight into the problem. Paragraph 3c to draft FRAGO 4 (OCONUS IDES Processes) to MEDCOM OPORD 12-31 attempts to address these OCONUS issues but guidance is only a draft.

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As addressed in SC-2, many transferring Soldiers are being required to restart the IDES process to meet "local" criteria upon arriving at gaining units. This applied to Soldiers in line units in IDES and to Warriors in Transition who recently transferred from OCONUS WTUs for IDES processing. AR 40-501, paragraphs 7-4b and 7-8b provide clear guidance on permanent profiles and revision of permanent profiles. Both OCONUS WTU WTs and MEB doctors reported permanent profiles were rewritten or diagnosis testing was redone to satisfy local requirements upon arrival. Yet, rarely did a Soldier's profile change after the rewrite from its original P3 / P4 a lesser profile P2 / T3.

Senior interviewees told the team that a former VCSA told Senior Mission Commanders to use their own discretion on who goes into the WTUs despite established criteria. For at least one location, all WTU Application Packets must go to the General Courts Martial Convening Authority for the WTU acceptance decision leading to frustrations by other General Officers on the installation. The team received feedback from Soldiers, line unit Commanders, First Sergeants, Platoon Sergeants and WTU cadre that acceptance criteria on the local installation differed from their most recent assigned installation. Given application of these variances, it is possible for a Soldier with identical WTU Application Packets to be acceptable to the WTU at location A but not at location B.

Sensing session of Wounded Warriors (from another recent inspection) as well as Warriors in Transition indicates that the process of transferring medical records, both within Medical Commands, between Regions, and between CBWTU and WTUs, is rife with errors and incompatibility issues. This may be a contributing factor to local admission issues or an associated issue but merits mention. Although the team heard of efforts by the medical community, more attention is required to link up with the gaining WTU and forward the medical information for proper processing.

There are instances that records are not always complete. There were clear cases where this issue was differing local standards for admission to the WTU. Collectively, this causes entire cases / diagnosis, some well advanced, to be abandoned and restarted from scratch when a soldier is transferred. The effect of varied WTU local entry policy / criteria results in OCONUS IDES restarts and creates personal turmoil for SMs. The overall effect of differing local entry policy leads to delays, frustration and loss of faith in the system by Families and Soldiers in WTUs.

RECOMMENDATION:

OM-1.1 (reference # ID-1205-19.01): DCS, G-1 ICW CDR, MEDCOM enforce standardization of Warrior Transition Unit (WTU) acceptance criteria.

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STANDARDS:

ALARACT 374 / 2011, ALARACT HQDA EXORD 295-11, Implementation of OCONUS (Europe, Japan and Korea) Plan for Soldiers Referred to the Integrated Disability Evaluation System, DTG: P 010011Z SEP 11;

Department of the Army WTU Consolidated Guidance – 20 March 2009;

FRAGO 4 (OCONUS IDES PROCESSES) to MEDCOM OPORD 12-31 (MEDCOM Implementation of Integrated Disability Evaluation System) **(DRAFT)** XXXXXXQ Sep 2012;

AR 40–501, Standards of Medical Fitness, 14 December 2007, with Rapid Action Revision (RAR) Issue Date: 4 August 2011.

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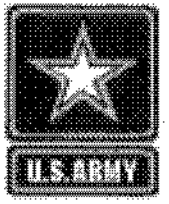

Methodology - Target Interviews

- MEDCOM Staff
- Regional Medical Command Leadership
- Hospital / Medical Facility Commander
- Hospital Administrators
- Medical Treatment Facility Leadership / Support Personnel
- Behavioral Health Professionals
  - Psychiatrists
  - Psychologists
  - Behavioral Nurse Practitioners
  - Licensed Clinical Social Workers
- Forensic Psychiatrists
- Patient Advocates (Legal)
- Ombudsman
- Narrative Summary (NARSUM) Doctors
- Medical Evaluation Board Members
- Physical Evaluation Board Liaison Officers
- Veterans Affairs Advisors
- Veterans Affairs Compensation and Pension Representatives
- Warrior Transition Unit / Command Staff
  - Nurse Case Managers
  - Squad Leaders
  - Primary Care Managers
- Tenant Unit Personnel (Leadership)
- Tenant Unit / WTU Personnel Undergoing MEB/PEB Process (Service Members)
- Family Members (voluntary)

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Team Breakout

DC Team (Operations and Fusion Cell)	Travel Team Composition (6)
IG Team Leader	Detailed IG x (6)
IG Ops Officer	Detailed / Assistant IG x (11)
IG Ops Management (DTS, VTC, Telecon)	Behavioral Health Psychiatrist x (6)
IG Writer (4)	Hospital Administrator x (6)
Behavioral Health Psychologist (PTSD Exp)	PEBLO SME x (6)
VA IDES SME	MEB Doctors (6)
PEBLO SME	
Forensic Psychiatrist	
MEB Doctor	**Reach back**
PEB SME	VA IDES SME
MEDCOM IDES SME	VA Compensation and Pension Rep

55 Personnel (47 Augmentees)

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Detailed Inspection Schedule

	Start	End	End Location	Medical Treatment Facility	Insp Days
2-1 / OCONUS	14-Jun	30-Jun	TDY to DC	Prepare	
	30-Jun	9-Jul	July 4th Week / Training	Holiday Week	
	9-Jul	15-Jul	Vicenza, Germany	Bavaria MEDDAC	5
	15-Jul	21-Jul	Landstuhl / Heidelberg, Germany	Landstuhl Regional Medical Center / ERMC	5
	21-Jul	29-Jul	TDY to DC	Prepare	
	29-Jul	4-Aug	Camp Zama, Japan	BG Crawford Sams Army Health Center	5
	3-Aug	10-Aug	Honolulu, HI	Tripler Army Medical Center / Scofield WTU	5
	18-Aug	25-Aug	TDY to DC	Analyze and Reset	
	25-Aug	3-Sep	Richardson, AK	Richardson Health Clinic	4
	3-Sep	8-Sep	Wainwright, AK	Bassett Health Clinic	4
	8-Sep	14-Sep	TDY to DC	Analyze and Write Final Report	
2-2 / Western	14-Jun	30-Jun	TDY to DC	Prepare	
	30-Jun	9-Jul	July 4th Week / Training	Holiday Week	
	9-Jul	14-Jul	Fort Huachuca, AZ	Raymond W. Bliss Army Health Center	4
	14-Jul	21-Jul	Joint Base Lewis-McChord, WA	Madigan Army Medical Center	4
	21-Jul	29-Jul	TDY to DC	Analyze and Reset	
	29-Jul	4-Aug	Fort Bliss, TX	William Beaumont Army Medical Center	4
	4-Aug	11-Aug	Fort Carson, CO	Evans Army Community Hospital	5
	11-Aug	17-Aug	Sacramento, CA	CBWTU-CA (McClellan Airfield)	2
	17-Aug	27-Aug	TDY to DC	Analyze and Reset	
	27-Aug	1-Sep	Fort Irwin, CA	Weed Army Community Hospital	2
	1-Sep	4-Sep	TDY to DC	Analyze and Reset	
	4-Sep	8-Sep	Riverton, UT	CBWTU-UT	2
	8-Sep	14-Sep	TDY to DC	Analyze and Write Final Report	
2-3 / Central	14-Jun	30-Jun	TDY to DC	Prepare	
	30-Jun	9-Jul	July 4th Week / Training	Holiday Week	
	9-Jul	14-Jul	Fort Leavenworth, KS	Munson Army Health Center	4
	14-Jul	20-Jul	Fort Riley, KS	Irwin Army Community Hospital	4
	20-Jul	29-Jul	TDY to DC	Analyze and Reset	
	29-Jul	1-Aug	Fort Leonard Wood, MO	Leonard Wood Army Community Hospital	2
	1-Aug	4-Aug	Rock Island Arsenal, IL	CBWTU-IL	2
	4-Aug	10-Aug	Fort Knox, KY	Ireland Army Community Hospital	3
	10-Aug	17-Aug	Fort Campbell, KY	Blanchfield Army Community Hospital	4
	17-Aug	26-Aug	TDY to DC	Analyze and Reset	
	26-Aug	31-Aug	Fort Buchanan, Puerto Rico	Rodriguez Army Community Hospital / CBWTU-PR	4
	31-Aug	14-Sep	TDY to DC	Analyze and Write Final Report	

	Start	End	End Location	Medical Treatment Facility	Insp Days
2-4 / Southern	14-Jun	30-Jun	TDY to DC	Prepare	
	30-Jun	9-Jul	July 4th Week / Training	Holiday Week	
	9-Jul	11-Jul	Redstone Arsenal, AL	Fort Rucker Health Clinic / CBWTU-AL	2
	11-Jul	14-Jul	Fort Chaffee, AR	Fort Chaffee Health Clinic	2
	14-Jul	20-Jul	Fort Polk, LA	Bayne-Jones Army Community Hospital	2
	20-Jul	30-Jul	TDY to DC	Analyze and Reset	
	30-Jul	4-Aug	Fort Sill, OK	Reynolds Army Community Hospital	4
	4-Aug	11-Aug	Fort Hood, TX	Darnall Army Medical Center	3
	11-Aug	15-Aug	Joint Base San Antonio, TX	Brooke Army Medical Center	4
	15-Aug	2-Sep	TDY to DC	Analyze and Reset	
	2-Sep	7-Sep	Fort Dix, NJ	Guthrie Army Health Clinic	3
	7-Sep	14-Sep	TDY to DC	Analyze and Write Final Report	
2-5 / South Eastern	14-Jun	30-Jun	TDY to DC	Prepare	
	30-Jun	11-Jul	July 4th Week / Training	Holiday Week	
	11-Jul	15-Jul	Orlando, FL	CBWTU-FL	3
	15-Jul	20-Jul	Fort Rucker, AL	Lyster Army Health Clinic	4
	20-Jul	29-Jul	TDY to DC	Analyze and Reset	
	29-Jul	4-Aug	Fort Benning, GA	Martin Army Community Hospital	4
	4-Aug	11-Aug	Fort Gordon, GA	Eisenhower Army Medical Center	5
	11-Aug	18-Aug	Fort Stewart, GA	Winn Army Community Hospital	4
	18-Aug	26-Aug	TDY to DC	Analyze and Reset	
	26-Aug	31-Aug	Fort Jackson, SC	Moncrief Army Community Hospital	3
	31-Aug	14-Sep	TDY to DC	Analyze and Write Final Report	
2-6 / Northern	14-Jun	30-Jun	TDY to DC	Prepare	
	30-Jun	9-Jul	July 4th Week / Training	Holiday Week	
	9-Jul	11-Jul	West Point, NY	Keller Army Community Hospital	2
	11-Jul	14-Jul	Cocoing, MA	CBWTU-MA	2
	14-Jul	16-Jul	TDY to DC	Analyze and Reset	
	16-Jul	20-Jul	Fort Lee, VA	Kenner Army Health Clinic	4
	20-Jul	30-Jul	TDY to DC	Analyze and Reset	
	30-Jul	31-Jul	Bethesda, MD	Walter Reed National Military Medical Center	2
	1-Aug	3-Aug	Fort Meade, MD	Kimbrough Ambulatory Care Center	2
	3-Aug	5-Aug	TDY to DC	Analyze and Reset	
	5-Aug	11-Aug	Joint Base Langley-Eustis, VA	McDonald Army Health Clinic	5
	11-Aug	15-Aug	Virginia Beach, VA	CBWTU-VA	2
	15-Aug	20-Aug	TDY to DC	Analyze and Reset	
	20-Aug	24-Aug	Fort Bragg, NC	Womack Army Medical Center	3
	24-Aug	14-Sep	TDY to DC	Analyze and Write Final Report	
Local DC	11-Jun	13-Jun	Pinellas Park, FL	RC Sector Medical Support Center (RC SMSC)	1
	14-Jun	30-Jun	Crystal City, VA	Belvoir Army Community Hospital (Fire Insp 27-29)	3
	30-Jun	9-Jul	July 4th Week / Training	Holiday Week	
	9-Jul	14-Sep	Crystal City, VA		

SME and Augmentee Breakdown				
Command	#	Specialty	Assigned Team	Duration
FORSCOM	6	Inspector General	Travel Teams	13 Jun - 14 Sep
NGB	1	Inspector General	Travel Teams	13 Jun - 14 Sep
IMCOM	4	Inspector General	Travel Teams	13 Jun - 14 Sep
USARC	1	Inspector General	Travel Teams	13 Jun - 14 Sep
MEDCOM	4	Inspector General	DC Team	13 Jun - 14 Sep
	7	BH Professionals	(1) DC (6) Travel	13 Jun - 14 Sep
	6	Patient Administrators	Travel Teams	13 Jun - 14 Sep
	1	Warrior Transition Command	DC Team	13 Jun - 14 Sep
	1	Forensic Psychiatrist	DC Team	13 Jun - 14 Sep
	7	MEB Doctors	(1) DC (6) Travel	13 Jun - 14 Sep
	7	PEBLOs	(1) DC (6) Travel	13 Jun - 14 Sep
	1	IDES SME	DC Team	13 Jun - 14 Sep
HRC	1	Physical Eval Board SME	DC Team	13 Jun - 14 Sep
	47			
Veterans Affairs	1	VA IDES SME	DC Team	13 Jun - 14 Sep
	1	VA Compensation and Pension	Travel Teams	13 Jun - 14 Sep
	2			
	49			

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DEPARTMENT OF THE ARMY
OFFICE OF THE INSPECTOR GENERAL
1700 ARMY PENTAGON
WASHINGTON DC 20310-1700

SAIG-ID 6 June 2012

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Behavioral Health (BH) Process, Disability Evaluation System (DES) and Integrated Disability Evaluation System (IDES) Inspection

1. **DIRECTIVE:** The Secretary of the Army directed the comprehensive review and corrective action plan of the Behavioral Health Process, Disability Evaluation System and Integrated Disability Evaluation System (Encl 1).

2. **INSPECTION PURPOSE:** To determine if the DES and the IDES have been influenced by factors other than the considered opinion of medical professionals applying the appropriate standard of care.

3. **INSPECTION OBJECTIVES:**

a. Assess whether commanders, Soldiers and other participants in DES / IDES are sufficiently informed about, and understand, their respective roles; their rights and duties; and the sources of information and assistance available to them; all with a view to optimizing their participation in, and the overall effectiveness of, DES / IDES processes.

b. Review the effect of the Army's implementation of IDES on the diagnosis and evaluation of behavioral health conditions.

c. Review and evaluate the sufficiency of appeal procedures available to Soldiers participating in the DES / IDES processes.

d. To the extent arising from tasks outlined in this directive, collect and report to the Under Secretary and the VCSA any observations that command climate or other non-medical factors affected behavioral health diagnoses and evaluations.

4. **TASK ORGANIZATION:**

a. The Inspection Team will consist of members of the Department of the Army Inspector General Agency (DAIG) and subject matter experts and augmentees from US Army Forces Command, the National Guard Bureau, Installation Management

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Command, US Army Reserve Command, Medical Command, Human Resources Command and Department of Veterans Affairs.

b. The composition of the DAIG Inspection Team (with security clearances indicated) is as follows:

Rank/Name	Security Clearance
(b)(6)	TS
	S
	TS
	TS
	S
	TS
	S
United States Forces Command (IG)	TBD
National Guard Bureau (IG)	TBD
Installation Management Command (IG)	TBD
United States Reserve Command (IG)	TBD
Medical Command (IG and Select SMEs)	TBD
Department of Veterans Affairs (SME)	TBD

5. **INSPECTION LOCATIONS AND SCHEDULE:** The Inspection Team will conduct interviews with Medical Command and US Army Physical Disability Agency personnel as indicated in Enclosure 2 (Inspection Timeline).

Team Mission Planning	21 – 25 May 2012
Behavioral Health Train Up	18 June – 6 July 2012
SME IG Training	26 June 2012
Fort Belvoir Hospital Training Inspection	27 – 29 June 2012
BH Process, DES / IDES Inspection	9 July – 14 September 2012

6. **INSPECTION METHODOLOGY:**

a. This inspection will be based on information / data gathered through research, document reviews and interviews with leaders, staff, Soldiers, Family members and DA civilian employees associated with the BH Process, DES and IDES. The Inspection Team will develop findings and recommendations based on the information / data gathered and provide these to the Secretary of the Army in a written report; staffed through The Inspector General, the Vice Chief of Staff of the Army and the Chief of Staff of the Army.

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b. The Inspection Team will review policies, processes and procedures that govern the administration of the Army's BH process, DES and IDES.

c. This inspection will include, but is not limited to, Medical Command and the US Army Physical Disability Agency.

d. The DAIG will coordinate with your agency to identify a Point of Contact (POC) for this inspection. The agency POC will serve as coordinating agent for the DAIG inspection as outlined in the distribution list. As coordinating agent, the local agency POC will coordinate with the DAIG team POC to develop an itinerary for the inspection visit. The basic methodology for each inspection includes interviews with designated personnel. Additionally, the Inspection Team will review local policies, plans, programs, SOPs and other related documents. A strawman schedule for Team travel in general and site specific scheduling is at Enclosure 2.

7. **PERSONNEL TO INTERVIEW:**

a. The DAIG team will conduct interviews with members of select agencies who are involved with the administration of the BH process, DES and IDES. Focus areas include, but are not limited to:

- Command and SM understanding of the DES and IDES
- Assessment of the overall understanding of the DES and IDES
- Review of the effect of DES and IDES diagnoses
- Sufficiency of the appeals process
- Command Climate issues
- Reports of Senior Leader misconduct

b. Interviews may occur in the interviewee's office or another site that is relatively quiet and free from interruptions and telephone calls. The agency POC should schedule a 60-minute block for each interview. Personnel assigned to the following positions will be interviewed by the Inspection Team during inspection visits:

- MEDCOM Staff
- Regional Medical Command Leadership
- Hospital / Medical Facility Commander
- Hospital Administrators
- Medical Treatment Facility Leadership / Support Personnel
- Behavioral Health Professionals:
  - Psychiatrists

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  - Psychologists
  - Behavioral Nurse Practitioners
  - Licensed Clinical Social Workers:
- Forensic Psychiatrists
- Patient Advocates (Legal)
- Ombudsman
- Narrative Summary (NARSUM) Doctors
- Medical Evaluation Board Members
- Physical Evaluation Board Members
- Physical Evaluation Board Liaison Officers
- Department of Veterans Affairs Advisors
- Department of Veterans Affairs Compensation and Pension Representatives
- Warrior Transition Unit / Command Staff
  - Nurse Case Managers
  - Squad Leaders
  - Primary Care Managers
- Tenant Unit Personnel (Leadership)
- Tenant Unit Personnel (Service Members)
- Family Members
- Inspectors General
- Judge Advocates General
- Physical Disability Agency Representatives

c. A more detailed and inclusive list will be provided to agency POCs no later than one week before the scheduled inspection visit.

d. The Agency POC may adjust the interview schedule, in coordination with the DAIG team POC.

8. **DOCUMENTS / PROGRAMS TO REVIEW.** The intent of the document review is to inspect or review documents that relate to the management and administration of the BH process, DES and IDES. A list of documents required for the Inspection Team's review is shown below; they are divided into two categories: pre-inspection document requests and on-site document review. The coordinating agent will provide or assist the DAIG team POC in obtaining these documents.

a. Pre-Inspection - Organizational structure for Medical Treatment Facility.

b. On-site - Standard Operating Procedures, local policies, internal procedures and applicable MOUs / MOAs.

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9. **SURVEY:** The team will conduct separate surveys of BH professionals, tenant unit leadership and Soldiers currently involved in the DES and IDES.

10. **EVENTS / PROCESSES TO OBSERVE:** Ongoing Medical Evaluation Board procedures. Other DES and IDES processes as deemed appropriate at the time of the inspection.

11. **DAIG TEAM RESOURCES:** It is not necessary for the coordinating agent to accompany the DAIG team during interviews.

12. **ADMINISTRATIVE SUPPORT REQUIREMENTS:** The DAIG team will require the inspected agency to provide access to a fax, printer, computer projector (with screen), digital scanner, copier and a secure private office space for up to 15 personnel to conduct daily team meetings.

13. **REPORT COMPLETION TIMELINE:** The results of this inspection are the basis for a written report that will be distributed to your agency, once approved by the SecArmy. This report is expected to be released on / about 1 December 2012.

14. **SUSPENSE SUMMARY:** The DAIG team POC will coordinate with agency POCs to schedule inspection visits and interviews of personnel at each location identified in Paragraph 7 above.

15. Point of contact is (b)(6) Inspections Division. Email address: (b)(6) *Phone: COM* (b)(6) *alternate POC is* (b)(6) (b)(6) Inspections Division. Email Address: (b)(6) Phone: COM (b)(6)

(b)(6)

2 Encls
1. SecArmy Inspection Directive
2. Inspection Location/Schedule

DISTRIBUTION:
Commander, United States Army Forces Command
Commander, National Guard Bureau
Commander, Installation Management Command
Commander, United States Army Reserve Command

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Commander, Medical Command
Commander, Human Resources Command

CF: (w/encl)
The Inspector General
DAIG, Chief, Inspections Division
DAIG, Chief, Assistance Division
DAIG, Chief, Investigation Division
DAIG, Chief, Legal Division

Inspectors General:
United States Forces Command
National Guard Bureau
Installation Management Command
United States Army Reserve Command
Medical Command
Human Resources Command

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Team Travel

	(TM 1) OCONUS	(TM 2) Western	(TM 3) Central	(TM 4) Southern	(TM 5) South Eastern	(TM 6) Northern
April	Submit SME Request (30 April)					
May	Soldier Medical Support Center (Pinellas Park, FL – 11-13 June)					
June	Receive SMEs (13-15 June)					
	Conduct SME Training (18 June - 7 July)					
	Pre-Inspection Training (Fort Belvoir, VA - 27-29 June)					
July	Independence Day					
	9-20 (GE)	9-14 (AZ)	9-20 (KS)	8-14 (AL / AR)	11-15 (FL)	9-13 (MD)
		14-20 (WA)		14-21 (LA)	15-20 (AL)	15-21 (NC)
Aug	29-8 (JP)	30-4 (TX)	29-1 (MO)	29-4 (OK)	29-18 (GA)	30-15 (VA)
	8-18 (HI)		15-27 (KY)	4-18 (TX)		
		4-11 (CO)	1-5 (IL)			
		11-18 (CA)	5-17 (KY)			
	25-8 (AK)	27-30 (UT)	26-31 (PR)	26-30 (NY)	26-30 (SC)	26-31 (NY / MA)
Sept		Labor Day				

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Behavioral Health Disability Evaluation System Integrated Disability Evaluation System Inspection
Travel Sites

	Start	End	End Location	Medical Treatment Facility	Travel Notes
TM 1	8-Jul	15-Jul	Vilseck, Germany	Bavaria MEDDAC	IAD - FRA / Rental Car
	15-Jul	21-Jul	Landstuhl / Heidelberg, Germany	Landstuhl Regional Medical Center / ERMC	Rental Car / FRA - IAD
	28-Jul	4-Aug	Camp Zama, Japan	BG Crawford Sams Army Health Center	IAD - NRT / HNL
	4-Aug	13-Aug	Honolulu, HI	Tripler Army Medical Center / Scofield WTU	HNL - IAD
	25-Aug	1-Sep	Richardson, AK	Richardson Health Clinic	DCA - ANC / Rental Car
	1-Sep	8-Sep	Wainright, AK	Bassett Health Clinic	Rental Car / ANC - DCA
TM 2	9-Jul	14-Jul	Fort Huachuca, AZ	Raymond W. Bliss Army Health Center	DCA - TUS
	14-Jul	20-Jul	Joint Base Lewis McChord, WA	Madigan Army Medical Center	SEA - DCA
	30-Jul	4-Aug	Fort Bliss, TX	William Beaumont Army Medical Center	DCA - ELP
	4-Aug	11-Aug	Fort Carson, CO	Evans Army Community Hospital	ELP - COS
	11-Aug	15-Aug	Sacramento, CA	CBWTU-CA (McClellan Airfield)	COS - SMF
	15-Aug	18-Aug	Fort Irwin, CA	Weed Army Community Hospital	SMF - ONT / ONT - DCA
	27-Aug	30-Aug	Riverton, UT	CBWTU-UT	DCA - SLC / SLC - DCA
TM 3	9-Jul	14-Jul	Fort Riley, KS	Irwin Army Community Hospital	DCA - MCI / Rental Car
	14-Jul	20-Jul	Fort Leavenworth, KS	Munson Army Health Center	MCI - DCA
	29-Jul	1-Aug	Fort Leonard Wood, MO	Leonard Wood Army Community Hospital	DCA - STL
	1-Aug	5-Aug	Rock Island Arsenal, IL	CBWTU-IL	STL - MLI
	5-Aug	13-Aug	Fort Knox, KY	Ireland Army Community Hospital	MLI - SDF / Rental
	12-Aug	17-Aug	Fort Campbell, KY	Blanchfield Army Community Hospital	Rental / BNA - DCA
	26-Aug	31-Aug	Fort Buchannan, Puerto Rico	Rodriguez Army Community Hospital / CBWTU-PR	DCA - SJU / SJU - DCA
TM 4	8-Jul	11-Jul	Redstone Arsenal, AL	Fox Army Health Clinic / CBWTU-AL	DCA - HSV / Rental Car
	11-Jul	14-Jul	North Little Rock, AR	CBWTU-AR	Rental - Fort Polk
	14-Jul	20-Jul	Fort Polk, LA	Bayne-Jones Army Community Hos	AEX - DCA
	30-Jul	4-Aug	Fort Sill, OK	Reynolds Army Community Hospital	DCA - LAW
	4-Aug	12-Aug	Fort Hood, TX	Darnall Army Medical Center	LAW - AUS / Rental Car
	12-Aug	17-Aug	Joint Base San Antonio, TX	Brooke Army Medical Center	Rental / AUS - DCA
	27-Aug	31-Aug	Fort Drum, NY	Guthrie Army Health Clinic	DCA - SYR / SYR - DCA
TM 5	11-Jul	15-Jul	Orlando, FL	CBWTU-FL	DCA - MCO / Rental Car
	15-Jul	23-Jul	Fort Rucker, AL	Lyster Army Health Clinic	Rental / DHN - DCA
	30-Jul	4-Aug	Fort Stewart, GA	Winn Army Community Hospital	DCA - SAV / Rental Car
	4-Aug	11-Aug	Fort Gordon, GA	Eisenhower Army Medical Center	Rental - Ft Benning
	11-Aug	17-Aug	Fort Benning, GA	Martin Army Community Hospital	Rental / ATL - DCA
	27-Aug	31-Aug	Fort Jackson, SC	Moncrief Army Community Hospital	DCA - CAE / CAE - DCA
TM 6	8-Jul	11-Jul	West Point, NY	Keller Army Community Hospital	Rental - West Point
	11-Jul	14-Jul	Concord, MA	CBWTU-MA	Rental - Concord / Return to VA
	16-Jul	20-Jul	Fort Lee, VA	Kenner Army Health Clinic	Rental - Ft. Lee
	30-Jul	31-Jul	Bethesda, MD	Walter Reed National Military Medical Center	No Overnight/Use Carpool Vehicles
	1-Aug	5-Aug	Fort Meade, MD	Kimbrough Ambulatory Care Center	No Overnight/Use Carpool Vehicles
	5-Aug	11-Aug	Joint Base Langley-Eustis, VA	McDonald Army Health Clinic	Rental - Langley
	11-Aug	15-Aug	Virginia Beach, VA	CBWTU-VA	Rental - Virginia Beach
	20-Aug	24-Aug	Fort Bragg, NC	Womack Army Medical Center	Rental - Ft. Bragg
DC TM	11-Jun	13-Jun	Pinellas Park, FL	RC Soldier Medical Support Center (RC SMSC)	DCA - TPA / TPA - DCA
	14-Jun	30-Jun	Crystal City, VA	Belvoir Army Community Hospital (Pre Insp[27-29]	Local DC Team
	9-Jul	14-Sep	Crystal City, VA		

8

SECRETARY OF THE ARMY
WASHINGTON

MEMORANDUM FOR SEE DISTRIBUTION 15 MAY 2012

SUBJECT: Comprehensive Review and Corrective Action Plan

1. The Chief of Staff, Army (CSA) and I have been advised of allegations that certain behavioral health diagnoses and disability ratings of Soldiers processed through the Disability Evaluation System (DES) and the Integrated Disability Evaluation System (IDES) may have been influenced by factors other than the considered opinion of medical professionals applying the appropriate diagnostic criteria. Mindful of our responsibilities and commitment to our Soldiers, I hereby direct the following:

2. The Under Secretary of the Army and the Vice Chief of Staff Army (VCSA), shall:

a. Review and assess how the Army addresses behavioral health diagnoses and evaluations, especially as to Post-Traumatic Stress Disorder (PTSD), in the context of DES/IDES and make, where needed, recommendations for improvement.

b. Develop and present for my approval a comprehensive plan to correct any systemic breakdowns or concerns identified in the DES/IDES systems as they affect the diagnosis and evaluation of behavioral health conditions. This comprehensive plan must also articulate courses of action by which redress can be offered to Soldiers who have participated in the DES/IDES process, at any location across the Army, and who have been adversely impacted by any behavioral health system breakdown or concern identified. Subject to my approval of all or part of this comprehensive corrective action plan, the Under Secretary and the VCSA, shall execute same.

(1) Development of the comprehensive corrective action plan shall begin with a detailed review and evaluation of all pertinent reviews, inspections, investigations and assessments completed as of the date of this directive, and shall extend to include ongoing reviews, investigations, inspections and assessments as they are completed, or as relevant information becomes available, whichever first occurs. Access to all or part of these reviews, investigations, inspections and assessments may be curtailed only as required by law or regulation. This review will identify any remaining gaps in information or data collection, as well as any further express and implied tasks, and shall propose how such matters should be addressed or examined, taking into account the need for a timely, but full, exposition of the facts and a fair and final resolution of any issues or allegations.

Encl 1

(2) The comprehensive corrective action plan shall include the development of a synchronization matrix on which any recommendation rendered in the context of any prior review, investigation, inspection or assessment, together with any recommendation formulated under the cognizance of the Under Secretary and VCSA, and approved by me, shall be recorded, tracked, evaluated, acted on by appropriate authority and, as appropriate, implemented.

(3) As an integral part of the development of the comprehensive corrective action plan, The Surgeon General/Commanding General, U.S. Army Medical Command, or her designee, as appropriate, with oversight by the Under Secretary and the VCSA, shall:

(a) Within 90 days from the date of this directive, conduct a statistical review and analysis of outcome diagnoses for Soldiers evaluated for behavioral health conditions in the DES/IDES from October 7, 2001 through April 30, 2012 and provide a report documenting same to the Under Secretary and VCSA. The report shall include, at minimum, the data elements set forth in Enclosure 1, for every clinic or military treatment facility (MTF) that conducted Medical Evaluation Boards (MEBs) between 2001 and the present. The Surgeon General, or her designee, may expand the scope of data collection and analysis as may be necessary, appropriate and practicable. Given the imperative of executing this task to the highest standards of accuracy and thoroughness within the time allowed, The Surgeon General, or her designee, may request, and shall receive, the assistance and support of qualified experts and/or other personnel and resources from any Army command, organization or activity.

(b) With full consideration of the information and insights generated in the course of the data collection, review and analysis referenced in paragraph 2b(3)(a), above, thoroughly evaluate the need for the collection and analysis of additional data, as may be required to effect the taskings set forth in this directive and propose courses of action for the collection of same. I reserve to myself the authority to determine the nature and scope of follow-on action to be undertaken. Accordingly, not later than 110 days from the date of this directive, the report generated under provisions of paragraph 2b(3)(a), above, together with the underlying data and the proposed courses of action for the collection of any additional data shall be presented to me for decision as to the way forward.

(c) In light of my intent to effect a comprehensive solution to any breakdowns or concerns identified in the DES/IDES systems as they affect the diagnosis and evaluation of behavioral health conditions, propose any needed follow-on actions, including, if necessary, appropriate means of offering redress to any Soldier or group of Soldiers who have been adversely affected by any such breakdown or concern.

(d) Transmit expeditiously to the VCSA the two investigations conducted under provisions of Army Regulation 15-6, entitled "Investigation of Madigan Army Medical Center (MAMC) Behavioral Health Role in the Integrated Disability Evaluation System (IDES)" (appointed on 8 February 2012) and "Command Climate under COL Homas' tenure and any improper influence on Forensic Psychiatry Section (FPS)" (appointed 24 February 2012), with all allied papers. Notwithstanding the provisions of any Army regulation, directive, policy or practice, authority over both investigations is hereby withdrawn from The Surgeon General/Commanding General, U.S. Army Medical Command and/or her subordinate officials. Separate and apart from the duties assigned to him above and notwithstanding any other provision of this directive, I hereby vest in the VCSA all requisite authority and jurisdiction to review and take action on the findings and recommendations set forth in both investigations, including the authority to take adverse administrative action against military personnel, to refer allegations against military personnel to a commander for review and appropriate action and to delegate to other Department of the Army officials the authority to take disciplinary and administrative actions against Department of the Army civilian personnel.

(e) Constitute a multi-disciplinary panel of medical experts to advise the Under Secretary and VCSA on the policies and procedures that should govern the Army's diagnosis and evaluation of PTSD. The panel also shall advise the Under Secretary and VCSA on the adequacy of personnel (*e.g.*, sufficiency of numbers, quality and diversity of expertise and training) across the behavioral health community.

(f) Support the Army Research Institute in developing and administering a survey of every behavioral health provider or evaluator, regardless of professional discipline and no matter where located, as to whether considerations other than the appropriate diagnostic criteria influenced the diagnosis or evaluation of PTSD or other behavioral health conditions in the Army. The results of this survey shall be provided to the Under Secretary and the VCSA. Survey responses that suggest in any way that considerations other than the appropriate diagnostic criteria influenced the diagnosis or evaluation of PTSD or other behavioral health conditions will be brought to the attention of the Under Secretary and VCSA.

(g) The Deputy Chief of Staff, G-1, Headquarters, Department of the Army and the U.S. Army Physical Disability Agency shall diligently assist and support The Surgeon General/Commanding General, U.S. Army Medical Command, or her designee, in the execution of the above-referenced tasks.

3. The Sergeant Major of the Army shall serve as a special advisor to the Under Secretary and VCSA in this matter.

4. A temporary Task Force shall be established to assist the Under Secretary and the VCSA in the execution of the above tasks, in tracking and responding to related taskings as they may arise and in synchronizing related efforts across the Army. A Task Force Charter, including information about the objectives/tasks, structure and cost of the Task Force, shall be submitted through the CSA, for my review and approval, no later than 14 days from the date of this directive.

5. The officials and organizations designated below shall undertake the actions tasked independently of the Under Secretary, VCSA and Task Force. The tasked officials and organizations shall provide periodic updates on their activities to the Under Secretary, VCSA and the Task Force to ensure synchronization of effort Army-wide, to avoid duplication and, as appropriate, to share relevant information as soon as practicable. Such periodic reports may, as necessary, apply appropriate caveats to ensure the confidentiality of shared information protected by law and regulation and to maintain the viability of investigative, advisory and/or deliberative processes. Further, the formal findings, recommendations and/or other results of actions undertaken as set forth below shall be shared, to the extent authorized by law and regulation, with the Under Secretary, VCSA and/or Task Force to inform the development and execution of the comprehensive corrective action plan.

a. The Assistant Secretary of the Army (Manpower and Reserve Affairs) shall, in light of his responsibilities for the overall supervision of the manpower and reserve affairs of the Department of the Army:

(1) On request from the Under Secretary or VCSA, provide subject matter expertise and advice in support of the execution of the tasks set forth in this directive.

(2) Review the draft comprehensive corrective action plan, together with any associated report and allied papers, prior to submission to the CSA and me, and provide the Under Secretary and VCSA with comment thereon, particularly as to the feasibility, advisability and suitability of any findings and recommendations pertaining to medical and health affairs policy or the DES/IDES systems. The Under Secretary and VCSA shall append any comments submitted by the Assistant Secretary of the Army (Manpower and Reserve Affairs) to the final report submitted to the CSA and me.

(3) Participate in any Interim Progress Review provided to the CSA or me.

(4) Acting through the Deputy Assistant Secretary of the Army (Review Boards), collaborate with The Surgeon General/Commanding General, U.S. Army Medical Command, or her designee, in the execution of her task to propose any needed follow-on action, including, if necessary, appropriate means of offering redress to any Soldier or group of Soldiers who have been adversely affected by any breakdown or concern identified in the DES/IDES systems as they affect the diagnosis and evaluation of behavioral health conditions. The Deputy Assistant Secretary of the Army (Review Boards) shall ensure that her agency's involvement in any such course of action presented to the CSA and me as part of the final comprehensive corrective action plan appropriately facilitates the correction of individual records of Soldiers who may have been adversely impacted by any breakdown in the behavioral health system, if warranted when considering all aspects of the case.

b. The Inspector General is hereby directed:

(1) To conduct a special inspection, with the following objectives:

(a) Assess whether commanders, Soldiers and other participants in DES/IDES are sufficiently informed about, and understand, their respective roles; their rights and duties; and the sources of information and assistance available to them; all with a view to optimizing their participation in, and the overall effectiveness of, DES/IDES processes.

(b) Review the effect of the Army's implementation of IDES on the diagnosis and evaluation of behavioral health conditions.

(c) Review and evaluation of the sufficiency of appeal procedures available to Soldiers participating in the DES/IDES processes.

(d) To the extent arising from tasks outlined in this directive, collect and report to the Under Secretary and the VCSA any observations that command climate or other non-medical factors affected behavioral health diagnoses and evaluations.

(e) In furtherance of this special inspection, The Inspector General may, in his discretion, require the assistance and support of qualified inspectors general from any Army command, activity or other organization. Complaints or concerns submitted to, or received by, any Army inspector general regarding any matter addressed in this directive will be forwarded immediately to The Inspector General, who will, in turn, coordinate with the Under Secretary of the Army and the VCSA and issue appropriate guidance or instruction to the Army inspector general who forwarded the matter. No inspector general assessment, inspection or investigation related to any matter addressed in this directive may be initiated absent advance coordination with, and approval by, The Inspector General.

(f) In the course of this special inspection, The Inspector General is authorized unlimited access to Army activities and personnel, locations, organizations and documents, including any pertinent investigations, inquiries and audits, whether complete or ongoing. If, at any time in the conduct of his special inspection, The Inspector General believes that I should consider enlarging, restricting or terminating his inspection, or otherwise modifying this directive, he shall report this situation to me, together with his recommendation as to the action I should take in response. The Inspector General shall keep the CSA and me fully and currently informed as to the status of his special inspection and advise the CSA and me immediately of any matters that require immediate action.

(g) To provide the CSA and me a report of his special inspection no later than 180 days from the date of this directive.

(h) To ensure appropriate coordination with the Department of Defense Inspector General on all matters pertinent to the special inspection directed above and other related matters.

(i) If any matter generates an allegation that a senior official of the Army has engaged in impropriety or misconduct, to include the alleged failure to oversee properly any part of the DES/IDES process for which that senior official exercised some responsibility, that allegation will be referred immediately to The Inspector General for review and action, as appropriate.

c. The Army Auditor General shall complete the audit of the U.S. Army Medical Command Ombudsman Program and shall provide me his report of same no later than 180 days from the date of this directive.

6. The following officials shall provide general support to me, the CSA, the Under Secretary, the VCSA, the Task Force and to any Army official or organization designated herein, throughout the pendency of this matter:

a. The Chief of Legislative Liaison (CLL) shall communicate with Congress and coordinate, as appropriate, with the Assistant Secretary of Defense for Legislative Affairs on all matters related to the development and execution of the comprehensive corrective action plan and related actions. In addition, the CLL will assist in the preparation of information for Members of Congress and shall ensure the accuracy, consistency and synchronization of responses to Congressional inquiries and requests for information and documents related to these matters. All actions and communications by the Budget Congressional Liaison, Office of the Assistant Secretary of the Army (Financial Management and Comptroller) (SAFM-BUL) in regard to the matters at issue, shall be undertaken in full coordination with the CLL.

b. The Chief of Public Affairs (CPA) will ensure appropriate coordination with the Assistant Secretary of Defense (Public Affairs), prepare appropriate public affairs guidance in anticipation of the public announcement of Army activities regarding the development and execution of the comprehensive corrective action plan and related matters and shall spearhead the development and execution of the Army Strategic Communication effort in this matter.

c. The General Counsel and The Judge Advocate General shall ensure the provision of appropriate legal support to the efforts described above.

d. The Administrative Assistant to the Secretary of the Army, in coordination with the Director of the Army Staff, shall provide the Under Secretary of the Army, the VCSA, the Task Force and the officials enumerated above, with appropriate administrative support, to include National Capital Region Office space and office furnishings, equipment and supplies, as may be available.

e. The Assistant Secretary of the Army (Financial Management and Comptroller) shall coordinate additional funding, as available, that may be required by the Under Secretary of the Army, the VCSA, the Task Force and by the officials and organizations enumerated above in the execution of tasks assigned by this directive.

7. The Under Secretary of the Army and the VCSA will work with the CSA and me to provide appropriate information and liaison to the Office of the Secretary of Defense and to the Chairman of the Joint Chiefs of Staff.

8. The Under Secretary and the VCSA will provide the CSA and me with Interim Progress Reviews at 30-day intervals, beginning on the date of this directive. Except as otherwise stated, the officials and organizations named in this directive, including the Task Force, will complete all assigned and implied tasks and submit to the CSA and me a report documenting same, together with their findings and any recommendations for follow-on action, within 210 days from this date.

9. Although the effort described above focuses on behavioral health diagnoses and evaluations, should any official or organization tasked become aware of information, or make findings and recommendations that may affect aspects of the DES/IDES as regards other medical or health conditions, that official or organization shall bring to the attention of appropriate officials the broader context to which such information, finding or recommendation may be applicable.

10. Nothing in this memorandum is intended to be construed as interfering with or undermining the independent discretion of commanders or supervisors in determining the appropriateness of any disciplinary or adverse action within their purview and relating to the matters at issue.

11. All commands, organizations, activities and personnel of the Department of the Army will fully support the above named officials and organizations in the execution of their tasks.

John M. McHugh

Enclosure

SUBJECT: Comprehensive Review and Corrective Action Plan

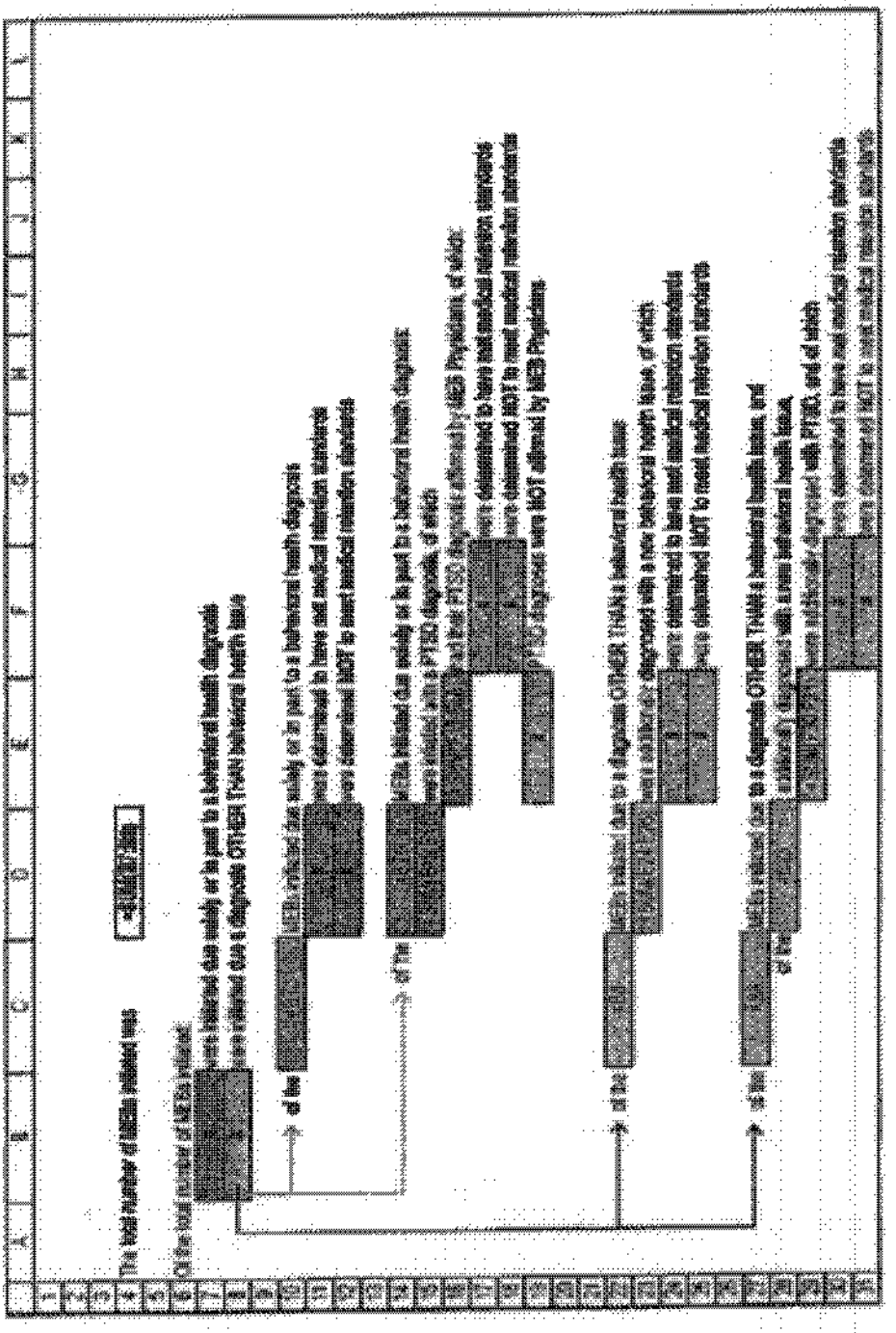
DISTRIBUTION:
Principal Officials of Headquarters, Department of the Army
Commander
- U.S. Army Forces Command
- U.S. Army Training and Doctrine Command
- U.S. Army Materiel Command
- U.S. Army Europe
- U.S. Army Central
- U.S. Army North
- U.S. Army South
- U.S. Army Pacific
- U.S. Army Africa
- U.S. Army Special Operations Command
- Military Surface Deployment and Distribution Command
- U.S. Army Space and Missile Defense Command/Army Forces Strategic Command
- Eighth U.S. Army
- U.S. Army Network Enterprise Technology Command/9th Signal Command (Army)
- U.S. Army Medical Command
- U.S. Army Intelligence and Security Command
- U.S. Army Criminal Investigation Command
- U.S. Army Corps of Engineers
- U.S. Army Military District of Washington
- U.S. Army Test and Evaluation Command
- U.S. Army Installation Management Command

Superintendent, U.S. Military Academy
Director, U.S. Army Acquisition Support Center

CF:
Director, Office of Business Transformation
Commander, U.S. Army Cyber Command
Executive Director, Army National Cemeteries Program

SUBJECT: Comprehensive Review and Corrective Action Plan

Enclosure 1



9

a. All Army Activities (ALARACT) 148/2011: Overview of the Integrated Disability Evaluation System (IDES) for Installation Company/Detachment Pre-Command Courses (PCC) or Orientation, 14 April 2011

b. All Army Activities (ALARACT) 159/2012, Enlisted Administrative Processing – Final Medical Disposition, June 2012

c. American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR). Arlington, VA.

d. Army Regulation (AR) 5-1, Total Army Quality Management, 15 March 2002

e. Army Regulation (AR) 11-2, Managers' Internal Control Program, 26 March 2012 (RAR)

f. Army Regulation (AR 20-1), Inspector General Activities and Procedures, 03 July 2012 (RAR)

g. Army Regulation (AR) 40-66, Medical Administration and Healthcare Documentation, 4 January 2010

h. Army Regulation (AR) 40-400, Patient Administration, 15 September 2011(RAR)

i. Army Regulation (AR) 40-501, Standards of Medical Fitness, 04 August 2011 (RAR)

j. Army Regulation (AR) 135-178, Enlisted Administrative Separations, 13 September 2011 (RAR)

k. Army Regulation (AR) 635-40, Physical Evaluation for Retention, Retirement or Separation, 20 March 2012 (RAR)

l. Army Regulation (AR) 635-200, Active Duty Enlisted Administrative Separations, 17 December 2009 (RAR)

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m. Department of the Army (DA) A Memorandum for Presidents, U.S. Army Physical Evaluation Boards (PEBs), Instructions for Completing DA Form 7652, Physical Disability Evaluation System (PDES) Commander's Performance and Functional Statement, December 14, 2010

n. Department of the Army Warrior Transition Unit Consolidated Guidance (Administrative), 20 March 2009

o. Department of Defense Instruction1332.38, Physical Disability Evaluation, 01 July 2006

p. Department of Defense Instruction 6490.10, Continuity of Behavioral Health Care for Transferring and Transitioning Service Members , March 26, 2012

q. Directive-Type Memorandum (DTM) on Implementing Disability Related Provisions of the National Defense Authorization Act of 2008, (Pub 1. 110-181), March 13, 2008

r. Directive Type Memorandum 11-015, Integrated Disability Evaluation System, 03 May 2012

s. Executive Order (EXORD) 080-12, Army DES Standard, 17 February 2012

t. Executive Order (EXORD) 180-11 Execution of The Reserve Component Soldier Medical Support Center (RC SMSC)

u. HQDA Letter 635-08-01, DA 7652, Physical Disability Evaluation System (PDES) Commander's Performance and Functional Statement, 8 December 2008

v. Memorandum of Agreement (MOA) between Department of Veterans Affairs (VA) and Department of Defense (DoD), Subject: Expansion of the *DoD/VA* Integrated Pilot Disability Evaluation System (IPDES) Providing a Single Disability Evaluation/Transition Medical Examination and Single Source Disability Rating, 16 January 2009

w. National Defense Authorization Act (NDAA) for Fiscal Year 2008, Public Law 110–181, 110th Congress, 28 January 2008

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x. National Guard Regulation (NGR) 600-200, Enlisted Personnel Management, 31 July 2009

y. Operations Order (OPORD) 11-35, Implementation of the IDES in AMEDD, 29 April 2011
   1) FRAGO 1 (01 August 2011)
   2) FRAGO 2 (03 August 2011)
   3) FRAGO 3 (27 October 2011)

z. Operations Order (OPORD) 12-31, MEDCOM Implementation of IDES, 05 April 2012
   1) FRAGO 1 (161900Q July 2012), Annex O
   2) FRAGO 2 (101430Q August 2012)
   3) FRAGO 3 (170900Q September 2012)
   4) Appendix 1: OTSG/MEDCOM Memorandum, Subject: Summary of MEB Core Implementation Policy, OPORD 12-31,
   5) Appendix 2, NARSUM Guide Book, undated

aa. OTSG/MEDCOM Policy 11-046, Medical Evaluation Board (MEB) Processing Guidance, 10 June 2011

bb. OTSG/MEDCOM Policy 12-035, Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder, 10 April 2012

cc. Under-Secretary for Defense Policy Memorandum, Subject: Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008 (Pub 1. 110-181), October 14, 2008

dd. Veterans Administration Fast Letter 12-07, 9 March 2012

ee. Veterans Affairs (VA)/Department of Defense (DoD) (2010). Clinical Practice Guideline for the Management of Post-Traumatic Stress. The Management of Post-Traumatic Stress Working Group, Version 2.0.

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ff. Warrior Transition Battalion-Europe, OPORD 12-017 Execution of Europe OCONUS IDES, Exception to Policy, 101200 July 2012

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10

ACRONYMS:

AC
Active Component

AHLTA
Armed Forces Health Longitudinal Technology Application

ALARACT
All Army Activities

AMC
Army Medical Center

AMEDD
United States Army Medical Department

APA
American Psychiatric Association

AR
Army Regulation

ARFORGEN
Army Force Generation

ASD(HA)
Assistant Secretary of Defense for Health Affairs

ASD(RA)
Assistant Secretary of Defense for Reserve Affairs

BCMR
Board for Correction of Military Records

BH
Behavioral Health

BHD
Behavioral Health Division

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C&P
Compensation and Pension

CAPRI
Compensation and Pension Record Interchange system

CBWTU
Community Based Warrior Transition Unit

CCFSC
Company Commander-First Sergeant Course

CDR
Commander

CIO
Chief Information Office

CoC
Chain of Command

Compo
Component

CONOP
Current Operation Plan

CONUS
Continental United States

DA
Department of the Army

DAC
Disability Advisory Council

DAIG
Department of the Army Inspector General

DAJA-AL
Office of the Judge Advocate General – Administrative Law

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DASD (WWCTP)
Deputy Assistant Secretary of Defense (Wounded Warrior Care and Transition Policy)

DCA
Deputy Commander for Administration

DCS
Deputy Chief of Staff

DCCS
Deputy Commander for Clinical Services

DES
Disability Evaluation System

DHA
Direct Hire Authority

DoD
Department of Defense

DMDC
Defense Manpower Data Center

D-RAS
Disability evaluation system Rating Activity Site

DRO
Decision Review Officer

DSM
Diagnostic and Statistical Manual of Mental Disorders

DSM-IV-TR
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision

DSM-V
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

DTM
Directive-Type Memorandum

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eDES
Electronic Disability Evaluation System

eMEB
Electronic Medical Evaluation Board

EMR
Electronic Medical Record

ePEB
Electronic Physical Evaluation Board

eProfile
Electronic Profile

EPTS
Existing Prior To Service

ES
Execution Shortfalls

EXORD
Execution Order

FRAGO
Fragmentary Order

FPEB
Formal Physical Evaluation Board

FY
Fiscal Year

GCMCA
General Court Martial Convening Authority

GOSC
General Officer Steering Committee

HIPAA
Health Insurance Portability and Accountability Act

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HQDA
Headquarters, Department of the Army

HRC
United States Army Human Resources Command

IAW
In Accordance With

ICW
In Coordination With

IDES
Integrated Disability Evaluation System

IEHR
Integrated Electronic Health Record

IET
Initial Entry Trainee

IG
Inspector General

IMR
Impartial Medical Review

IOC
Initial Operating Capacity

IPDES
Integrated Pilot Disability Evaluation System

IPR
Impartial Provider Review

IT
Information Technology

JAG
Judge Advocate General

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JBLM
Joint Base Lewis-McChord

IMCOM
United States Army Installation Management Command

IMR – Impartial Medical Review

IPEB
Informal Physical Evaluation Board

IPR – Impartial Provider Review

JPTA
Joint Patient Tracking Application

LoA
Line of Action

LoD
Line of Duty

MEB
Medical Evaluation Board

MEBITT
Medical Evaluation Board Internal Tracking Tool

MEBROC
Medical Evaluation Board Remote Operating Cell

MEBTO
Medical Evaluation Board Tracking Office

MEDCOM
United States Army Medical Command

MILPER
Military Personnel

MTT
Mobile Training Teams

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MOS
Military Occupational Specialty

MRDP
Medical Retention Determination Point

MSC
Military Services Coordinator

MTF
Military Treatment Facility

NARSUM
Narrative Summary

NCOES
Non-Commissioned Officer Education System

NCR
National Capitol Region

NDAA
National Defense Authorization Act

NG
National Guard

NGB
National Guard Bureau

NOD
Notice of Disagreement

OCONUS
Outside the Continental United States

OES
Officer Education System

OPORD
Operations Order

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OTJAG
Office of The Judge Advocate General

OTSG
Office of the Surgeon General (Army)

PAD
Patient Administration Division (Directorate)

PCC
Pre-Command Course

PCS
Permanent Change of Station

PD
Position Description

PDA
(United States Army) Physical Disability Agency (USAPDA)

PDES
Physical Disability Evaluation System

PEB
Physical Evaluation Board

PEBLO
Physical Evaluation Board Liaison Officer

PO
Process Oversight

POC
Point of Contact

POI
Program of Instruction

PTDY
Permissive Temporary Duty

PTSD
Post-Traumatic Stress Disorder

RAR
Rapid Action Revision

RC
Reserve Component

RC-SMSC
Reserve Center – Soldier Medical Support Center

RMC
Regional Medical Command

SC
Synchronization Concerns

SECARMY
Secretary of the United States Army

SFAC
Soldier Family Assistance Center

SJA
Staff Judge Advocate

SM
Service Member

SMC
Senior Mission Commanders

SME
Subject Matter Expert

SMEBC
Soldiers' Medical Evaluation Board Counsel

SOC
Statement of Case

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SPDC
Separation Program Designator Code

STR
Service Treatment Record

TAG
The Adjutant General

TBI
Traumatic Brain Injury

TDRL
Temporary Disability Retired List

TIG
The Inspector General

TRADOC
United States Army Training and Doctrine Command

TRANSPROC
Transition Point Processing System

UCMJ
Uniform Code of Military Justice

USA
United States Army

USACE
United States Army Corps of Engineers

USAMEDCOM
United States Army Medical Command

USAF
United States Air Force

USD (P&R)
Under Secretary of Defense, Personnel and Readiness

USMC
United States Marine Corps

USN
United States Navy

USARC
United States Army Reserve Component

VA
Department of Veterans Affairs

VASRD
Veterans Administration Schedule for Rating Disabilities

VBA
Veterans Benefits Administration

VERIS
Veterans Examination Request Information System

VETSNET
Veterans Service Network

VCAA
Veterans Claims Assistance Act

VCSA
Vice Chief of Staff of the Army

VHA
Veterans Health Administration

VIP
Veterans Information Portal

VISTA
Veterans Health Information Systems and Technology Architecture

VTA
Veterans Tracking Application

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WOES
Warrant Officer Education System

WTU
Warrior Transition Unit

WWCTP
Wounded Warrior Care and Transition Policy

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11

SAIG-ID

Subject: Enclosure 11 (Ongoing Actions) to Memorandum, Subject Inspection of the Behavioral Health Process; Disability Evaluation System and Integrated Disability Evaluation System

DAIG Recommendation #	Subject	Task	Suspense	Status	Lead	Support	Action	Status Details
[illegible]								
PD-1.1	MEB	Add MEB processing capability	1-Oct-12	[illegible]	OTSG		IDW, MEDCOM recently established two additional MEB/PEOs at JBLM and Fort Carson and is evaluating the need for further expansion	Establishing additional capacity for MEB processing by establishing MEB Remote Operations Centers (MEB ROCs)
PD-1.1	PEB	Increase PEB output	1-Nov-12	[illegible]	G-1 PDA		PDA recently directed PEB to reduce "informal" PEB staffing from three to two board members. Formal PEB membership remains unchanged at three members	Increasing PEB throughput without impacting quality control or having adverse impact on Soldier rights
PD-2.2	Standards	Achieve IDES Standardization – Ensure all community provisions standard	31-Jan-13	[illegible]	MEDCOM		IDW, MEDCOM has directed MEDCOM IG to conduct a compliance inspection of the [illegible] elements of Annex O	MEDCOM IG is conducting compliance visits to confirm execution (under Annex O guidance). ACTION COMPLETE
PD-4.1	IDES Proponency	Develop a credible proponent capability for the IDES process	1qtr	[illegible]	G-1	HRC	[redacted] (b)(6) [redacted] assigned as IDES Champion	Identified personnel "Champion" responsible for oversight and coordination of proponent actions & guidance to all IDES actors
PD-4.1	Standards	Achieve IDES Standardization – Ensure all commands have one standard	1-Oct-12	[illegible]	OTSG	G-1, VA	MEDCOM, IDES Standardization (Guidebook issued)	Guidebook issued to each installation / MTF that schedule IDES MEB processes will maintain a certified and validated standard operating procedure and provide appropriate socialization
[illegible]								
SD-1.1	IDES Proponency	Establish a formal method for routine discussion of IDES-related policies to synchronize the implementation of regulatory changes across Army	1-Dec-12	[illegible]	G-1	MEDCOM	First data-sharing forum occurred 27 week in October; we found was institutionalizing processes	Created an effective forum for addressing complexity of IDES program to ensure all elements of the program are communicated, coordinated, and implemented across the force
SD-2.1	OCONUS-WTUs	Improve the current process for OCONUS IDES Soldiers – ensure communication and assistance to Soldiers in CONUS WTU	1-Sep-12	[illegible]	WTUs		FRAGO 4 to MEDCOM OPORD 12-31 currently in staffing	MEDCOM IDES PAD developed Annex H (DOCUMENTIDES) to MEDCOM OPORD 12-31 (IDES Implementation) to improve and standardize processes. FRAGO 4 to MEDCOM OPORD 12-31 currently in staffing
SD-3.1	IDES IT	Develop and implement an end-to-end IDES IT Tracking Solution	1-Jan-13	[illegible]	G-1 PDA	DPD / G-8	Contract established for an end-to-end IT solution	Contract will allow an end-to-end IT solution to track status of Soldier's actions in IDES
SD-6.1	Legal Options	Improve Commanders' understanding of options available to address Soldier's misconduct or substandard performance while Soldier is Pending Medical Disposition from MEB or PEB	N/A	[illegible]	OTJAG (DAJA-AL)	G-1	OTJAG published an Information Paper on 28 August 2012, SUBJECT: Actions Action Processing While Pending Medical Disposition	Provide Information Paper highlighting actions available for commanders and processes to follow to address misconduct or substandard performance when a Soldier is pending a Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB).
[illegible]								
ES-1.1	IDES	Ensure compliance and reinforce implementation of Annex O (MEB Phase Implementation Guidance to OPORD 12-31)	1-Oct-12	[illegible]	OTSG	G-1, VA	OTSG / MEDCOM FRAGO 2 (OPORD 12-31) provided protocols in Annex O (Implementation Guidance) and confirmation of required guidelines	Each installation / MTF that conducts IDES MEB processes will maintain a certified and validated standard operating procedure and provide appropriate socialization
ES-2.1	IDES Appeals	Ensure MEB, appeals and IWRs are conducted by an independent provider	1-Oct-12	[illegible]	OTSG	G-1, VA	IDES Guidebook issued on 1 Oct 12 reinforcing existing regulation that prohibits MEB members from appeal and IWR adjudication.	IDES Guidebook reiterates that Soldiers' **appeals and IWRs are to be conducted only by a provider** (independent of the MEB process for IWR that provided a NARSUM for the same physician diagnosis and review). Actions at ES-1.1 and PD-2.2 will add degree of assurance that guidance is followed.
ES-3.1	IDES – WTU	Ensure MEB/IDES briefings to all Soldiers upon arrival at a WTU - part of reception and integration operations	1-Oct-12	[illegible]	WTU		WTU in collaboration with MEDCOM PAD developed standardized familiarization for WTU/CBWTU Soldiers, Families and unit cadre (partial solution).	WTU IDW MEDCOM PAD developed the standardized IDES familiarization training for WTU/CBWTU Soldiers, Families and unit cadre. WTU published W10 OPORD 12-13 (IDES Familiarization Training in WTU/CBWTUs) on 24 Sep 12 and directed WTU/CBWTUs to begin IDES training as part of their Soldier in processing procedures. (Does not address IDES in the unit)
ES-4.1	IDES – PEBLO	Review of all PEBLO and support team Position Descriptions complete and standardized throughout MEDCOM	1-Oct-12	[illegible]	MEDCOM	G-1 CHRA	MEDCOM is conducting a review of all PEBLO and support team position descriptions.	Current fill rate for PEBLOs is 100% including contractors and ECDs but MEDCOM and CHRA are reviewing all PEBLO and support team Position Descriptions complete and standardized throughout MEDCOM
ES-4.1	IDES – PEBLO	Align PEBLOs to Units - Issue FRAGO - Suspense 28 Sep 12; Compliance 90 Days later	1-Oct-12	[illegible]	OTSG		OTSG / MEDCOM FRAGO 3 to OPORD 12-31 directed Alignment of PEBLOs to supported units (partial solution BCTs only).	MEDCOM published revised FRAGO 3 to MEDCOM OPORD 12-31 tasked to align PEBLOs to BCTs or 28 SEP 12, with a suspense of 1 OCT 12. Regional Medical Commands have submitted their PEBLO/Unit alignment matrices. (Updated 1 OCT).
ES-4.1	IDES – PEBLO	Improve PEBLO Customer Service by addressing training shortcomings so they can effectively perform their duties.	1-Oct-12	[illegible]	OTSG		OTSG monitoring customer service training across MEDCOM.	Developed Customer Service training for PEBLOs. MEDCOM trained 6 sites in Sep & Oct (Ft. Benning, Ft. Riley, and SANMC, Ft. Campbell, Ft. Hood and JBLM). Two person MTTs will travel to smaller PEBLO/IDES teams at RMCs. 28 Oct 12 full day of "**Bugs with the IWRCS**" added to the **JCADS MEM PEBLO / IDES** training curriculum. Remainder of PEBLO/IDES Staff Cadre training from Oct '12 - Jan '13. **Judge outcome by** using Participant Feedback, Evaluations and data from the WTU Satisfaction Survey
ES-4.2	IDES – PEBLO	Improve PEBLO Customer Service by addressing shortcomings of birth and on the job training	1-Oct-12	[illegible]	OTSG		PEBLO Mobile Training Teams (MTT) assigned	Created PEBLO Mobile Training Teams to address need for additional PEBLO training at smaller installations to address training shortfalls and lack of certification