

**Army Regulation 40–58**

**Medical Services**

# **Warrior Care and Transition Program**

**Headquarters  
Department of the Army  
Washington, DC  
23 March 2015**

**UNCLASSIFIED**

# ***SUMMARY***

AR 40-58

Warrior Care and Transition Program

This new regulation, dated 23 March 2015--

- o Implements Memorandum, Deputy Secretary of Defense, Subject: Medical Care for Members of the Armed Forces Recovering from Serious Injuries or Illness, 1 April 2010 (para 10-5).
- o Implements Department of Defense Directive 1241.01 (throughout).
- o Implements Department of Defense Instructions 1300.18, 1300.24, 1300.25, 1332.18, 1341.2, and 6490.04 (throughout).

Medical Services

Warrior Care and Transition Program

By Order of the Secretary of the Army:

RAYMOND T. ODIERNO  
General, United States Army  
Chief of Staff

Official:



GERALD B. O'KEEFE  
Administrative Assistant to the  
Secretary of the Army

**History.** This publication is a new Department of the Army regulation.

**Summary.** This regulation on the Warrior Care and Transition Program consolidates policies on the Comprehensive Transition Plan and Warrior care for transitioning wounded, ill, or injured Soldiers back into the force and/or Veteran status. It incorporates major Department of the Army changes in the Warrior Care and Transition Program. During the past 10 years, the Army has been heavily engaged in managing the health, welfare, and readiness of Soldiers who are wounded, ill, or injured. The Army created Warrior Transition Units and Community Based Warrior Transition Units to which Soldiers may be assigned or attached while undergoing medical care and rehabilitation. On 2 October 2013, The Secretary of the Army approved the realignment of Community Based Warrior Transition Units to Community Care Units to improve the care and transition of Soldiers across the Warrior Care and Transition Program. Community Care Units are aligned as companies under Warrior Transition Units

and are assigned on Army installations within their respective regional medical command. Thus, Warrior Transition Units when used in this regulation refer to both Warrior Transition Unit and Community Care Unit unless specifically stated otherwise.

**Applicability.** This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated.

**Proponent and exception authority.** The proponent of this regulation is the Office of the Surgeon General, unless otherwise delegated. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

**Army internal control process.** This regulation contains internal control provisions in accordance with AR 11–2 and identifies key internal controls that must be evaluated (see appendix B).

**Supplementation.** Supplementation of this regulation and establishment of command and local forms is prohibited without prior approval from The Surgeon General of the Army, 7700 Arlington Boulevard, Falls Church, VA 22042–5142.

**Suggested improvements.** Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Warrior Transition Command, G–3/5/7, Plans, Policy, and Procedures, Policy Writer, 200 Stovall Street, Suite 7S37, Alexandria, VA 22332–4009.

**Committee management.** AR 15–1 requires the proponent to justify establishing and/or continuing committee(s), coordinate draft publications, and coordinate changes in committee status with the U.S. Army Resources and Programs Agency, Department of the Army Committee Management Office (AARP–ZA), 9301 Chapek Road, Building 1458, Fort Belvoir, VA 22060–5527. Further, if it is determined that an established “group” identified within this regulation, later takes on the characteristics of a committee, as found in the AR 15–1, then the proponent will follow all AR 15–1 requirements for establishing and continuing the group as a committee.

**Distribution.** Distribution of this guidance is available in electronic media only and is intended for command levels C, D, and E for the Active Army, the Army National Guard, the Army National Guard of the United States, and the U.S. Army Reserve.

**Contents** (Listed by paragraph and page number)

**Chapter 1**

**Introduction, page 1**

*Section I*

*Overview, page 1*

Purpose • 1-1, *page 1*

References • 1-2, *page 1*

Explanation of abbreviations and terms • 1-3, *page 1*

Responsibilities • 1-4, *page 1*

Principles of support • 1-5, *page 1*

General • 1-6, *page 1*

*Section II*

*Responsibilities, page 2*

Assistant Secretary of the Army (Manpower and Reserve Affairs) • 1-7, *page 2*

Deputy Chief of Staff, G-1 • 1-8, *page 2*

The Surgeon General and/or Commanding General, U.S. Army Medical Command • 1-9, *page 2*

Assistant Chief of Staff for Installation Management • 1-10, *page 3*

Assistant Secretary of the Army (Financial Management and Comptroller) • 1-11, *page 4*

The Deputy Chief of Staff, G-3/5/7 • 1-12, *page 4*

Chief, National Guard Bureau • 1-13, *page 4*

Office of the Chief, Army Reserve and/or the Commanding General, U.S. Army Reserve Command • 1-14, *page 5*

Commanders of Army commands, Army service component commands, and direct reporting units • 1-15, *page 5*

*Section III*

*Non-Army Organizational Roles, page 5*

Office of Secretary of Defense — Office of Warrior Care Policy • 1-16, *page 5*

Defense Finance and Accounting Service • 1-17, *page 5*

Defense Health Agency • 1-18, *page 6*

Department of Veterans Affairs • 1-19, *page 6*

Department of Labor • 1-20, *page 6*

**Chapter 2**

**General, page 7**

*Section I*

*Organization of Warrior Transition Command, page 7*

Mission • 2-1, *page 7*

Purpose • 2-2, *page 7*

Army Wounded Warrior Program • 2-3, *page 7*

*Section II*

*Major Components of the Warrior Care and Transition Program, page 7*

Purpose • 2-4, *page 7*

Goal • 2-5, *page 7*

Warrior Transition Command • 2-6, *page 7*

Warrior Transition Units and Community Care Units • 2-7, *page 7*

Army Wounded Warrior Program • 2-8, *page 8*

Comprehensive Transition Plan • 2-9, *page 9*

Army Warrior Care and Transition System • 2-10, *page 9*

Career and Education Readiness Program • 2-11, *page 9*

Adaptive Reconditioning Program • 2-12, *page 10*

Organizational Inspection Program and Staff Assistant Visits • 2-13, *page 10*

## **Contents—Continued**

Community Partnership Programs • 2–14, *page 10*  
Soldier and Family Assistance Centers • 2–15, *page 10*

### *Section III*

*Roles and Responsibilities within the Warrior Care and Transition Program, page 11*  
Regional medical command • 2–16, *page 11*  
Regional Medical Command Warrior Transition Office • 2–17, *page 11*  
Commander military treatment facilities • 2–18, *page 12*  
Commander of Warrior Transition Units and Community Care Units • 2–19, *page 12*  
Headquarters and headquarters company, Warrior Transition Units • 2–20, *page 14*  
Soldier • 2–21, *page 14*  
Triad of Care • 2–22, *page 15*  
Triad of Leadership • 2–23, *page 16*  
The key brigade and battalion Warrior Transition Unit staff and support members • 2–24, *page 16*  
Key company Warrior Transition Unit staff members • 2–25, *page 21*  
Family readiness support assistants • 2–26, *page 25*  
Religious and spiritual care • 2–27, *page 25*

### *Section IV*

*Command Communication with Soldiers, page 25*  
Army goals • 2–28, *page 25*  
Town hall meetings and open door policy • 2–29, *page 25*

### *Section V*

*Government Owned and Leased Housing Assignment and Termination, Facility Maintenance, Inspection Standards, and Reporting, page 25*  
Background • 2–30, *page 25*  
Purpose • 2–31, *page 26*  
Policy • 2–32, *page 26*  
Lodging assignment and hospitality • 2–33, *page 26*  
Soldier transitions and lodging • 2–34, *page 26*  
Maintenance standards • 2–35, *page 26*  
Inspection standards • 2–36, *page 27*  
Reporting procedures • 2–37, *page 27*

### *Section VI*

*Medical Command Medical Assistance Group Ombudsmen Program, page 27*  
Background • 2–38, *page 27*  
Ombudsman Program • 2–39, *page 27*

## **Chapter 3**

### **Comprehensive Transition Plan, page 28**

Policy • 3–1, *page 28*  
Comprehensive Transition Plan structure • 3–2, *page 28*  
In-processing • 3–3, *page 29*  
Goal setting • 3–4, *page 29*  
Transition review • 3–5, *page 29*  
Rehabilitation • 3–6, *page 30*  
Reintegration • 3–7, *page 30*  
Post-transition • 3–8, *page 31*  
Triad meetings • 3–9, *page 31*  
Transition program metrics • 3–10, *page 32*  
Accountability • 3–11, *page 32*

## **Contents—Continued**

### **Chapter 4**

#### **Risk Assessment and Mitigation Planning, page 32**

##### *Section I*

*General, page 33*

Purpose • 4-1, page 33

Background • 4-2, page 33

Policy • 4-3, page 33

Management and mitigation • 4-4, page 34

Reassessment • 4-5, page 34

Responsibilities • 4-6, page 34

##### *Section II*

*High-Risk Medication Review and Sole Provider Program, page 37*

Policy • 4-7, page 37

Responsibilities • 4-8, page 37

### **Chapter 5**

#### **Medical Care Management, page 38**

##### *Section I*

*Primary Care, page 38*

Primary care manager • 5-1, page 38

Medical retention determination point • 5-2, page 38

Medical evaluation board referral • 5-3, page 38

Transition standards • 5-4, page 39

Medically optional surgeries, procedures, and treatments • 5-5, page 39

Service animals in Warrior Transition Units and Community Care Units • 5-6, page 39

##### *Section II*

*Case Management, page 40*

Nursing case management • 5-7, page 40

Education and training and certification • 5-8, page 40

Case management process • 5-9, page 40

##### *Section III*

*Clinical Social Work Care Management, page 41*

Purpose • 5-10, page 41

Policy • 5-11, page 41

Responsibilities • 5-12, page 41

Provision of behavioral health care standards and timelines • 5-13, page 41

Case complexity estimate • 5-14, page 44

Supportive counseling, brief treatment intervention, and referral • 5-15, page 44

Care management • 5-16, page 44

Clinical documentation in the medical record • 5-17, page 45

Limits of confidentiality for clinical information and consent to assessment and/or treatment • 5-18, page 45

Behavioral health information release • 5-19, page 45

Resources • 5-20, page 45

##### *Section IV*

*Occupational Therapy, page 45*

Purpose • 5-21, page 45

Policy • 5-22, page 45

Responsibilities • 5-23, page 45

Provision of occupational therapy registered care standards and timelines • 5-24, page 46

## **Contents—Continued**

### *Section V*

*Physical Therapy, page 47*

Purpose • 5–25, *page 47*

Policy • 5–26, *page 47*

Responsibilities • 5–27, *page 48*

Provisions of physical therapy care standards and timelines • 5–28, *page 48*

## **Chapter 6**

### **Human Resources and Administrative, page 50**

#### *Section I*

*Entry, Exit, and Transfer into the Warrior Care and Transition Program, page 50*

General • 6–1, *page 50*

Eligibility • 6–2, *page 50*

Ineligibility • 6–3, *page 50*

Procedures for medical retention processing for Reserve Component Soldiers • 6–4, *page 51*

Senior grade entry approval to Warrior Transition Units • 6–5, *page 51*

Location of care determination • 6–6, *page 51*

Exit criteria for component 1, and component 2 and 3 Active Guard Reserve Soldiers • 6–7, *page 52*

Exit criteria for component 2 and 3 Soldiers not in Army Guard Reserve status • 6–8, *page 52*

Unit notification • 6–9, *page 52*

Coordinating instructions and screening for entry into a Warrior Transition Unit • 6–10, *page 53*

Determination of eligibility and ineligibility for transfer to Community Care Units • 6–11, *page 53*

Exception to eligibility for transfer • 6–12, *page 54*

Care in a non-Army medical facility • 6–13, *page 55*

Administrative procedures for disposition of component 1 Soldiers assigned in continental United States Warrior Transition Units • 6–14, *page 56*

Disposition of non-mobilized Reserve component personnel • 6–15, *page 56*

Non-Army personnel • 6–16, *page 56*

Geographically dispersed personnel • 6–17, *page 56*

#### *Section II*

*Cadre Assignments, page 56*

Cadre selection • 6–18, *page 56*

Approval authorities for assignments of cadre • 6–19, *page 57*

Component mismatch assignments. • 6–20, *page 57*

Responsibilities • 6–21, *page 58*

Cadre stability • 6–22, *page 58*

Exemption from Professional Filler System • 6–23, *page 58*

Collateral duty exemption • 6–24, *page 59*

#### *Section III*

*Career and Education Readiness Work Site Selection, page 59*

Definition • 6–25, *page 59*

Policy • 6–26, *page 59*

Continental United States and outside the continental United States work site placement • 6–27, *page 59*

#### *Section IV*

*Leave and Passes, page 59*

Leave and Pass Management Program • 6–28, *page 59*

Respite Pass Program • 6–29, *page 60*

Medical care while on leave or pass • 6–30, *page 60*

Removal from the Warrior Care and Transition Program – Non-compliance to the Warrior Care and Transition Program • 6–31, *page 60*

## **Contents—Continued**

### *Section V*

*Army Body Composition Program, page 61*

General • 6–32, *page 61*

Exemption • 6–33, *page 62*

### *Section VI*

*Inspection Programs, page 62*

Organizational Inspection Program • 6–34, *page 62*

Staff Assistance Visits • 6–35, *page 62*

## **Chapter 7**

### **Automation Systems Supporting the Warrior Care and Transition Program, page 62**

#### *Section I*

*The Army Warrior Care and Transition System, page 62*

Purpose • 7–1, *page 62*

General • 7–2, *page 63*

Responsibilities • 7–3, *page 63*

#### *Section II*

*Medical Operational Data System-Warrior Transition, page 63*

Purpose • 7–4, *page 63*

Responsibilities • 7–5, *page 63*

## **Chapter 8**

### **Community Partnership and Interaction, page 64**

#### *Section I*

*Donations, page 64*

General • 8–1, *page 64*

Acceptance of donations • 8–2, *page 64*

Solicitation of gift and donation • 8–3, *page 65*

#### *Section II*

*Community Organizations Support, page 65*

Use of Community Organizations Support • 8–4, *page 65*

The Community Support Network • 8–5, *page 65*

Types of Services • 8–6, *page 65*

Rules and limitations affecting the community support network • 8–7, *page 66*

Organizations not accepted into the community support network • 8–8, *page 66*

## **Chapter 9**

### **Family Programs, page 66**

#### *Section I*

*Family Support Groups, page 66*

Warrior Transition Unit Family Readiness Support Assistance • 9–1, *page 66*

Family Readiness Groups • 9–2, *page 67*

#### *Section II*

*Nonmedical Attendants, page 68*

Background • 9–3, *page 68*

Entitlements • 9–4, *page 68*

Nonmedical attendant responsibilities • 9–5, *page 69*

Command responsibilities • 9–6, *page 70*

Nonmedical attendant designation process • 9–7, *page 71*

## **Contents—Continued**

Removal from nonmedical attendant status • 9–8, *page 72*

Nonmedical attendant training requirements • 9–9, *page 72*

### *Section III*

*Memorial Ceremonies and Services, page 72*

Background • 9–10, *page 72*

Policy • 9–11, *page 72*

## **Chapter 10**

**Benefits and Special Compensation, page 73**

### *Section I*

*Special Compensation for Assistance with Activities of Daily Living, page 73*

Background • 10–1, *page 73*

Appeal process • 10–2, *page 73*

### *Section II*

*Family Caregiver Benefit and Compensation, page 73*

Direct billing for nonmedical attendant lodging expenses at Veterans Health Administration Polytrauma Rehabilitation Centers • 10–3, *page 73*

Military escorts for Family members or nonmedical attendants traveling on official orders at Warrior Transition Units only • 10–4, *page 73*

Medical care benefit for caregivers of members of the Armed Forces recovering from serious injuries or illnesses • 10–5, *page 73*

## **Chapter 11**

**Training Requirements, page 74**

### *Section I*

*Warrior Transition Unit Orientation and Sustainment Training, page 74*

Warrior Transition Unit training requirements • 11–1, *page 74*

Training priorities • 11–2, *page 74*

Required unit training • 11–3, *page 74*

Required leader training • 11–4, *page 75*

Major training events • 11–5, *page 76*

Training safety • 11–6, *page 76*

### *Section II*

*Adaptive Reconditioning Program, page 76*

Purpose • 11–7, *page 76*

Background • 11–8, *page 76*

Adaptive reconditioning team • 11–9, *page 76*

Policy • 11–10, *page 76*

Adaptive reconditioning equipment • 11–11, *page 77*

Responsibilities • 11–12, *page 77*

### *Section III*

*Comprehensive Soldier and Family Fitness, page 81*

General • 11–13, *page 81*

Responsibilities • 11–14, *page 81*

Unit requirement • 11–15, *page 81*

## **Appendixes**

**A.** References, *page 82*

**B.** Internal Control Evaluation, *page 90*

## **Contents—Continued**

### **Table List**

Table 6–1: Current location fields, *page 55*

### **Figure List**

Figure 5–1: Algorithmic summary of the management of optional surgeries, *page 49*

### **Glossary**

# Chapter 1 Introduction

## Section I Overview

### 1–1. Purpose

This regulation prescribes the organization and functions of the Warrior Transition Unit (WTU) to include the Community Care Unit. It specifies regulatory guidance and establishes standards for the operational activities conducted by assigned and attached cadre personnel in supporting the Comprehensive Transition Plan (CTP), including all clinical and non-clinical care. This regulation further provides clear guidance regarding expectations for the personal conduct of WTU Soldiers.

### 1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

### 1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this publication are explained in the glossary.

### 1–4. Responsibilities

Responsibilities are listed in section II of chapter 1.

### 1–5. Principles of support

*a.* The Warrior Transition Command (WTC) is subordinate and reports directly to the Commander of the U.S. Army Medical Command (MEDCOM). The Commander of the WTC is also the Assistant Surgeon General (ASG) for Warrior Care and Transition and reports to The Surgeon General (TSG). The WTC provides strategic oversight and policy development support for the Office of The Surgeon General (OTSG)/MEDCOM Warrior Care and Transition Program (WCTP) and provides a focal point for the coordination and support of the Warrior Transition mission.

*b.* Regional medical commands (RMCs) exercise mission command of military treatment facilities (MTFs) within their regions except for the National Capital Region (NCR).

*c.* MTFs exercise mission command of WTUs within their areas of support and ensure quality care is provided to wounded, ill, or injured Soldiers (except for the NCR).

*d.* WTUs are subordinates to the MTFs and provide mission command, primary care, and medical management (M2) for Soldiers; establish the conditions for their healing; and promote timely return to the force and/or transition to Veteran status.

*e.* WTUs within the NCR are directly subordinate to the northern RMC.

*f.* The regional Warrior Transition Offices (WTOs) implement strategic direction and execute plans, policies, and resources for warrior care initiatives and programs dedicated to the support, care, and healing of wounded, ill, or injured Soldiers, within their respective regions.

*g.* The Army Medical Department Center and School (AMEDDC&S) is subordinate and reports directly to the Commander of the MEDCOM. The School is the education and training proponent for the MEDCOM.

*h.* Cadre and Family or caregivers work together to ensure advocacy for Soldier's continuity of care, and seamless transition back to the force and/or to Veteran status.

### 1–6. General

*a.* WTUs are designed to meet the needs of Soldiers who are wounded, ill, or injured and who require medical case management through the Triad of Care and other medical and nonmedical providers forming an interdisciplinary team.

*b.* The Triad of Leadership consists of the senior commander (SC) and command sergeant major (CSM); the MTF commander and CSM; the WTU commander and CSM, and first sergeant (1SG). The Triad of Leadership executes policy for the WTU entry, management, and exit of a Soldier in order to maintain a balanced WTU structure and capability that is dynamic and responsive to the medical needs of every Soldier.

*c.* The Triad of Care consists of the primary care manager (PCM), nurse case manager (NCM), and squad leader (SL) or platoon sergeant (PSG) forming the M2 and mission command. This Triad of Care works in concert with the Triad of Leadership and other medical and nonmedical providers to develop a plan of care, specific to each Soldier that addresses medical treatment, administrative and support needs, and disposition. Each assigned WTU Soldier receives a Triad of Care to direct and supervise the healing process.

*d.* The interdisciplinary team includes all personnel to include the Triad of Care that play a role in the Soldier's healing, recovery, and transition.

*e.* A WTU Soldier is a wounded, ill, or injured Soldier who requires clinical and case management through the

Triad of Care. A WTU Soldier falls under the mission command and M2 of a WTU. A WTU Soldier's primary mission is to heal and transition.

f. Assignment or attachment of a Soldier to a WTU will not be performed solely to facilitate the early requisitioning of replacement personnel or for purely compassionate reasons.

## **Section II Responsibilities**

### **1-7. Assistant Secretary of the Army (Manpower and Reserve Affairs)**

The ASA (M&RA) will—

- a. Provide overall policy oversight for administrative management of WTU Soldiers.
- b. Coordinate, as necessary, personnel policy for WTUs with Headquarters, Department of the Army (HQDA) staff elements, other Army commands (ACOMs), Army service component commands (ASCCs), and direct reporting units (DRUs).
- c. Assist the Deputy Chief of Staff, G-1, (DCS, G-1) in developing WTU administrative management in coordination with MEDCOM, Office of the Assistant Chief of Staff, Installation Management (OACSIM), U.S. Installation Management Command (IMCOM), U.S. Army Human Resources Command (HRC), Physical Disability Agency (PDA), National Guard Bureau (NGB), U.S. Army Reserve (USAR), U.S. Financial Management Command (USAFMCOM), and Defense Finance and Accounting Service (DFAS).

### **1-8. Deputy Chief of Staff, G-1**

- a. The DCS, G-1 will—
  - (1) Develop personnel policy for WTU Soldiers administrative management in coordination with ASA (M&RA), OACSIM, MEDCOM, HRC, PDA, NGB, USAR, USAFMCOM, and DFAS.
  - (2) Provide policy guidance for WTU Soldiers as directed by ASA (M&RA).
  - (3) Monitor and update Department of Army personnel policies pertaining to the WCTP.
  - (4) Advocate and implement Department of Army policies that support the WCTP.
  - (5) Develop and implement policies for the management of the Army Physical Disability Evaluation System (PDES).
- b. U.S. Army PDA Director will—
  - (1) Assist the DCS, G-1 in developing personnel policy for WTU operations in coordination with ASA (M&RA), MEDCOM, IMCOM, HRC, NGB, USAR, USAFMCOM, and DFAS.
  - (2) Coordinate with DCS, G-1 and develop policies, procedures, and programs for the management of the PDES.
  - (3) Approve disability findings for the Secretary of the Army (SECARMY) except in those cases in which the decision is reserved to higher authority.
  - (4) Manage the temporary disability retired list.
- c. The DCS, G-1 delegates WCTP personnel administrative oversight to the Commanding General (CG), HRC. The CG HRC will—
  - (1) Assist the DCS, G-1, in developing personnel policy for WTU operations in coordination with ASA (M&RA), MEDCOM, OACSIM, PDA, NGB, USAR, USAFMCOM, and DFAS.
  - (2) Develop procedures for technical and quality control of personnel actions, assignment, attachment, and ensure accountability and Soldier welfare for WTUs.
  - (3) Provide military personnel administrative support for WTU operations.
  - (4) Ensure the PDA coordinates with DCS, G-1 and develops policies, procedures, and programs for the management of the PDES.
  - (5) Ensure PDA manages WTU cases referred to the physical evaluation board (PEB) are processed timely and effectively.
  - (6) Act as the proponent for the Soldier for Life – Transition Assistance Program.

### **1-9. The Surgeon General and/or Commanding General, U.S. Army Medical Command**

- a. TSG and/or CG, MEDCOM will—
  - (1) Assist the DCS, G-1 in developing personnel policy for WTU operations in coordination with the ASA (M&RA), OACSIM, IMCOM, HRC, PDA, NGB, USAR, USAFMCOM, and DFAS.
  - (2) Support synchronizing efforts of NGB, Office of the Chief, Army Reserve (OCAR), and other agencies in support of WTU operations.
  - (3) Develop and implement medical standards and policy to support WTU operations, to include provision of clinical care, case management, monitoring outcomes, treatment tracking, ensuring appropriate and adequate clinical resources and support, and providing staff orientation and education.
  - (4) Provide overall technical supervision and quality control over all medical aspects of the WCTP.

- (5) Manage and provide manpower and funding requirements to support WTU operations.
- (6) Maintain ownership of WTU dedicated assets, tasking authority, and funding responsibility.
- (7) Establish medical decision criteria, and make individual evaluations on type and location of medical treatment for Soldiers.
- (8) Ensure the RMCs provide mission command, personnel, logistical, fiscal, legal, chaplain, and communications coordination and support to WTUs.
- (9) Establish technical procedures to conduct quality assurance review of the medical evaluation board (MEB) and the physical evaluation board liaison officer (PEBLO) functions.
- (10) Provide personnel, logistical, and finance support for WTU operations.
- (11) Exempt WTU cadre and WTC staff from Professional Officer Filler System (PROFIS), medical augmentee, and individual assignments. Exceptions apply (see para 6–23).
- (12) Exempt WTU Soldiers and cadre from performing collateral duties (for example, staff duty officer, staff duty noncommissioned officer (NCO), charge of quarters, financial liability investigations of property loss (FLIPLs), funeral duties) (see para 6–24 for additional details).
- (13) The AMEDDC&S will design, develop, and conduct WTU and cadre training in collaboration with WTC.
  - b.* Warrior Transition Commander will—
    - (1) Act as the proponent for policies on the WCTP.
    - (2) Establish, revise, and set the conditions for the implementation of policies to execute the Army's WCTP.
    - (3) Set the strategic mission and vision for the WTUs.
    - (4) Conduct command and staff inspections, as well as staff assistance visits (SAVs) to ensure WTUs comply with policies and procedures.
    - (5) Coordinate through MEDCOM with USAFMCOM for Organizational Inspection Program (OIP) support from DFAS.
    - (6) Manage manpower and funding requirements in coordination with MEDCOM.
    - (7) Develop and conduct operational training for WTU and cadre.
    - (8) Provide personnel and finance support for WTU operations.
    - (9) Manage the Army Wounded Warrior (AW2) program for the severely wounded, injured, or ill Soldiers and Veterans.
    - (10) Synchronize the efforts of NGB, OCAR, and other agencies in support of WTU operations.

#### **1–10. Assistant Chief of Staff for Installation Management**

The Assistant Chief of Staff for Installation Management, through the CG, IMCOM, will—

- a.* Collaborate as required with the DCS, G–1 in developing personnel policy for WTU operations in coordination with ASA (M&RA), OACSIM, MEDCOM, HRC, PDA, NGB, USAR, USAFMCOM, Installation Defense Military Pay Office, Soldier and Family Assistance Center (SFAC), and Army Community Service (ACS).
- b.* Provide administrative policy guidance and procedures for WTU operations as directed by ASA (M&RA) DCS, G–1, and HRC.
- c.* Provide administrative, logistical, housing, and finance support for WTU operations.
- d.* Conduct IMCOM specific deployment cycle support, Stage V, re-deployment, and tasks for WTU Soldiers and their Families in accordance with the Department of the Army (DA) Deployment Cycle Support Directive located at <http://www.armyg1.army.mil/dcs>.
- e.* Ensure SFAC provide a continuum of services to WTU Soldiers, their Families, and caregivers.
- f.* Work with installation or garrison commander to provide appropriate buildings and support to resident WTU Soldiers.
- g.* Ensure Army Substance Abuse Program (ASAP) personnel work closely with the Triad of Care and the Triad of Leadership on WTU Soldiers attending ASAP services.
- h.* Ensure facilities meet Soldier accessibility needs in terms of meeting the Americans with Disability Act standards.
- i.* Develop interservice support agreement (ISSA) to support WTUs.
- j.* Through the Installation Soldier for Life–Transition Assistance Program Director will—
  - (1) Help eligible Army wounded, ill, or injured Soldiers, their Family members, and caregivers successfully transition from military service.
  - (2) Provide transition and employment personalized counseling and assistance.
  - (3) Assist Soldiers in applying to Federal jobs, how to locate and review vacancy announcements, create and submit resume, and track application status.
  - (4) Provide Veterans benefits briefings.

### **1–11. Assistant Secretary of the Army (Financial Management and Comptroller)**

The Assistant Secretary of the Army (Financial Management and Comptroller), through the Commander, USAFMCOM, will—

- a.* Assist the DCS, G–1 in developing personnel policy for WTU operations in coordination with OACSIM, IMCOM, HRC, PDA, NGB, USAR, USAFMCOM, and DFAS.
- b.* Conduct oversight of finance roles and responsibilities in all aspects of WTU operations, to include SFAC operations.
- c.* Coordinate and ensure compliance of finance procedures with installation MTF, WTU, and SFAC to obtain WTU Soldiers duty status and to maintain accurate pay accounts.
- d.* Coordinate and schedule with DFAS, military pay training on the Wounded Warrior pay management program and travel preparation.
- e.* Assist and train the financial management personnel in the WTU on technical support (military and travel pay, pay systems, security forms, software and so forth) and operations.
- f.* Brief WTU commanders, staff, and cadre personnel when necessary on the requirements and timely processing of military travel pay and other pay-affecting documents.
- g.* Coordinate with DFAS, Army National Guard (ARNG) and USAR Pay Ombudsman Offices for pay support and provide procedural, policy, and pay systems guidance.
- h.* Coordinate, when necessary, with DFAS, ARNG, and USAR Pay Ombudsman Offices to support the WCTP missions, SAVs, and OIPs.
- i.* Ensure compliance by finance offices on the DFAS Wounded Warrior Pay Management Program.
- j.* Provide assistance in resolving military pay or travel pay inquiries.

### **1–12. The Deputy Chief of Staff, G–3/5/7**

The DCS, G–3/5/7 will—

- a.* Ensure that the DA Military Operations Force Management Directorate (DAMO–FM) provides guidance for the organization, integration, decision-making, and execution of activities encompassing requirements definition, force development, force integration, force structure, combat elements, training developments, resourcing, and prioritization.
- b.* Ensure that Comprehensive Soldier and Family Fitness (DAMO–CSFF) will provide resilience training policy and guidance for the staff, Soldier, and Family (see chap 11).

### **1–13. Chief, National Guard Bureau**

The Chief, NGB through the Director, ARNG will—

- a.* Serve as the primary point of contact (POC) among DA and The Adjutant Generals (TAGs).
- b.* Assist DCS, G–1 in developing Reserve Component (RC) wounded, ill, or injured warrior policies in coordination with MEDCOM, OACSIM, IMCOM, HRC, PDA, USAR, USAFMCOM, and DFAS.
- c.* Provide personnel resources in support of the WCTP.
- d.* Coordinate and assist DFAS to complete pay account reviews and maintenance in accordance with the DFAS Wounded Warrior Pay Management Program.
- e.* Assist the USAFMCOM and DFAS to respond to inquiries or pay account audits, not limited to, Congressional, U.S. Government Accountability Office, U.S. Army Audit Agency, Department of the Army Inspector General and Department of Defense (DOD) Inspector General requests.
- f.* Coordinate, when necessary, with the USAFMCOM, DFAS, and ARNG Pay Ombudsman Offices to assist the local Defense Military Pay Offices and WTUs resolve military pay and travel pay inquiries, to include Family member travel voucher processing and payment.
- g.* Ensure the ARNG Financial Service Center located at DFAS–Indianapolis, processes medical retention processing orders into the reserve pay system for ARNG Soldiers. The ARNG Financial Service Center is also responsible for providing overall pay support to ARNG Soldiers attached to the Community Care Units.
- h.* Provide support and guidance to wounded, ill, or injured ARNG Soldiers and their Families regarding available benefits and entitlements as they transition through the medical care system.
- i.* Advocate and support ARNG wounded, ill, or injured Soldiers and their Family members in navigating Federal and State systems.
- j.* Ensure nonmedical needs are met through all the phases of the CTP.
- k.* Assist ARNG wounded, ill, or injured Soldiers and their Families with the necessary financial, educational, employment, legal, and medical resources.
- l.* Provide links to valuable Federal programs, including health care, retirement and disability compensation, transition assistance, Veterans Affairs (VA) adaptive housing and vehicle assistance, VA education and training, VA Vocational Rehabilitation and Employment (VR&E), and Department of Labor programs.
- m.* Provide quality candidates to fill all WCTP coded ARNG positions within a timely manner.

### **1–14. Office of the Chief, Army Reserve and/or the Commanding General, U.S. Army Reserve Command**

The OCAR and/or the CG, USARC will—

- a.* Assist the DCS, G–1 in developing personnel policy for WTU operations in coordination with MEDCOM, IMCOM, HRC, PDA, NGB, USAFMCOM, and DFAS.
- b.* Coordinate and assist DFAS to complete pay account reviews in accordance with the DFAS Wounded Warrior Pay Management Program.
- c.* Assist the USAFMCOM and DFAS respond to inquiries or pay account audits to comply with, but not limited to, Congressional, U.S. Government Accounting Office, U.S. Army Audit Agency, DA Inspector General, and DOD Inspector General requests.
- d.* Coordinate, when necessary, with the USAFMCOM, DFAS, and USAR Pay Ombudsman Offices to assist the local Defense Military Pay Offices and WTUs resolve military pay and travel pay inquiries, to include Family member travel processing and payment.
- e.* Provide, upon request, personnel for WTU and Community Care Units operations on-installation sites.
- f.* Provide quality candidates to fill all WCTP coded USAR positions within a timely manner.

### **1–15. Commanders of Army commands, Army service component commands, and direct reporting units**

These commanders will—

- a.* Ensure all WTU Soldiers on their installation are properly managed.
- b.* Ensure quality officers and NCOs are selected to serve as commanders, 1SGs, PSGs, and SLs for WTUs.
- c.* Ensure the WTU is staffed with the specified cadre assignment ratio.
- d.* Serve as a member of the Triad of Leadership.
- e.* Attend semiannual WTU town halls with Soldiers and Families.
- f.* Conduct sensing sessions with cadre, at minimum, annually.
- g.* Provide personnel, logistical, and finance support for WTU operations.
- h.* Exempt WTU cadre and WTC Staff from PROFIS, medical augmentee, and individual assignments. Exceptions apply (see para 6–23).
- i.* Exempt WTU Soldiers and cadre from performing collateral duties (for example, staff duty officer, staff duty NCO, charge of quarters, FLIPLs, funeral duties, and so forth) (see para 6–24 for additional details).
- j.* Ensure that temporary duty assignment (TDY) orders are issued for Soldiers who elect to make a personal appearance and testify before the PEB at the Soldier’s formal hearing. If a Soldier is represented by the Office of Soldier’s PEB Counsel, the Soldier must arrive at least one business day in advance of their hearing to allow for final hearing preparations with their assigned counsel during regular business hours.
- k.* Provide a numerical installation summary report to RMC commanders on Soldiers who have 18 months assigned or attached to the WTU without a MEB referral. RMC commanders will provide a community care unit numerical summary report to the MEDCOM commander.

## **Section III**

### **Non-Army Organizational Roles**

#### **1–16. Office of Secretary of Defense — Office of Warrior Care Policy**

The Deputy Assistant Secretary of Defense (Warrior Care Policy), under the authority, direction, and control of the Assistant Secretary of Defense for Health Affairs—

- a.* Manages the Education, Employment, and Internship Program and provides oversight of its implementation and guidance for continuous process improvement.
- b.* Synchronizes all programs and processes throughout the DOD that support the Education, Employment, and Internship Program and Operation Warfighter (OWF), including those provided by the Military Departments and United States Special Operations Command.
- c.* Ensures each Military Department and United States Special Operations Command have policies and procedures in place that provide education, employment, and internship support services and resources for recovering Servicemembers.
- d.* Verifies the accuracy and updates the content of information contained on the National Directory Web site.

#### **1–17. Defense Finance and Accounting Service**

*a.* The Director of DFAS assists DCS, G–1 in developing personnel policy for WTU operations in coordination with MEDCOM, OACSIM, IMCOM, HRC, PDA, NGB, USAR, and USAFMCOM. The DFAS Director also ensures the following:

- (1) Establishes finance procedures with installation MTF, WTU, and SFAC to obtain WTU Soldiers' duty status to ensure an accurate pay account.
  - (2) Briefs WTU commanders, cadre, and staff personnel on the requirements and timely processing of military and travel pay, and other pay-effecting documents as necessary.
  - (3) Acts as the primary pay support office, assistance and training for the financial management personnel in the WTU on technical support (military and travel pay, pay systems, security forms, software and so forth) and operations.
  - (4) Processes Family members' travel advances and voucher settlements for payment.
  - (5) Assists Wounded Warriors at medical and field sites when required and approved through appropriate channels, ensuring accounts are paid correctly, debts are suspended, and applications for remissions are submitted.
  - (6) Updates and maintains the DFAS Wounded Warrior Program database.
  - (7) Processes Medical Retention Processing orders into the Reserve pay system for ARNG and USAR soldiers and ensuring accuracy of pay and allowances upon initial transition into the program.
  - (8) Coordinates with the WTC through USAFMCOM, to support MEDCOM request to conduct OIP on WTU financial management operations.
- b.* See DOD 7000.14-R, chapters 1 and 4 for additional information and responsibilities.

### **1-18. Defense Health Agency**

*a. Tri-Service medical care.* TRICARE is the DOD's health care program for Servicemembers, their Families, and survivors, and retirees (see Department of Defense Directive (DODD) 6010.04). TRICARE Management Activity ensures the following:

- (1) Access to high-quality health care services is provided while maintaining the capability to support military operations.
- (2) The delivery of health care services in the direct care system is optimized.
- (3) The highest level of patient satisfaction is attained through the delivery of a world-class health care benefit.

*b. National Capital Region Medical Directorate.* The NCR Medical Directorate oversees the transformation of military health care and delivers world class service to Soldiers and their Family members. The Directorate has the authority to ensure effective and efficient delivery of military health care within the NCR through an Integrated Delivery System, and advancement in the provision of care to wounded, ill, or injured Soldiers and their Families, and is committed to ensuring different health care delivery elements are provided from the perspectives of patient, Family, and interservice.

### **1-19. Department of Veterans Affairs**

*a.* The Department of Veterans Affairs (DVA) provides the following:

- (1) Federal benefits to eligible military Veterans and their Families.
  - (2) Health care to eligible Soldiers.
  - (3) Financial assistance, compensation payment for disabilities, pension, and death related to military service.
  - (4) Education assistance, home loan guaranty, burial, life insurance, vocational rehabilitation, and a medical care program that incorporates home, clinics, and medical centers.
  - (5) Support for the recovery, rehabilitation, and reintegration of severely wounded, ill, or injured Servicemembers and Veterans through the Federal Recovery Coordination Program.
  - (6) Vocational Rehabilitation and Employment services to eligible Soldiers prior to discharge.
  - (7) Veterans Health Administration (VHA) and Veterans Benefits Administration liaisons to MTFs or WTUs.
- b.* See Title 38 United States Code (USC) for additional information and responsibilities.

### **1-20. Department of Labor**

The Department of Labor (DOL) protects the reemployment rights of mobilized federalized Guard and Reserve members and active duty Servicemembers separating from military service to return to their pre-Service employers through DOL's Veterans' Employment and Training Service and through its network of American Job Centers throughout the States, Puerto Rico, Virgin Islands, and Guam. DOL provides—

- a.* Labor market information.
- b.* Job search assistance.
- c.* Resume writing classes and job interviewing techniques.
- d.* Supplemental training for specific jobs, licenses, or certificates.
- e.* Unemployment insurance while seeking employment.
- f.* Online tools to identify civilian occupations in line with military training and step-by-step processes to assist transitioning Servicemembers perform a self-directed job search.
- g.* Classes in stress and financial management, when needed.
- h.* Pre-separation staff assistance regarding jobs and careers planning for wounded, ill, and injured Servicemembers

and their Families through the staff of the Disabled Veterans Outreach Program. (See Public Law (PL) 101–510 and 10 USC 1144.)

## **Chapter 2 General**

### **Section I Organization of Warrior Transition Command**

#### **2–1. Mission**

The WTC provides centralized oversight, guidance, and advocacy empowering wounded, ill, or injured Soldiers, Veterans, and Families through a CTP for successful reintegration back into the force or into the community with dignity, respect, and self-determination.

#### **2–2. Purpose**

To provide guidance and policy for all Army WTUs to include Community Care Units. The WTC has policy development and oversight for the daily operations of WTUs and conducts command and staff inspections, as well as SAVs to standardize continuous operational improvement, identify, and propagate best practices among the WTUs.

#### **2–3. Army Wounded Warrior Program**

AW2 is an Army program under WTC supervision and guidance that provides long term individualized support to severely wounded, ill, or injured Soldiers, Veterans, and their Families who meet certain criteria (see AW2 eligibility criteria in para 2–8).

### **Section II Major Components of the Warrior Care and Transition Program**

#### **2–4. Purpose**

The WCTP ensures recovering wounded, ill, or injured Soldiers receive equitable, consistent, and high-quality support and services. WTU Soldiers and their Families are assisted through effective collaboration efforts, proactive communication, responsive policy, and program oversight.

#### **2–5. Goal**

The goal of the WCTP is to successfully transition Soldiers and their Families back to the force and/or to Veteran status, through a comprehensive program of medical care, rehabilitation, professional development, and achievement of personal goals. The Soldier's own commitment to heal and transition, through adherence to medical instructions and command directives, is the centerpiece of the WCTP. At the same time, the WTU chain of command must provide accessible, responsive, and compassionate leadership, and serve as the avenue of choice for Soldiers seeking assistance. Through sustained interaction, commanders at all levels build confidence among Soldiers that the chain of command is committed to each Soldier's success.

#### **2–6. Warrior Transition Command**

The WTC serves as the lead proponent for the Army's WCTP. It supports the Army's commitment to the rehabilitation and successful transition of wounded, ill, or injured Soldiers back to the force and/or to Veteran status. The WTC provides strategic direction, develops, integrates, synchronizes, and assesses plans, policy, capabilities, and resources for warrior care initiatives and programs dedicated to the support, care and healing of wounded, ill, or injured Soldiers, their Families and caregivers.

#### **2–7. Warrior Transition Units and Community Care Units**

*a.* WTUs provide critical support to wounded, ill, or injured Soldiers. A WTU resembles a "line" Army unit, with a professional cadre and integrated Army processes that build on the Army's strength of unit cohesion and teamwork so that wounded, ill, and injured Soldiers can focus on healing to transition back to the force and/or Veteran status. Each wounded, ill, or injured Soldier works with a Triad of Care – PCM, NCM, and SL – who coordinate their care with other clinical and non-clinical professionals. The WTU is designed to care for Soldiers who are in need of six months or more of rehabilitation care and complex M2 in an inpatient or outpatient status.

*b.* Community Care Units are assigned to an installation WTU, and also provide critical support to wounded, ill, and injured Soldiers healing in their home communities. Community Care Units allow RC Soldiers to heal in their home communities using MTFs at installations, the TRICARE network, and the DVA while remaining on active duty. Soldiers in Community Care Units are assigned or attached directly to a WTU on an installation with direct Triad of

Leadership and SC involvement. Their care has standardized oversight with increase number of available cadre, access to Army leadership, MTF staff, WTU staff, and installation resources. Active Component Soldiers may be attached to a Community Care Unit on a case-by-case basis (see para 6–12 for exception for transfer).

c. Eligibility criteria for assignment or attachment and transfer to a WTU is outlined in chapter 7 of this regulation and in DCS, G–1, Army Policy, Procedures, and Management of wounded, ill, or injured Soldiers.

## **2–8. Army Wounded Warrior Program**

The AW2 offers support to severely wounded, ill, or injured Soldiers, Veterans, and their Families or caregivers. AW2 eligible Soldiers and Veterans are assigned an AW2 advocate who provides individualized non-clinical case management throughout their “Wounded Warrior Lifecycle” from evacuation through the transition back to the force and/or as a Veteran returning to their community.

a. *Eligibility.* Soldiers who suffered from wounds, illness, or injuries incurred in the line of duty (LOD) after 10 September 2001 and received, or are expected to receive at least a 30 percent rating from the Integrated Disability Evaluation System (IDES) for one of the categories listed in paragraphs 2–8a(1) through 2–8a(10), or received a combined 50 percent IDES rating for any other Combat or Combat Related Condition may meet eligibility criteria for the AW2 Program. The severity of the injury is determined based on the Army disability rating of at least 30 percent or more.

- (1) Blindness or severe loss of vision.
- (2) Loss of limb.
- (3) Severe hearing loss or deafness.
- (4) Severe burns or permanent disfigurement.
- (5) Spinal cord injury or severe paralysis.
- (6) Severe traumatic brain injury.
- (7) Severe post traumatic stress disorder or a behavioral health (BH) condition that was caused or exacerbated by combat and/or combat related condition caused by an instrumentality of war.
- (8) Fatal or incurable disease with limited life expectancy less than a year.
- (9) Receive a 30 percent Army disability rating for any other combat and/or combat related condition caused by an instrumentality of war.
- (10) Receive a combined 50 percent Army disability rating that includes a combat and/or combat related condition caused by an instrumentality of war.

b. *Services.* AW2 advocates, along with other AW2 staff subject matter experts (SMEs) in critical areas, medical policy, military human resources (HR), finance, employment, education, and VA, provide support in navigating Federal, State, and private benefits and resources in order to mitigate gaps incurred during transition to Veteran with services, such as, but not limited to—

- (1) Facilitating a Traumatic Servicemembers Group Life Insurance application.
- (2) Assistance with auditing finance records.
- (3) Assistance with VA disability compensation and benefits.
- (4) Applying for VA adaptive housing and vehicle assistance.
- (5) Applying for Combat Related Special Compensation; concurrent retirement and disability pay.
- (6) Briefing employers about the AW2 Soldiers, Veterans, and their Families or caregivers.
- (7) Assistance with coordinating changes to retirement dates.
- (8) Assistance with applying for continued on active duty (COAD) or continued active Reserve (COAR) programs.
- (9) Providing side by side comparisons of medical retirement pay and VA disability compensation.
- (10) Coordinating with Soldier for Life – Transition Assistance Program.
- (11) Assisting with employment and education opportunities.
- (12) Assisting Families with fiduciary issues.
- (13) Locating lost awards and arranging award ceremonies such as the Purple Heart and Combat Action Badge.
- (14) Referring Soldier with Army Board of Correction of Military Records to the appropriate agency.
- (15) Assisting the Soldier or Family member with citizenship process.
- (16) Arranging financial counseling.
- (17) Assisting and referring Soldier with Supplemental Security Income Disability Compensation to the appropriate agency.
- (18) Facilitating the development of AW2 program partnerships with the National Guard, Army Reserve, not-for-profit organizations, and other State and local organizations by network development and maintaining an up-to-date contact list within AW2 advocates database.
- (19) Providing job vacancy information to AW2 clients currently seeking employment.
- (20) Assisting Soldiers and AW2 Veterans with resume development and referrals utilizing AW2 centric hiring programs and authorities.

(21) Providing career guidance to AW2 clients.

(22) Referring Soldiers or Veterans to VA liaison for health care or VA Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and/or Operation New Dawn (OND) program manager for educational and coordination of health care.

*c. Army Wounded Warrior advocate locations.* Services to AW2 Soldiers and Veterans, their Families or caregivers are not limited by geography or physical locations or constrained by recovery or rehabilitation timelines AW2 advocates provide assistance wherever the AW2 Soldier or Veteran is located. AW2 Soldiers may not necessarily be assigned or attached to a WTU. AW2 advocates are embedded into major Army installations, Army medical centers, VA clinics and VA Polytrauma Medical Centers (Tampa, FL; Richmond, VA; Minneapolis, MN; Palo Alto, CA; and San Antonio, TX) and some National Guard and Reserve centers.

*d. Army Wounded Warrior database.* AW2 Soldiers and Veterans are tracked and managed utilizing the Army Warrior Care and Transition System (AWCTS). Authoritative data from other sources are fed directly into the AW2 database to empower AW2 staff with the vital information needed to assist an AW2 Soldier or Veteran's situation.

*e. Army Wounded Warrior Contact Center.* Army Wounded Warrior Contact Center's primary focus is to locate and sustain connection with the AW2 Soldiers or Veterans. Throughout the Wounded Warrior Lifecycle, many AW2 Veterans become transient and lose contact after transition. The AW2 contact center provides a means for continuous support to Soldiers and Veterans by locating, making, and receiving calls to and from Soldiers, Veterans, and their Families or caregivers, and then referring them to the appropriate AW2 staff member. Contact center personnel also provide administrative support for the AW2 program with special events and projects.

## **2-9. Comprehensive Transition Plan**

The CTP is a strategic tool generated to primarily focus on the Soldier's goals to heal and successfully transition back to the force and/or Veteran status. The WTU cadre assists the Soldier in developing realistic goals, executing those goals, and validating the Soldier's CTP. The CTP is owned by the Soldier and empowers the Soldier to take charge of his or her own transition with the support of his or her Family or caregiver and the interdisciplinary team. The CTP focuses on the Soldier's future through six processes (in-processing, goal setting, transition review, rehabilitation, reintegration, and post-transition) (see chap 3) and aligns with six domains of strength within the Comprehensive Soldier and Family Fitness model of career, physical, emotional, social, family, and spiritual.

*a. Career* — Creating and capitalizing on opportunities to prepare for career success in the military and/or after the military, including achieving educational goals, acquiring new job skills or experience, and preparing for employment search, consistent with long-term career goals.

*b. Physical* — Performing and excelling in physical activities that require aerobic, fitness, endurance, strength, healthy body composition and flexibility derived through exercise, nutrition, and training.

*c. Emotional* — Approaching life's challenges in a positive, optimistic way by demonstrating self control, stamina, and good character with choices and actions.

*d. Social* — Developing and maintaining trusted, valued relationships and friendships that are personally fulfilling and foster good communication including a comfortable exchange of ideas, views, and experiences.

*e. Family* — Being part of a family unit that is safe, supportive, and loving and provides the resources needed for all members to live in a healthy and secure environment.

*f. Spiritual* — One's purpose, core values, beliefs, identity, and life vision. These elements, which define the essence of a person, enable one to build inner strength, make meaning of experiences, behave ethically, persevere through challenges, and be resilient when faced with adversity. An individual's spirituality draws upon personal, philosophical, psychological, and/or religious teachings, and forms the basis of their character.

## **2-10. Army Warrior Care and Transition System**

The AWCTS is an evolving automation system that captures the execution of the six CTP processes. It is the primary tool for the execution of the CTP and plays a critical role in the collection and assessment of Soldier CTP records across the WTC. AWCTS is incorporated in the CTP and is discussed throughout this regulation.

## **2-11. Career and Education Readiness Program**

*a.* The Career and Education Readiness (CER) Program prepares each WTU Soldier for success in a long-term career that is personally meaningful, rewarding, and enables the Soldier to achieve financial independence. WTUs will provide CER Program through a disciplined, purposeful approach by evaluating Soldiers goals and connecting them with a CER work site that is therapeutic and contributes to their rehabilitation. Soldiers will participate in a CER activity or activities as soon as they are determined to be eligible for CER activity. To be effective, Soldiers' CER activities must be consistent with their long-term career goals developed as part of the CTP process.

*b.* Eligibility for CER activity is based on two distinct evaluations made by the WTU commander and the M2.

(1) The M2 evaluation must conclude that the Soldier is medically, emotionally and physically ready to participate in a CER activity or activities while continuing medical treatment. The NCM in collaboration with the interdisciplinary team is responsible for coordinating the M2 evaluation of CER eligibility.

(2) The command evaluation must conclude that the Soldier demonstrates the initiative and self-discipline required to participate in a CER activity or activities. The WTU commander is responsible for the command evaluation of CER eligibility and the SL is responsible for documentation. CER is further discussed throughout the CTP in chapter 3 and work site selection is discussed in chapter 6 of this regulation.

## **2-12. Adaptive Reconditioning Program**

The Adaptive Reconditioning Program helps Soldiers in the WTUs achieve a successful transition through alternate rehabilitation methods with the included guidance of the CTP. An Adaptive Reconditioning Program can offer several adaptive reconditioning activities that supplement a Soldier's recovery. All Soldiers in WTUs will participate in some type of adaptive reconditioning activity within the limits of their profile. The Adaptive Reconditioning Program is further discussed throughout chapters 3, 6, and 12 of this regulation.

## **2-13. Organizational Inspection Program and Staff Assistant Visits**

*a.* The WTC commander is responsible to ensure that each WTU is inspected with the appropriate frequency and by a qualified team in order to ensure enterprise-wide effectiveness of the WCTP. The WTC OIP is a comprehensive, written plan that addresses all inspections and audits of a Warrior Transition Battalion (WTB) and equivalent sized WTU. Inspections conducted at a WTB or WTU are designed to assess a unit's ability to accomplish their mission by determining compliance against established standards, as well as to determine the root cause of non-compliance.

*b.* Inspections conducted are generally one of two types: a command or staff inspection is characterized by a formal process of inspection and follow-up on corrective actions as needed. Although most inspections will be planned in advance, some may be "no-notice" inspections. A SAV is a more informal process and may either be directed by higher headquarters or requested by a unit commander. SAVs generally focus on education, training, and assistance support for critical areas to better understand standards and goals, gauge strengths and weaknesses, and learn how best to ensure compliance or implement new procedures. The assistance team will provide feedback to the commander, thus, during a SAV, a corrective action report from the unit is not required. SAVs are normally conducted by the RMCs, but may be conducted by WTC headquarters upon request.

*c.* Although either inspection may be somewhat disruptive to normal operations, they are critical to assessing and/or improving unit effectiveness and should be treated with the appropriate priority by all commanders and staff involved. Each inspection will be governed in accordance with Army regulation (AR) 1-201, this regulation, and MEDCOM policies on Command OIP.

## **2-14. Community Partnership Programs**

*a.* The WTC, Community Support Network, acts as a liaison to connect local organizations with wounded, ill, or injured Soldiers, Veterans, their Families, and caregivers (henceforth known as the "Community Support Network population").

*b.* All services, resources, or products offered by Community Support Network members to the Community Support Network population must be either freely given, covered by insurance, or significantly reduced in price with all costs being disclosed up front and prior to any agreement.

*c.* Organizations that are interested in becoming a member of the Community Support Network must complete and sign the Community Support Network registration application which can be found at the following link: <http://www.wtc.army.mil/modules/support%20network/index.html>. Once the application is completed it can be submitted by email or fax to the Community Support Network coordinator for review and processing. A review process begins once the Community Support Network coordinator receives the organization's application. Screening includes ongoing checks on various Web sites and other forms of media to validate the organization, its intent, and integrity. If approved, a brief synopsis about the organization will be included on the WTC Community Support Network resource Web site page (<http://www.wtc.army.mil/modules/support%20network/index.html>) and the organization will be invited to participate in various events, (for example: regional job fairs, wounded warrior employment conferences, and quarterly conference calls). If the organization is not approved to become a member, they will be notified in writing (electronic or otherwise) by the Community Support Network coordinator.

*d.* Being included in the Community Support Network does not constitute a partnership, affiliation or endorsement by or between the organization, Community Support Network, WTC, AW2 Program, the U.S. Army, or DOD. The use of any Army logos is expressly prohibited by any outside organization. The WTC reserves the right to discontinue hosting or using any organization's information, products, and/or services at any time for any reason.

## **2-15. Soldier and Family Assistance Centers**

*a.* SFACs are located at most MTFs to serve Soldiers, their Families, and caregivers. Most SFAC services are available at a central location on the installation. SFAC's staff can also coordinate additional services on an as-needed basis. The SFAC is incorporated within the CTP process and is discussed throughout the chapters of this regulation. AR 608-1 governs the policies and the services SFAC can provide.

*b.* Commanders should maximize use of the SFAC and the opportunities available on Community Support Network for meeting the needs of the Community Support Network population.

### **Section III**

#### **Roles and Responsibilities within the Warrior Care and Transition Program**

##### **2–16. Regional medical command**

The RMC provides mission command, logistical, fiscal, legal, chaplain, and communications coordination and support to WTUs. RMC will—

- a.* Provide oversight of all WTUs in their region and the implementation of the WCTP.
- b.* Conduct SAVs to all WTU within the region and provide personnel to assist WTC with OIPs.
- c.* Ensure all WTUs are appropriately staffed.
- d.* Ensure all WTUs have the appropriate facilities to do their mission.
- e.* Ensure all WTUs have an ISSA in place with their installation.
- f.* Serve as the supported command synchronizing WTU operations.
- g.* Synchronize the efforts of ARNG Directorate, USAR, and other agencies in support of operations.
- h.* Executes and implement medical standards and WTC policy to support WTU operations, to include provision of clinical care, case management, monitoring outcomes, treatment tracking, ensuring appropriate and adequate clinical resources and support, and providing staff orientation and education.
- i.* Provide overall technical supervision and quality control over all medical aspects of the WCTP.
- j.* Manage and provide manpower and funding requirements to support WTU operations.
- k.* Maintain ownership of WTU dedicated assets, tasking authority, and funding responsibility.
- l.* Identify, monitor, and analyze trends and conditions affecting timely and efficient IDES processing for Soldiers assigned to WTUs.
- m.* Ensure MTFs provide medical, personnel, logistical, and finance support for WTU operations.
- n.* Attend annual WTU town halls with Soldiers and Families.
- o.* Attend annual WTU town halls with cadre.
- p.* Provide oversight of WTU Soldiers within the IDES process. Approve or disapprove continuation in the WCTP for all Soldiers that have been in the program for more than 270 days without entering into the IDES process.
- q.* Develop and conduct training for WTU Soldiers and cadre.
- r.* Exempt WTU cadre and WTC staff from PROFIS, medical augmentee, and individual assignments. Exceptions apply (see para 6–23).
- s.* Ensure non-WTU commanders at all level do not task WTU cadre for collateral duties (for example staff duty officer, staff duty NCO, charge of quarters, FLIPL, funeral duties, and so forth) (see para 6–24 for additional details).
- t.* Ensure WTU commanders utilizing Soldiers in the WCTP to perform unit level tasking comply with paragraph 6–24.
- u.* Coordinate and resolve with Soldier Transfer and Regulating Tracking Center (STARTC) any Soldier Transfer issues that negatively impact the Soldier’s movement between WTUs.
- v.* Ensure MTF commanders designate personnel by roles who will be authorized to release information to unit surgeons and/or unit command officials.
- w.* Ensure all WTU clinical and non-clinical cadre who have access to Soldiers protected health information (PHI) are trained and are in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
- x.* Monitor policy execution and track risk levels and appropriate mitigation plans across their commands (see chap 4).

##### **2–17. Regional Medical Command Warrior Transition Office**

The WTOs provide staff assistance to support the WTUs to include Community Care Units in the areas of mission command, HR, and M2 of WTU Soldiers in the RMC area of responsibility. WTO duties include but not limited to the following:

- a.* Facilitate the execution of the WCTP and ensure WTU Soldiers receive appropriate medical care and services.
- b.* Advise RMC commanders on policies and issues related to the WCTP.
- c.* Support WTU and Community Care Unit to ensure compliance with WCTP policies and procedures.
- d.* Serve as the principle element for WTUs and Community Care Units in WCTP issues, tasker, and information flow.
- e.* Monitor and ensure appropriate staffing ratios are within standards.
- f.* Conduct SAVs to WTUs and Community Care Units.
- g.* Serve as certification agency for Special Compensation for Assistance with Activities of Daily Living (SCAADL) application packets for the region.

- h.* Collaborate with OTSG, MEDCOM and WTC on WTU issues.
- i.* Collaborate with MEDCOM STARTC, other RMCs, ARNG, USAR, Active Component Units, and WTC on patient movement, entry, and exit matters.
- j.* Collaborate with RMC clinical operations to ensure enhanced access to care standards for Soldiers are met.
- k.* Coordinate and participate in MEDCOM and WTC command inspections of WTUs and Community Care Units to ensure standardized best practices across all WTU and Community Care Units.
- l.* Coordinate and facilitate meetings between RMC, WTC, WTUs, and Community Care Units.
- m.* Coordinate strategic planning with MEDCOM readiness division in support of mobilization and demobilization operations.
- n.* Serve as the liaison for DVA.
- o.* Respond to internal and external inquiries from legislators, USAR, ARNG, and support groups.

## **2-18. Commander military treatment facilities**

MTFs will—

- a.* Provide mission command to WTUs and provide oversight of all medical and administrative care of Soldiers assigned to the WTUs.
- b.* Provide oversight to WTU activities and the implementation of the WCTP.
- c.* Ensure the WTU is appropriately staffed, to include direct support clinical personnel as needed.
- d.* Assist with the development of an ISSA to support WTU functions with garrison.
- e.* Attend at minimum, semiannually WTU town halls with Soldiers and Families.
- f.* Conduct, at minimum, semi-annual town halls with WTU cadre.
- g.* Provide oversight of WTU Soldiers within the IDES process. Approve or disapprove continuation in the WCTP for all Soldiers that have been in the program for more than 180 days without entering into the IDES process.
- h.* In coordination with the WTU commander, conduct monthly barracks inspections.
- i.* Coordinate with TRICARE Management Activity and the DVA to optimize access to care to WTU Soldiers being released from active duty or separated from the Service.
- j.* Exempt WTU cadre and WTC staff from PROFIS, medical augmentee, and individual assignments. Exceptions apply (see para 6-23).
- k.* Ensure non-WTU commanders at all level do not task WTU cadre for collateral duties (for example: staff duty officer, staff duty NCO, charge of quarters, FLIPL, funeral duties) (see para 6-24 for additional details).
- l.* Ensure WTU commanders utilizing Soldiers in the WCTP to perform unit level tasking comply with paragraph 6-24.
- m.* Ensure all MTF providers are trained and have access to eProfile system, and ensure that all profile (both temporary and permanent) are entered into eProfile.
- n.* Ensure enhanced access to care standards are met for WTU Soldiers.
- o.* Ensure all clinical and non-clinical cadre who have access to Soldiers PHI are trained and are in compliance with the HIPAA.
- p.* Designate personnel by roles who will be authorized to release information to unit surgeons and/or unit command officials.
- q.* Designate adequate space and access for VA liaisons to ensure coordination of health care for Soldiers transitioning to VA health care.
- r.* Implement the risk assessment and mitigation policy (see chap 4).

## **2-19. Commander of Warrior Transition Units and Community Care Units**

The Commander of WTUs and Community Care Units will—

- a.* Establish the leadership climate to foster holistic care, healing, discipline, and unit cohesiveness (see AR 600-20).
- b.* Assist and enable Soldiers to heal and transition successfully.
- c.* Provide mission command for the accountability and administrative support for Soldiers.
- d.* Establish conditions that facilitate Soldier's healing process physically, emotionally, socially, and spiritually, to include career and Family.
- e.* Receive frequent updates on the status of Soldiers in the command.
- f.* Direct actions as necessary to ensure that all standards of care and transition for Soldiers are met.
- g.* Ensure continuing contact and liaison with RC Soldiers' assigned chain of command.
- h.* Provide a network of Triad of Care and Triad of Leadership working together to ensure advocacy for WTU Soldiers, continuity of care and a seamless transition back to the force and/or to Veteran status.
- i.* Ensure the interdisciplinary team work together to collect Soldier data and information that will be used as a plan of care specific to each Soldier to address medical treatment, administrative support, needs, and disposition.
- j.* Conduct periodic risk assessment and mitigation plan as instructed in chapters 3 and 4.

- k. Ensure Soldiers not meeting Army Body Composition Program (ABCP) in accordance with AR 600–9 are flagged in accordance with AR 600–8–2, enrolled in nutrition counseling, and data documented in the CTP. (See AR 600–9 and/or chap 6, sec VI of this regulation for additional information on ABCP and exemption from the program.)
- l. Ensure Soldiers participate in the Adaptive Reconditioning Program within the limitations of their physical profiles and enforce all medical and physical profiles.
- m. Conduct random urinalysis testing in accordance with AR 600–85.
- n. Implement and manage a CER Program for wounded, ill, or injured Soldiers.
- o. Ensure all performance data (whether submitted manually or via AWCTS) reported to higher authorities is accurate and factual.
- p. Direct and support the Commanders' Safety Program that incorporates risk management and accidents prevention to reduce accident, illnesses, and worker compensation cost in accordance with AR 385–10.
- q. Provide clear guidance regarding expectations for the personal conduct of Soldiers and outline Soldier and WTU cadre responsibilities in supporting the CTP, including all clinical and non-clinical care.
- r. Maintain good order and discipline, and enforce all applicable ARs and policies.
- s. Seek interdisciplinary team input on the impact, if any, of prescribed medications and the Soldier's medical condition on performance when considering disciplinary action for misconduct.
- t. Consult with servicing judge advocate as part of the disciplinary process.
- u. Coordinates for activities that are supported in the ISSA with garrison and MTF.
- v. Develop a health and welfare inspection program that provides for the safety of Soldiers and their Families and is respectful to Soldiers' healing needs.
- w. Exempt WTU cadre and WTC staff from PROFIS, medical augmentee, and individual assignments. (Exceptions apply in para 6–23.)
- x. Exempt WTU Soldiers and cadre from performing collateral duties (for example: staff duty officer, staff duty NCO, charge of quarters, FLIPL, funeral duties) (see para 6–24 for additional details).
- y. Ensure WTU Soldiers and cadre complete Department of Defense (DD) Form 2796 (Post-Deployment Health Assessment (PDHA)), DD Form 2900 (Post Deployment Health Reassessment (PDHRA)), periodic health assessment (PHA), and all applicable preventive health requirements.
- z. Develop a Respite Pass Program that enables cadre staff members to take regular or compensation leave, and/or respite pass without overburdening other cadre staff members (see para 6–29).
- aa. Ensure the command verify with STARTC the requirements to transfer a Soldier between WTUs.
- ab. All patients arriving by air evacuation will receive an initial clinical review within 24 hours of landing.
- ac. Conduct quarterly briefs to O–6 level command teams on their installation to ensure all WTU eligible Soldiers get the opportunity to receive the right level of care and to ensure leaders understand the WCTP entrance criteria. WTU commanders will maintain a memorandum for record of completed briefs which will be reviewed during WTU organizational inspections. Possible briefing venues include unit status reports (USRs), officer professional development (OPD), desk side, and at a minimum, the brief will include the following information:
- (1) Refer to chapter 6 for entry and exit criteria.
  - (2) WTU entry procedures to include active duty, Medical Readiness Processing, Medical Readiness Processing–Evaluation and active duty medical extension (ADME) orders.
  - (3) Benefits of assignment to a WTU for the Soldier, unit, and Army.
  - (4) AW2 overview of benefits, eligibility criteria, number eligible in the unit(s) being briefed, and number enrolled from the unit(s).
  - (5) Number of Soldiers from the unit(s) being briefed that are assigned to the WTU.
  - (6) Common Soldier issues for Soldiers such as medical evacuation, awards paperwork, evaluations, LODs, 179-day limit for Component (COMPO) 1 Soldiers.
  - (7) Ensure the unit trained Master Resilience Trainer (MRT) and/or designate staff member monitors and reports the USR.
- ad. Ensure all clinical and non-clinical cadre that have access to Soldiers PHI are trained and are in compliance with the HIPAA.
- ae. Designate personnel by roles who will be authorized to release information to unit surgeons and/or unit command officials.
- af. Ensure WTUs finance personnel brief new commanders, staff, and cadre personnel within 30 days after arrival into the unit on the importance, accuracy, and timely processing of the unit commander's finance report, unit commander's pay management report, DA Form 31 (Request and Authority for Leave) policy and accountability, internal controls, and pay and allowances.
- ag. Conduct random urinalysis testing in accordance with AR 600–85. Illegal drugs are prejudicial to good order and discipline and their use is inconsistent with healing. Use of illegal drugs may result in mandatory separation processing in accordance with AR 635–200. It may also result in Uniform Code of Military Justice (UCMJ) action if deemed appropriate by the Soldier's commander. In accordance with AR 635–200, "processed for separation" means

that separation action will be initiated and processed through the chain of command to the separation authority for appropriate action.

## **2–20. Headquarters and headquarters company, Warrior Transition Units**

*a.* Headquarters and headquarters company (HHC) is responsible for the accountability of military patients arriving from an overseas area of operation in coordination with the MTF's patient administration evacuation section until returned to duty or assigned or attached to a WTU.

*b.* Evacuated Soldiers will be on temporary change of station (TCS) orders. If the initial clinical and BH assessments can occur within the order period, the Soldier may be returned to duty, released from active duty, attached or assigned to the WTU, or attached temporarily to the HHC. In all cases, action will be initiated to return to duty (RTD), release from active duty (REFRAD), or attach or assign to the WTU within 30 days of arrival.

*c.* Soldiers arriving on TCS orders are not automatically considered a WTU Soldier. The Triad of Care and Leadership will determine if the patient qualified for entry into the WTU based on the nature of the clinical status, treatment, recovery, and rehabilitation. This applies to all WTU Soldiers regardless of the means or mode of arrival.

*d.* Ensure Soldiers arriving on medical evaluation orders are evaluated appropriately and prescribed the appropriate care and transitioned back to their unit; or are placed on medical retention orders in a timely manner.

*e.* Provide mission command of all medical TDY Soldiers.

## **2–21. Soldier**

*a.* The WCTP is a voluntary program and non-compliance with any aspect of transition may result in removal from the program, administrative separation, or UCMJ action. Soldiers own their CTP and are empowered to take charge of their own transition with the support of their Families and the interdisciplinary team. As part of Soldiers' mission, they will incorporate TSG's Performance Triad. The components of the Performance Triad include activity, nutrition, and sleep. Soldiers are encouraged to get at least 150 minutes of moderate intensity exercise per week, strive to improve their sleep and their nutrition. Soldiers are expected to be accountable and actively participate in meeting their goals outlined in their individual CTP.

*b.* Soldiers will—

(1) Begin their CTP within the first 30 days of assignment in a WTU and accountable for establishing and meeting their goals.

(2) Complete all the requirements related to their CTP such as goal setting, scrimmages, focused transition reviews (FTRs), and self-assessments as directed by their command teams (commanders and senior enlisted advisors).

(3) Update their self-assessment weekly while in-processing or as directed by the commander and provide a complete and honest assessment of their transition status. The Soldiers' personal efforts, in concert with the Army Values and Warrior Ethos, will determine their success.

(4) Be on time at expected place of duty such as unit formations, assigned work site educational program or internship, clinical and non-clinical appointments. Clinical appointments take precedence over all other appointments, unit training requirements, activities, and events.

(5) Follow and use prescription and over-the-counter medications as directed by physicians. A PCM must approve the use of all over-the-counter medications, as these drugs may have adverse effects and/or reactions when taken in conjunction with prescribed medications. Adherence to all medical instructions from providers and NCMs is essential to healing and transition.

(6) Report any side effects to the Triad of Care and chain of command immediately. Medication taken after the expiration date, or taken in a manner contrary to their intended medical purpose, or in excess of the prescribed dosage, or the sharing, or distributing of prescriptions is strictly prohibited, and may result to UCMJ or adverse administrative action.

(7) Report the use of all non-prescription medications (to include herbals, supplements, and energy drinks) to their NCM and PCM.

(8) Obtain PCM referral and approval prior to scheduling initial or specialty medical or surgical appointments.

(9) Obtain NCM's approval prior to cancelling any medical appointments.

(10) Adhere to all medical profiles to include no-alcohol profiles and carry an individual copy of profile at all times; profiles are designed to ensure a positive rehabilitative process and healing.

(11) Make daily contact with SL and weekly contact with NCM.

(12) Comply and maintain the ABCP standards in accordance with AR 600–9 and medical physical profile. Soldiers in non-compliance with AR 600–9 will be flagged in accordance with AR 600–8–2 and enrolled in the ABCP. Soldiers who fail to make satisfactory progress in the ABCP will remain flagged, and subject to involuntary separation in accordance with AR 635–200 (enlisted) and AR 600–8–24 (officers). Soldiers exempt from the ABCP must maintain a Soldierly appearance in accordance with AR 600–9.

(13) When eligible, participate and be actively engaged in a CER program (work site, education program, or internship) that align with their track preference and long term career goals. Soldiers will treat these locations as a duty site.

(14) Participate and be actively engaged in the Adaptive Reconditioning Program as directed by their commander and their interdisciplinary team, and incorporate the Performance Triad recommendations for physical activity into their medical recovery plan.

(15) Comply with standard Army safety and occupational health rules, regulations, and standards.

(16) Adhere to rules and regulations regarding the use, possession, and distribution of illegal drugs which are in violation of the UCMJ. Illegal drugs are prejudicial to good order and discipline and their use is inconsistent with healing, and may result in UCMJ action if deemed appropriate by the commander.

(17) Use and maintain personal protective clothing and equipment provided for safety and report any unsafe or unhealthful working conditions and accidents to immediate supervisor.

(18) Remain subject to and adhere to ARs, customs and courtesies, administrative policies, the Joint Ethics Regulations (JERs), and the UCMJ. Do not actively solicit for donations.

(19) Notify commander of personally owned weapons and their locations.

(20) Attend formations, town halls, and other WTU-sponsored activities.

(21) Contribute to the day-to-day operations for the unit (based upon medical and recovery needs and limitations).

(22) Assist Family (if able) with transition to military life and administrative requirements.

(23) During the rehabilitative phase, mentor other Soldiers on the WCTP and serve as a role model that exemplifies successful transitioning.

(24) Engage WTU leadership on issues as early as possible.

(25) Obtain medical clearance authorization and commander's counseling on all therapeutic and leisure trips and/or events (see chap 11, sec II for further details).

(26) Maintain all individual medical readiness requirements.

(27) Participate in senior leader and elected official visits.

(28) Secure their medications and their containers in a locked safe place when not being taken or administered and maintain safe control and use of their medications.

(29) Serve as a mentor for other WTU assigned Soldiers once medically ready to do so.

(30) Actively participate in IDES activities, if in the IDES process.

(31) Assist family with transition to military life and administrative requirements.

(32) Comply with the yearly requirement for completing assessment in the Comprehensive Soldier and Family Fitness Global Assessment Tool.

(33) Comply with all individual medical readiness requirements and complete all deployment health assessments, as required.

## **2-22. Triad of Care**

The Triad of Care which includes the PCM, NCM, SL, or PSG, works together to collect Soldier data and information; develops a plan of care specific to each Soldier that addresses medical treatment, administrative, supports needs and disposition; and develops and implements a CTP. Specific roles and responsibilities are outlined throughout the regulation. In general—

*a.* The PCM (primary care physician, physician assistant, or nurse practitioner) provides primary health care to the Soldier, while evaluating the holistic medical requirements, and planning, directing, and overseeing all Soldiers' care during their time in the WTU. The relationship developed between the Soldier and their PCM is the basis for successful prevention-oriented, coordinated health care. The Soldier benefits from consistent health care and improved overall health.

*b.* The NCM, a registered nurse who works with the Soldier throughout the CTP six processes. The NCM assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet Soldier's health needs. The NCM, also, advocates for their Soldiers and Families. Serves as the primary coordinator between the M2 and mission command elements of the WTU. In addition, the NCM documents care and coordination efforts in Armed Forces Health Longitudinal Technology Application (AHLTA), AWCTS, Essentris-Inpatient System (when required) and Medical Operational Data System (MODS) databases.

*c.* The SL and/or PSG is accountable for the personal conduct of the WTU Soldier. The NCO works as part of the Triad of Care providing for the care of Soldiers and their Family. The SL and/or PSG—

(1) Provides direct mission command support for Soldiers. Counsels Soldiers on their medical and military responsibilities as described in the chapters throughout this regulation within 5 days of arrival to the unit.

(2) Ensures Soldiers attend necessary medical and administrative appointments. Clinical appointments take precedence over all other appointments, unit training requirements, activities, and events.

(3) Ensures Soldiers participate in an adaptive reconditioning program and encourages Soldiers to get at least 150 minutes of moderate intensity exercise per week, strive to improve their sleep and their nutrition as part of TSG's Performance Triad (see chap 11, sec II of this regulation).

(4) Maintains accountability of Soldiers whereabouts and their equipment (not applicable to Community Care Unit).

(5) Links Soldiers to SFAC for services and benefits. Soldiers will use local administrative services and benefits through their National Guard services and veteran organizations.

(6) Initiates requests for personnel actions (for example awards, decorations, promotions, UCMJ, finance, orders); ensures that the Soldier's records are transferred from losing unit to gaining unit.

(7) Inspects the condition of Soldier's billeting, clothing, and equipment (not applicable to Community Care Unit).

(8) Keeps immediate leadership informed on Soldiers medical status and requirements.

d. Ensures medically cleared Soldiers assigned to a work site, educational program or internship, treat these locations as assigned duty site. A Soldier's failure to be at their assigned location demonstrates a lack of compliance and mission failure and may result in removal from the program, separation, or UCMJ action.

e. Receives training on the PHI and the HIPAA upon arrival to the WTU.

f. Complies with the release of PHI and HIPAA policies when handling Soldiers' health and other personal information (see AR 40-66).

g. Roles and responsibilities within the CTP are outlined in chapter 3 of this regulation.

## **2-23. Triad of Leadership**

a. The Triad of Leadership (SCs and CSMs; MTF commanders and CSMs; and WTU commanders, CSMs, and 1SGs) will—

(1) Execute WTU entry, management, and exit policy.

(2) Establish an appropriate process to review and approve requests for entry and exit in WTUs. The Triad of Leadership will determine the following dispositions:

(a) Assignment or attachment to a WTU.

(b) Assignment consideration of a former WTU Soldier as WTU cadre.

(c) Disapprove WTU entry for Soldiers who have routine medical requirements.

(d) Evaluate and determine when Soldiers depart the WTU based on established policies.

(e) Ensure Soldiers and cadre are counseled on their medical and military responsibilities as described in the chapters throughout this regulation within 5 days of arrival to the unit.

(3) Maintain good order and discipline in WTUs, and enforce all applicable ARs and policies. Commanders should consider that every Soldier's case is unique when determining whether to discipline a Soldier.

(4) Seek Triad of Care input on the impact of prescribed medications and each Soldier's medical condition on Soldier performance.

(5) Consult with local staff judge advocate as part of the disciplinary process.

(6) Ensure Soldiers not meeting the Army Body Composition standards in accordance with AR 600-9 are flagged in accordance with AR 600-8-2, enrolled in nutrition counseling, and body composition standards and goals are annotated in the CTP. Soldiers who fail to show progress in accordance with AR 600-9 should be considered for separation action in accordance with AR 635-200, for enlisted or 600-8-24 for officers.

(7) Do everything possible to assist and enable Soldiers to heal and transition successfully.

(8) Use their experience and discretion to assess incidents of non-compliance and misconduct on a case-by-case basis. The decision to take punitive action in a particular case rests with that commander. The return to unit or REFRAD (COMPO 2 and 3) or RTD (COMPO 1) authority for a non-compliant Soldier from a WTU is the first O-6 commander in the chain of command, normally the MTF commander. Commanders should use written counseling and or UCMJ action prior to releasing a Soldier who is still in need of medical care from the program. Normally, commanders may not separate or REFRAD Soldiers who are currently in the MEB processing. However, this does not preclude commanders from administering UCMJ action, conduct written counseling with corrective training, or initiate separation action. Enlisted administrative separation during the MEB process will be followed in accordance with AR 635-200. Officer separations will be followed in accordance with AR 600-8-24.

(9) Create an alcohol-free zone around WTU unaccompanied housing. Commanders will ensure that their Soldiers acknowledge in writing that they understand the alcohol-free policy. Violations of this policy will subject them to discipline under UCMJ.

(10) Establish an Adaptive Reconditioning Program (see chap 11, sec II of this regulation).

b. Roles and responsibilities are further defined in chapters 3 and 4.

## **2-24. The key brigade and battalion Warrior Transition Unit staff and support members**

Commanders and leaders will ensure all Soldiers develop and execute their CTP within 30 days of assignment or attachment to the WTU. The interdisciplinary teams will assist Soldiers in the development and execution of their CTP; the Triad of Care will support and validate Soldiers' CTP; and staff and support members will assist WTU Soldiers in meeting their needs.

a. *Warrior Transition Unit commander.* The WTU commander is the individual appointed to provide mission command over the WTU. He is responsible for all that the WTU accomplishes or fails to accomplish.

*b. Warrior Transition Unit command sergeant major.* The CSM is the senior enlisted trainer and spokesperson. The CSM will—

- (1) Enforce established policies and standards for enlisted Soldiers pertaining to the conduct, performance, care, personal appearance, effective personal utilization, asset management, and Soldier training.
- (2) Ensure subordinate NCOs do the same.
- (3) Provide advice and recommendations to the commander and staff on all matters pertaining to enlisted Soldiers and their Families.
- (4) Assist in regular inspections of command activities, facilities, and personnel as prescribed by the commander.
- (5) Ensure adherence to command regulations and policies.
- (6) Ensure newly assigned enlisted personnel are instructed in military courtesy and customs of the Service.
- (7) Monitor and conduct training of enlisted Soldiers of the command.
- (8) Ensure Soldiers maintain the yearly requirement for completing assessment in the Comprehensive Soldier and Family Fitness Global Assessment Tool.
- (9) Ensures 1SGs and/or PSGs effectively manage the Respite Pass Program (see para 6–29).
- (10) Ensure WTU Soldiers and cadre complete DD Form 2796 and DD Form 2900 within 30 days of redeployment and between 90 to 180 days of redeployment respectively.
- (11) Ensure WTU Soldiers and cadre complete their individual medical readiness requirements.

*c. Warrior Transition Unit executive officer.* The WTU executive officer—

- (1) Oversees staff activities and assumes command in the absence of the commander.
- (2) Keeps the commander informed of Soldier issues which may require his attention.
- (3) Conducts weekly staff meetings.
- (4) Works with staff elements to resolve any Soldier care issues.
- (5) Receives daily updates on all unresolved Soldier issues.

*d. The Warrior Transition Unit surgeon.* Wherever feasible, the WTU surgeon should be either: (1) a physician residency-trained in a primary care or occupational medicine specialty (family, internal, or emergency medicine, pediatrics, physical and rehabilitative medicine, or occupational health); or (2) a mid-level provider specifically trained in a primary care realm of his or her discipline. The WTU surgeon—

- (1) Is the lead in the organization for all M2 issues.
- (2) Is the primary liaison with the MTF.
- (3) Provides direct oversight to the WTU PCMs.
- (4) Provides oversight to PCMs on special compensation for SCAADL program and nonmedical attendant (NMA) assignment.
- (5) Serves as the interface between the MTF IDES assets and the WTU. Minimizes any activities within the WTU's control that prolong the IDES process.
- (6) Attends Deputy Commander for Clinical Services (DCCS) level clinical meetings.
- (7) The WTU surgeon should devote a portion of his time each month to clinical practice.

*e. The Warrior Transition Unit supervisor nurse case manager.* The WTU supervisor NCM—

- (1) Oversees the nursing activities of the case managers within the command.
- (2) Ensures NCMs maintain all licensure and education requirements, and are trained and competent in performing their duties.
- (3) Provides professional development and counseling to NCMs within the command.
- (4) Serves as a direct liaison between the WTU nursing personnel and the MTF Deputy Commander for Nursing.
- (5) Incorporates interagency collaboration to facilitate care including partnership with VHA through VA liaisons to ensure successful transitioning of Soldiers to VA health care.
- (6) Executes policies and procedures and monitors nursing activities to ensure the delivery of effective, efficient, and quality care.
- (7) Establishes and conducts quality review and record in accordance with standard nursing practices and NCM Association.
- (8) Interfaces with the senior nursing leadership to coordinate clinical nursing issues.
- (9) Engages in interagency collaboration to facilitate care and establishes and conducts quality review and record in accordance with standard nursing practices and NCM Association.
- (10) Develops and monitors case management clinical outcomes metrics.
- (11) Attends deputy commander for nursing leadership meetings.
- (12) Assists with development of training programs that meet the needs of the WTU Soldiers and Families assigned to the WTU.
- (13) Responsible for the oversight of the transition process from inpatient to outpatient.
- (14) Responsible for attending command level Family meetings.

(15) Informs the commander on population demographics on a quarterly basis. Provides input on changes to length of stay metrics.

(16) Sets the conditions to enable NCMs to take respite pass (see para 6–29).

(17) Ensures the required coordination is completed during Soldiers' transfer between WTUs and Community Care Units.

(18) Ensures WTU Soldiers and cadre's Deployment Health Assessments (DD Form 2796 and DD Form 2900) are completed within 30 days of redeployment and between 90 to 180 days of redeployment respectively.

(19) Ensures WTU Soldiers and cadre complete their individual medical readiness requirements.

*f. The senior Licensed Clinical Social Worker.* A Licensed Clinical Social Worker (LCSW) has a master's degree in social work and is independently licensed by his or her State to conduct clinical social work assessments, diagnosis, and treatment. He or she possesses a national clinical credential to conduct therapy and/or has the highest level of licensure granted by his or her State. The senior LCSW—

(1) Provides oversight on the execution of responsibilities, compliance and professional development of all LCSW, Baccalaureate Level Social Worker (BLSW), and Social Services assistant (SSA) assigned to the WTU.

(2) Is the lead in BH issues in the WTU and works with the MTF and TRICARE regional contractor to ensure BH continuity of care for every Soldier.

(3) Conducts risk, comprehensive BH and psychosocial assessments.

(4) Performs BH care management.

(5) Enters information into automation systems (AHLTA, Psychological and Behavioral Health – Tools for Evaluation Risk and Management (PBH–TERM)), and AWCTS.

(6) Provides short-term therapy, counseling, Family, or caregiver support.

(7) Attends interdisciplinary meetings.

(8) Provides oversight or conducts scrimmages.

(9) Refers, educates and advocates for Soldiers, their Families, or caregivers.

(10) Provides briefings and cadre and peer support.

(11) Conducts preliminary BH needs and risk assessment outlined in chapters 4 and 5.

*g. The occupational therapist.* The occupational therapist (OT) responsibilities are a departure from the traditional role of Army OTs acting as a health care provider, but are within the scope of practice for occupational therapy. In a separate company, the OT provides all the assigned functions for occupational therapy. Separate companies without OTs will utilize the PSG and NCM to properly coordinate functional activities such as CER for their Soldiers. If an OT is not assigned, commanders will select the best qualified member of his cadre to provide the Phase I goal setting training using the established slides presentation software and workbook in conjunction with a WTU Comprehensive Soldier and Family Fitness Training Center. A regionally assigned OT will train the identified cadre member prior to assuming these duties. The OT—

(1) Conducts an initial screening for newly assigned Soldiers within 14 days which include housing needs.

(2) Initiates the goal setting process.

(3) Serves as the Computer and/or Electronic Accommodations Program representative.

(4) Provides guidance on Soldier activities of daily living (ADL) and training for advanced life skills.

(5) Provides Phase I goal setting training to Soldiers within 21 days of assignment or attachment and WTU cadre.

(6) Serves as referral source to Comprehensive Soldier and Family Fitness Training Center for Phase II goal setting training and complete Phase II within 90 days of Soldier's assignment or attachment.

(7) Provides functional assessments for work reintegration and work site placements.

(8) Conduct work site assessment when necessary.

(9) Collaborates with the career counselor and transition coordinator (TC) to implement an individual reintegration program for Soldiers, especially those who have suffered a major change in lifestyle due to sustained injuries.

(10) Collaborate with interdisciplinary team for Adaptive Reconditioning Program as required.

(11) Provides supervision, oversight and direction over all assigned WTU certified occupational therapist assistants (COTAs).

(12) Contributes to program outcome measurement and metrics.

(13) Additional roles and responsibilities are outlined in chapter 5 and throughout the regulation.

*h. The physical therapist.* The physical therapist's (PT's) responsibilities are a departure from the traditional role of Army PTs acting as a MTF-based health care provider, but are within the scope of practice for PTs. Separate companies will coordinate with the MTF or TRICARE regional contractor for required PT support. The PT—

(1) Is the Soldier Adaptive Reconditioning Program developer, manager, and SME for the WTU command.

(2) Is the SME for all adaptive reconditioning activities and physical training injury prevention.

(3) Conducts initial screenings, evaluations, and reassessments of Soldiers for participation in an Adaptive Reconditioning Program.

- (4) Completes initial assessment and develops an Adaptive Reconditioning Program tailored to individual Soldiers capabilities and needs within 30 days of assignment to the WTU.
  - (5) Provides contributions to goal setting, in any of the six CTP domains, for which adaptive reconditioning activities or other physical therapy assessment findings are appropriate.
  - (6) Reviews, modifies, or initiates physical profiles (eProfile).
  - (7) Assists with neuro-musculoskeletal care coordination.
  - (8) Provides supervision, oversight and direction of all assigned WTU physical therapy assistants (PTA).
  - (9) Performs all the functions of a WTU PTA, when assigned to a separate company.
  - (10) Contributes to program outcome measurement and metrics.
  - (11) Additional roles and responsibilities are outlined in chapter 5 and throughout the regulation.
- i. The Warrior Transition Battalion transition coordinator.* The TC works directly for and reports to the battalion executive officer. Commanders of separate companies will designate an individual from their staff to serve as the TC. In support of the Soldier's CER activities, the TC will—
- (1) Manage the CER program for all WTB Soldiers.
  - (2) Coordinate, track and report Federal internship opportunities both on and off the installation, including collaboration with the DOD OWF regional coordinator for OWF internships and the VA VR&E staff for Coming Home to Work internships.
  - (3) Coordinate, track and report educational opportunities provided through Army Continuing Education System (ACES) programs and the VA.
  - (4) Coordinate, track and report Soldier work site opportunities that align with the “remain in the Army” track.
  - (5) Coordinate, track and report Soldier completion of resume training and a completed resume of choice – Federal or non-Federal.
  - (6) Coordinate services with Soldier for Life – Transition Assistance Program counselors, ACES counselors, VA and VR&E counselors, Department of Labor representatives, and other SFAC and community support organizations.
  - (7) Coordinate and work closely with OT staff, career counselor, SL and/or PSG to select appropriate CER activities aligned with the Soldier's CTP track, anticipated final medical disposition, and career goals.
  - (8) Based on the OT assessment, assist the Soldier in the development and refinement of their CER plan and assist with and track with the completion of the CER plan, the reintegration and the transition readiness standards.
  - (9) Convene an interdisciplinary team meeting as required to address the Soldier's non-compliance with their CER plan or inability to execute their CER plan.
- j. Unit ministry team.* Unit ministry team (UMT) consists of a chaplain and chaplain assistant assigned at the battalion level and above. This team's mission is to respond to the religious, moral, and spiritual needs of Soldiers, their Families, and other assigned personnel. The chaplain is a personal staff officer to the commander who advises on matters of religion, morals and morale as affected by religion. Chaplains assigned to WTUs are specially trained in the integration of faith and health care. They lead in the role spirituality plays in a Soldier's physical healing. WTUs that do not have UMTs assigned will rely on the MTF, RMC, or Installation chaplain for area religious coverage. The UMT is constituted and trained to perform or provide religious support services including but not limited to the following:
- (1) Religious services.
  - (2) Rites, sacraments, and ordinances.
  - (3) Pastoral care and counseling.
  - (4) Religious education.
  - (5) Hospital visitation.
  - (6) Pastoral support to the commander and staff.
  - (7) Advice on ethics and ethical decisionmaking.
  - (8) Maintaining and managing ecclesiastical supplies.
  - (9) Facilitation of free exercise of religion for assigned personnel.
  - (10) Conducting marriage, Family, and Soldier retreats.
  - (11) Supporting and monitoring the Soldier's CTP Spiritual plan as necessary.
- k. Adjutant (S-1 officer).* In separate companies the senior HR NCO will perform the duties of the adjutant. The adjutant—
- (1) Conducts mission analysis of all matters concerning HR support (military and civilian).
  - (2) Considers factors relating to manning, personnel services, and support.
  - (3) Analyzes personnel strength data to determine current capabilities and projects future requirements for WTU manpower requirements.
  - (4) Analyzes unit strength maintenance, including monitoring, collecting, and analyzing data affecting Soldier readiness.
  - (5) Prepares estimates for personnel replacement requirements, based on estimated losses, and foreseeable administrative losses to include critical military occupational skill requirements.

- (6) Determines personnel services available to Soldiers (current and projected).
  - (7) Ensures RC Soldiers' medical retention processing orders remain current.
  - (8) Assists Family members and/or NMA on travel pay advances, voucher settlements, and so forth.
- l. The operations and training officer.* The operations officer (S3), with assistance by the S3 section—
- (1) Is responsible for plans, operations, and functions for the WTU.
  - (2) Prepares broad plans, policies, and programs for command organizations, operations, and functions based on the battalion commanders' guidance.
  - (3) Is responsible for developing the training programs and developing metrics to ensure all cadre personnel demonstrate satisfactory levels of understanding and work production.
  - (4) Makes training available through training modules that can be accessed either via the Internet or in a written document as reference material.
  - (5) Is responsible for providing Army Warrior training for Soldiers in the remain in the Army track.
  - (6) Is responsible for providing orientation and training on the CTP requirements and processes to all WTU Soldiers.
- m. The supply officer (S-4).* The S-4 is assisted by the S-4 section (or the supply specialist in separate companies) in—
- (1) Determining critical requirements for each service and support function and identifying potential problems and deficiencies.
  - (2) Assessing the status of all service and support functions required to support any possible courses of action and compares them to available assets.
  - (3) Monitoring logistics support for WTUs.
  - (4) Identifying potential shortfalls and recommending actions to eliminate or reduce their effects.
- n. Comprehensive Transition Plan management analyst.* The CTP management analyst—
- (1) Works directly for the S3 and ensures the integrity and accuracy of data in AWCTS.
  - (2) Ensures quality execution of the processes within AWCTS.
  - (3) Extracts reports and manages data for the commander.
  - (4) Serves as the local SME on the AWCTS and provides training and support to unit staff as needed.
  - (5) Collects and submits requests on AWCTS data deficiency report, and enhancement requests on behalf of unit staff.
- o. Medical evaluation board physician.* The MEB physician is normally managed by the MTF DCCS.
- p. Family readiness support assistant.* The Family readiness support assistant (FRSA)—
- (1) Helps with implementing and maintaining Family support services.
  - (2) Coordinates with community agencies.
  - (3) Coordinates briefings, orientation, and workshops to inform Soldiers and their Families about the functions of the Family readiness programs and reunion issues.
  - (4) Provides information to Families about WTU events, opportunities and initiatives.
  - (5) Coordinates with Community Care Unit commanders to ensure Community Care Unit Soldiers are connected with their unit Family support program.
  - (6) Ensure FRSA's provide a continuum of services to Family members and caregivers.
- q. Soldier and Family Assistance Center director.* SFAC director, while separate from the WTU structure, plays a key role to the success of SFAC programs in the WTUs. He or she provides program guidance and leadership while implementing a tailored, integrated administrative support services program that acts as an information broker and clearing house in a location proximate and convenient for Soldiers and their Family members (see AR 608-1, chap 2). This includes—
- (1) Providing the highest quality customer service.
  - (2) Offering accurate and timely information and/or needed referral services.
  - (3) Offering a goal oriented family support plan for Family members.
  - (4) Encourage Family members to participate in resilience training and education.
- r. Army Wounded Warrior advocate.* An AW2 advocate will provide the following assistance to their assigned AW2 Soldiers (see AW2 eligibility criteria in chap 2):
- (1) Review the AW2 AWCTS module dashboard.
  - (2) Enter AW2 information and assistance provided in the AW2 AWCTS module.
  - (3) Monitor Soldier goals and CTP action plans to mitigate Soldier issues.
  - (4) Participate in scrimmages, FTR, and interdisciplinary team meetings, and have access to all relevant Soldier information and documentation.
  - (5) Collaborate with the interdisciplinary team.
- (a) Advocate role in the interdisciplinary team—*
- 1. Contacts WTU command as a check and balance to identify and refer WTU and AW2 Soldiers.

2. Works with WTU case managers.
3. Works and assists with SFAC.
4. Coordinates with VA Remote Care for smooth transition.
5. Coordinates with PEBLOs, Patient Administration Division, and TRICARE Service Centers.
6. Notifies WTU of Soldiers interested and/or approved for COAD or COAR.
7. Assist and coordinate retirement and disability compensation, health care (TRICARE, VA Health Care Medicare and Medicaid), and other benefits.

(b) Coordinate post-WTU career plan with the TC and the AW2 Career Cell at medical retention determination point (MRDP) as appropriate.

s. *Career counselor.* The career counselor in a WTB will assist Soldiers in extending for continued medical care and provide counseling on all aspects of Soldiers' military career to include education, promotion, reclassification, retention, retraining, and transition into the RCs. He or she also serves as the liaison for COMPO 2 and 3 Soldiers while assigned to the WTU. The career counselor is the POC for expiration term of service changes and MOS Administrative Retention Review (MAR2) processing.

t. *Soldiers Medical Evaluation Board Counsel.* The Soldiers MEB Counsels are licensed uniformed and civilian attorneys of the Army Judge Advocate General Corps who are specifically trained and certified to provide legal advice representation to Soldiers in the MEB and PEB process. Soldiers' MEB Counsel represent and advise Soldiers and are bound to attorney-client confidentiality.

## **2–25. Key company Warrior Transition Unit staff members**

a. *Company commander.* The WTU commander is the individual appointed to provide mission command to the WTU. The commander is responsible for all the WTU accomplishes or fails to accomplish. The company commander is ultimately responsible for the successful execution of Triad meetings. The commander receives frequent updates on the health status of Soldiers in the command. He or she directs actions to ensure that all standards of care and transition for Soldiers are met. The commander is responsible for establishing the leadership climate of the unit and developing disciplined and cohesive units. This sets the parameters within which command will be exercised, and therefore, sets the tone for social and duty relationships within the command (see AR 600–20). The commander will—

(1) Ensure risk assessments are established and documented in AWCTS within 24 hours of attachment or assignment.

(2) Ensure appropriate risk mitigation measures for high risk Soldiers.

(3) Monitor and report appropriate unit metrics to track CTP execution.

(4) Complete commander's performance and functional statement or memorandum for submission to PEB (see AR 635–40).

(5) Review all Profiles (DA Form 3349 (Physical Profile)) on all assigned or attached Soldiers regardless of component.

(6) Ensure Soldiers are in compliance with ARs.

(7) Evaluate each Soldier for eligibility to participate in CER activities based on the Soldier's demonstrated initiative and self-discipline.

b. *First sergeant.* The 1SG will—

(1) Assist the commander in planning, coordinating, and supervising all activities that support the WTU mission.

(2) Advise the commander on Soldier issues to include duty profiles and status of Soldiers assigned or attached.

(3) Coordinate unit administration to include submission of required reports.

(4) Counsel and provides guidance to Soldiers and other subordinate personnel.

(5) Conduct inspections of unit activities and facilities, observes discrepancies, and initiates corrective action.

(6) Ensure Soldiers maintain the yearly requirement for completing assessment in the Comprehensive Soldier and Family Fitness Global Assessment Tool.

(7) Ensure PSG effectively manages the Respite Pass Program (see para 6–29).

(8) Ensure WTU Soldiers and cadre deployment health assessments (DD Form 2796 and DD Form 2900) completion within 30 days of redeployment and between 90 to 180 days of redeployment respectively.

(9) Ensure WTU Soldiers and cadre complete their individual medical readiness requirement.

c. *Platoon sergeant.* The PSG assists Soldiers and their Families with their medical needs and reports to the company commander and 1SG and will—

(1) Ensure and maintain daily accountability of Soldiers.

(2) Ensure Soldiers comply with all assigned tasks.

(3) Supervise SLs and routinely inspects counseling files, individual CTP, living quarters, and any other areas of Soldiers well-being and care designated by the commander.

(4) Maintain weekly oversight of Soldiers' self-assessment and ensures SL validations provide appropriate action oriented comments to action plans.

- (5) Manage Soldiers work site placements within the platoon and verifies quality of work through face to face or telephonic twice a week checks.
- (6) Manage the movement of Soldiers between SLs within the platoon in accordance with mission requirements to ensure adequate Soldier supervision.
- (7) Review, approve or disapprove Soldiers identified for cancellation of weekly self-assessment in AWCTS.
- (8) Teach, coach, and mentor all Soldiers within the platoon.
- (9) Assume the duties of the company 1SG as required.
- (10) Ensure Soldiers participate in an Adaptive Reconditioning Program tailored to the individual Soldier physical capabilities and needs.
- (11) Make face-to-face contact with Soldiers assigned to his or her platoon on a daily basis. It is imperative the PSG gets to know their Soldiers, so he or she can support the SL when Soldiers develop BH, personal, or other problems.
- (12) Develop a Respite Pass Program that enables SLs to take respite pass without overburdening other SLs (see para 6–29).
- (13) Maintain communication logs and notifies the NCM on any potential recovery issues.
- (14) Ensure Soldiers maintain the yearly requirement for completing assessment in the Comprehensive Soldier and Family Fitness Global Assessment Tool.
- (15) Ensure WTU Soldiers and SLs Deployment Health Assessments (DD Form 2796 and DD Form 2900) completion within 30 days of redeployment and between 90 to 180 days of redeployment respectively.
- (16) Ensure WTU Soldiers and SLs complete their individual medical readiness requirements. The Community Care Unit SL and/or PSG will—
  - (a) Make daily accountability calls to Soldiers.
  - (b) Have a periodic CTP call with the individual Soldiers to evaluate their progress on their CTP goals. The frequency of these calls will be based on Soldiers’ maturity, risk level, and commitment to the CTP.
  - (c) Assist Soldiers in finding appropriate CER opportunities that align with their career track and goals.
  - (d) Contact each work site supervisor monthly to assess the Soldiers’ work performance and participation.
  - (e) Fulfill the duties of the WTU SL as listed.
  - (f) Document the commander’s evaluation of eligibility to participate in CER activities for each Soldier.
- d. *The squad leader.* The SL is the critical link for the Soldier to the chain of command, the NCM, and the PCM. The SL is the first line supervisor for the Soldier. The SL should build a relationship of trust with everyone they contact in support of their Soldiers. Trust and confidence are the SL’s most valuable assets in assisting their Soldiers. The SL works as part of the Triad of Care providing for the care of their Soldiers and Families. The SL will—
  - (1) Maintain accountability of their Soldiers and equipment and report all accountability failures to the commander. Make face-to-face contact with Soldiers assigned to his or her squad on a daily basis.
  - (2) Coach, mentor, and counsel their individual Soldiers, including their eligibility to transfer.
  - (3) Document the commander’s evaluation of eligibility to participate in CER activities for each Soldier.
  - (4) Collaborate with the interdisciplinary team to maintain Soldier accountability related to CER activities, to include education classes, and work site placement and ensures Soldiers are at their respective place of duty.
  - (5) Report all work site absences to the TC.
  - (6) Contact each work site supervisor weekly to assess Soldier’s work performance. Where feasible visit each Soldier’s CER work site monthly.
  - (7) Link Soldiers to SFAC for administrative services and benefits.
  - (8) Submit requests for awards and decorations.
  - (9) Ensure that the Soldier’s records are transferred from losing unit to gaining unit.
  - (10) Inspect the condition of Soldier’s billeting, clothing, and equipment.
  - (11) Keep the PSG informed on squad’s medical status and requirements.
  - (12) Ensure their Soldiers participate in an Adaptive Reconditioning Program tailored to individual physical capabilities and needs.
  - (13) Meet with NCM assigned to SLs Soldiers daily.
  - (14) Validate Soldiers Self Assessments in accordance with AWCTS instructions.
  - (15) Conduct risk assessments as described throughout this chapter and chapters 3 and 4. Informs command of changes to Soldiers risk level if the Soldier increases in risk.
  - (16) Ensure Soldiers maintain the yearly requirement for completing assessment in the Comprehensive Soldier and Family Fitness Global Assessment Tool.
  - (17) Ensure WTU Soldiers Deployment Health Assessments (DD Form 2796 and DD Form 2900) completion within 30 days of redeployment and between 90 to 180 days of redeployment respectively.
  - (18) Ensure WTU Soldiers complete their individual medical readiness requirements.
- e. *Primary care manager.* The relationship developed between Soldiers and the PCM is the basis for successful prevention-oriented, coordinated health care. Soldiers benefit from consistent health care and improved overall health.

The PCM must play an active leadership role in each Soldier's care, through effective communication with other interdisciplinary team members, especially the other members of the Triad of Care. Wherever feasible, physician PCMs should be residency-trained in a primary care or occupational medicine specialty (family, internal, or emergency medicine, pediatrics, physical and rehabilitative medicine, or occupational health); midlevel provider PCMs should be specifically trained in the primary care realms of their respective disciplines. In separate companies, the PCM also serves as the WTU surgeon. The PCM—

(1) Provides primary health care and evaluates the holistic medical requirements for the Soldier, and plans, directs, and oversees all Soldiers care during their time in the WTU.

(2) Communicates with specialty and ancillary providers including BH, and ensures that their plans are included in Soldier care-related meetings and discussions.

(3) Advises the commander on all health-related issues for all assigned Soldiers.

(4) Writes permanent profiles with designators of three or four for all assigned Soldiers.

(5) Ensures Soldiers with permanent profiles with designators of three or four are referred to a MAR2 or MEB and PEB, as appropriate.

(6) Determines Soldiers immediate and ongoing need for NMAs.

(7) Determines if Soldiers are medically qualified for SCAADL.

*f. Nurse case manager officer in charge.* The NCM officer in charge (OIC)—

(1) Works for the company commander with supervisory oversight from the battalion, brigade, or RMC supervisor NCM.

(2) Is responsible for the supervision and oversight of NCM functions within the company.

(3) Coordinates and evaluates nursing activities to ensure safe and cost effective patient care through the efficient use of NCM staff and clinical resources.

(4) Plans, implements, and evaluates nursing activities in accordance with regulations, policies, and national standards of care.

(5) Ensures NCMs maintain the skills necessary to function competently within the standards of practice for case managers.

(6) Develops a Respite Pass Program that enables NCMs to take regular or compensation leave, or respite pass without overburdening other NCMs (see para 6–29).

(7) Monitors Soldier acuity and NCM ratios to ensure safe caseloads are maintained.

(8) Maintains an average caseload of up to 10 Soldiers when assigned to a brigade or battalion size WTU.

(9) Uses AWCTS to refer Soldiers who meet AW2 eligibility criteria to WTU-based advocate.

(10) Ensures coordination with VA liaison for health care or VA OEF/OIF/OND program manager for smooth transition to VA health care.

*g. Nurse case manager.*

(1) The NCM is a registered nurse who works with the Soldier throughout the medical treatment, recovery, and rehabilitation.

(2) Using a collaborative team approach, the NCM—

(a) Assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the complex health needs of Soldiers.

(b) Promotes appropriate, timely, clinically, and cost effective patient care.

(c) Works directly with the interdisciplinary team to ensure that each Soldier develops and executes an effective CTP.

(d) Documents the commander's evaluation of eligibility to participate in CER activities for each Soldier.

(e) Meets with Soldiers weekly and promptly documents correspondence meeting and/or telecom notes in AHLTA, Essentris, or Medical Operational Data System – Warrior in Transition (MODS–WT) module and AWCTS, as applicable.

(f) Meets with SLs assigned to the NCM's Soldiers daily.

(g) Informs company lead NCM of issues early.

(h) Conducts a visit to the Soldiers barracks room (if on post) along with SL at least once during the Soldiers first 30 days assigned to provide input to commanders on Soldiers risk, then every 6 months.

(i) Validates Soldiers self assessments in accordance with AWCTS instructions.

(j) Conduct risk assessments as in chapter 4. Informs command of changes to Soldiers risk level if the Soldier increases in risk.

(k) Works closely with PCM or nurse practitioner, assisting with administrative requirements, consultation and referral entry, and coordination.

(l) Ensure WTU Soldiers Deployment Health Assessments (DD Form 2796 and DD Form 2900) completion within 30 days of redeployment and between 90 to 180 days of redeployment respectively.

(m) Ensure WTU Soldiers complete their individual medical readiness requirements.

(n) Coordinates closely with VA liaison and identify Soldiers transitioning from the Army for transfer of health care to VA or to VA OEF, OIF, and/or OND program manager.

*h. Company licensed clinical social worker.* Company LCSWs have a masters degree in social work and are independently licensed by their State to conduct clinical social work assessments, diagnosis and treatment (therapy); have passed a National clinical exam to conduct therapy and/or have the highest level of licensure granted by their State. The LCSW cannot prescribe medications, conduct psychological testing or admit Soldiers to the hospital. A licensed master social worker under clinical supervision of the LCSW may perform the duties of the LCSW with some exceptions. Although licensed master social workers have a masters degree in social work, they have a non-clinical license and may only assess, diagnose, and treat under clinical supervision approved by the MTF credentialing board (see AR 40–68). The LCSW—

- (1) Is the lead regarding BH issues in the WTU.
- (2) Works with the Triad of Care, MTF, Sister Services, and TRICARE to ensure BH continuity of care for every Soldier.
- (3) Conducts risk assessments (see chaps 4 and 5, sec III).
- (4) Conducts comprehensive BH and psychosocial assessments.
- (5) Provides BH care management.
- (6) Enters information into automation systems (AHLTA, PBH–TERM, and AWCTS).
- (7) Provides short-term therapy, counseling, and Family or caregiver support.
- (8) Attends interdisciplinary meetings.
- (9) Conducts and provides oversight of scrimmages.
- (10) Refers, educates, and advocates for Soldiers, their Families or caregivers.
- (11) Provide briefings, cadre, and peer support.
- (12) Provides supervision of other LCSWs, licensed master social worker, BLSW, or SSA.

*i. The baccalaureate licensed social worker.* The BLSW has a bachelors degree in social work and may or may not have a license. SSAs also serve in this role under the supervision of the LCSW and may have a bachelor’s degree or experience, which qualified them for the position. These duties are performed by the Community Care Unit LCSW. The BLSW or SSA—

- (1) Leads, conducts, and coordinates the scrimmage of the six domains (may be conducted by the LCSW).
- (2) Manages, coordinates, monitors, and evaluates options and services to meet complex BH needs of the Soldier and Family.
- (3) Works with and directly supports the LCSWs and the WTU staff to ensure continuity of care of the Soldier and Family.
- (4) Conducts educational classes, seeks applicable resources, referrals, and advocacy for the Soldier, Family, and the WTU cadre.
- (5) Attends interdisciplinary team meetings.
- (6) Coordinates meetings and appointments.
- (7) Enters information into automation systems (AHLTA, PBH–TERM, and AWCTS).

*j. Certified occupational therapy assistant.* Following the initial assessment by the WTU OT, the WTU COTA implements the established plan and works under the supervision, direction and oversight of the WTU OT. The COTA assists with all aspects of program implementation, as directed by the OT, to ensure a successful transition for the Soldier. All COTA roles and responsibilities are within the scope of practice for occupational therapy.

*k. Physical therapy assistant.* Following the initial assessment by the WTU PT, the WTU PTA implements the established plan and works under the supervision, direction and oversight of the WTU PT. The WTU PTA assists with all aspects of program implementation, as directed by the WTU PT, to ensure a successful transition for the Soldier. All WTU PTA roles and responsibilities are within the scope of practice for a PTA.

*l. Comprehensive Transition Plan management analyst.* The CTP management analyst—

- (1) Works directly for the company commander.
- (2) Ensures the integrity and accuracy of AWCTS data.
- (3) Ensures the quality execution of the processes within AWCTS.
- (4) Prepares reports and manages data for the commander.

*m. Company executive officer.* The company executive officer—

- (1) Assumes command of the company in the absence of the commander.
- (2) Oversees company personnel activities.
- (3) Keeps the commander informed on Soldier issues that require their attention.
- (4) Conducts weekly meetings.
- (5) Works with company cadre and other company elements to resolve any Soldier standard of care issues.
- (6) Receives daily updates on unresolved Soldier issues.

*n. Human resources specialist.* The HR specialist—

- (1) Performs a wide variety of procedural and substantive clerical work in support of military personnel functions.
- (2) Is directly responsible for reviewing and ensuring all actions processed are in compliance with regulatory guidelines and local policies.
- (3) Maintains all company rosters and functional files in accordance with the approved Army filing system.
- (4) Conducts in-processing or out-processing counseling and is primarily responsible to update AWCTS data.
- (5) Screens records.
- (6) Executes platoon and NCM assignments.
- (7) Inputs personnel data into the Army Medical Department Human Resources and Warrior Transition Database for all newly assigned Soldiers.
- (8) Reviews consolidated reports, statistics, applications, and prepares recommendation for personnel actions to higher headquarters.

## **2-26. Family readiness support assistants**

FRSAs are located in major Army installations and serve as a conduit for Family members and caregivers by assisting the chain of command or the Family Readiness Group (FRG). FRSAs will—

- a. Execute well-being calls to Families of WTU Soldiers, by referring Family members to services located at the SFAC and ACS.
- b. Provide various command sponsored Family events and FRG activities.
- c. FRSA's responsibilities and services are described in AR 608-1.

## **2-27. Religious and spiritual care**

Religious support and spiritual care are important components of the WCTP. A holistic approach to health care requires that chaplains and other spiritual caregivers be integrated into the transition process. Chapters 3 and 4 further discuss the roles and responsibilities chaplains perform in the CTP.

## **Section IV**

### **Command Communication with Soldiers**

## **2-28. Army goals**

The Army seeks to provide a WTU chain of command that is accessible, responsive, and compassionate to the unique challenges of Soldiers and their Families or caregivers. Experience shows that when the chain of command does not exhibit these attributes, individual Soldiers' healing and transition are inhibited, and they will turn to external sources for support and redress.

## **2-29. Town hall meetings and open door policy**

a. Town hall meetings are for the dissemination of new information impacting Soldiers and their Families. It is an opportunity for SCs to address the Soldiers and listen to their concerns. The town hall is another avenue in addition to the meetings required in the CTP that commanders can use to interface with Soldiers and their Families in order to promote accessibility, responsiveness, and compassion. The town hall meeting is conducted in an open, non-retribution manner where Soldiers and their Families can voice their concerns, make suggestions to improve the program, and have their questions answered.

(1) The frequency of town hall meetings is at the commander's discretion, but should be conducted not less than quarterly. More frequent meetings are encouraged at commander's discretion.

(2) For Soldiers off the installation, attached to Community Care Unit, or other community based care, commanders should take advantage of and conduct their town hall meetings during the required quarterly musters held at the Community Care Unit, on the installation, or in the community.

b. In accordance with AR 600-20, commanders will establish an open door policy within their commands. WTU commanders will maintain an open door policy that allows WTU Soldiers the opportunity to speak with their chain of command and staff as their unique situation warrants. An open door policy provides the command with additional opportunity to be proactive in addressing Soldier's concerns and executing a successful resolution.

## **Section V**

### **Government Owned and Leased Housing Assignment and Termination, Facility Maintenance, Inspection Standards, and Reporting**

## **2-30. Background**

Wounded, ill, or injured Soldiers and their Families must be afforded the maximum opportunity to focus on their recovery and rehabilitation and not on maintenance problems and inadequate housing standards. WTU commanders and cadre should not settle on good-enough and must put in place policies and procedures to proactively address issues that affect the quality of life of Soldiers and their Families. WTU commanders must ensure Government owned and leased

unaccompanied housing are safe and provide a living environment that is clean, well maintained, and which provide a quality of life that facilitates recovery and rehabilitation.

### **2-31. Purpose**

To provide guidance regarding unaccompanied housing assignment and termination, facility maintenance standards, responsibility for correction actions, reporting responsibilities, inspection standards, and inventory utilization of lodging facilities for Soldiers in WTUs.

### **2-32. Policy**

*a.* Wounded, ill, or injured Soldiers and their Families and caregivers will be afforded the maximum opportunity to focus on their recovery and rehabilitation and not on maintenance problems and inadequate lodging. Commanders and cadre must put in place policies and procedures to proactively address issues that affect the quality of life of Soldiers and their Families and caregivers.

*b.* Soldiers and cadre in WTUs will take all available precautions to ensure that prescription and non-prescription medications are handled, stored and utilized in a safe and medically appropriate manner. Specifically, Soldiers, cadre, and caregivers will—

(1) Secure all medications and their containers other than when the medication is being taken or administered. Where available, medication will be secured in a safe or other locked storage.

(2) Allow medications only to be taken by or administered to the individual for whom they were prescribed or recommended. Medications will not be shared with any other person.

(3) Medications will be stored in either the original labeled container or a dispensing container specifically and professionally designed and approved for the purpose of dispensing medications.

(4) Ensure medications are taken or administered according to the label instructions.

(5) Ensure disposal of unused or unneeded medications is conducted according to applicable law and policy.

### **2-33. Lodging assignment and hospitality**

Commanders will ensure arriving Soldiers are welcomed professionally and accommodated properly in WTU barracks and installation owned or leased lodging facilities. This includes developing and following customer focused room assignment procedures to ensure Soldiers are assigned to lodging commensurate with their personal and medical requirements and the cadre and staffs are courteous and responsive to unique furniture arrangement needs of the WTU Soldier.

### **2-34. Soldier transitions and lodging**

Commanders must ensure WTU Soldiers' in-processing procedures are efficient, consolidated, customer service focused, and reflect a positive command climate. These procedures should apply to Soldiers and their Families and caregivers initially entering into the WCTP and those Soldiers at vulnerable points of transition (from inpatient to outpatient, Soldiers returning from treatment in the ASAP, WTU to Community Care Unit, Community Care Unit to WTU). Commanders must—

*a.* Establish a Soldier transition standard operating procedures (SOPs) specific to lodging practices.

*b.* Coordinate with the M2 staff to ensure smooth transition occurs between inpatient and outpatient environments. This transition must be rehearsed and must support the needs of the Soldier and Family and caregiver requirements.

*c.* Focus on the change in environment for the Soldier and Family member and caregiver. A positive first impression is essential and every effort must be made to allow Soldiers and their Families and caregivers to focus on their well being and their transition goals.

### **2-35. Maintenance standards**

Commanders must employ proactive lodging problem identification (ID) and ensure deficiencies do not distract Soldiers from their recovery and rehabilitation. Procedures to address lodging facility problems must include a decision point to move the affected Soldier to alternate lodging to minimize the impact on their quality of life. Soldiers should be the best source of information for deficiencies but cannot be the only method employed to identify and report problems with facilities. Establish a unit SOP that identifies how maintenance standards will be enforced and at a minimum addresses the following:

*a.* Ensure 1SGs are accountable for health, welfare, and security of all assigned Soldiers and all personnel residing in barracks under their First Sergeants Barracks Program footprint.

*b.* Command teams are accountable for appropriate work order tracking and resolution.

*c.* Appoint a barracks NCO or an individual on each floor for Soldiers to report deficiencies to and delegate barracks NCO to report, manage, and track completion of all work orders reported to Director of Public Works (DPW).

*d.* Assign charge of quarters.

*e.* Establish rules and procedures for barracks NCO to report unresolved deficiencies to 1SG for further action with DPW.

*f.* Establish work order tracking and resolution mechanism, and a timeline from the time the deficiency is reported to the time the deficiency is resolved. Timeline may vary based on installation DPW, however commanders must ensure the supporting Installation support team is aware of the enhanced necessity and sensitivity toward correction of WTU facilities issues (for example, in the event of heating, ventilation, and air conditioning or water heater failure, medical necessities of Soldiers recovering from surgical procedures or burns requiring faster attention from facilities personnel than a standard barrack).

*g.* Establish standards that ensure good order and discipline in the barracks are maintained at all times.

*h.* Ensure contingency plan is in place for potential Soldier relocation while significant maintenance problems are addressed.

*i.* Report any degradation of or adjustments impacting the infrastructure or provision of medical care supporting Soldiers assigned or attached to a WTU, including Government owned or leased housing, clinical or administrative support (for example, SFAC) activities to MEDCOM as a commander's critical information requirement item in accordance MEDCOM local policy.

*j.* Establish standards and procedures for command visits at off post and/or civilian housing to assess quality of life conditions.

## **2–36. Inspection standards**

*a.* Inspections must be thorough, involve the chain of command, and consider seasonal impacts (for example, heating, cooling, hot water). Relying on room sampling or another organization's inspection program is not sufficient to ensure that lodging facilities are at the standard of a Soldier's entitlement. Commanders must know the inspection intervals, process, and areas of emphasis of the various lodging facility inspections, and look for and address gaps.

(1) At a minimum, all WTU facilities must be inspected monthly by the chain of command and at least weekly by SL and/or PSG. Random room checks and walk through between inspections are highly encouraged.

(2) Ensure Soldiers, where applicable, secure their prescription and non-prescription medications in their original containers in a safe or other locked storage when not being taken or administered.

(3) Inspector general for each RMC will inspect quarters and housing facilities under their jurisdiction annually and will—

*(a)* Submit a report on their inspection to the post commander, the commanding officer of the hospital affiliated with the facility, TSG, the SECARMY, the Assistant Secretary of Defense for Health Affairs, and the Congressional Defense Committees.

*(b)* Post each report of inspection on the respective RMC's Internet Web site.

*(c)* Provide WTC a copy of their annual inspection dates and findings.

*b.* Reporting procedures. Commanders will establish commander's critical information requirements to identify facility issues as quickly as possible, and report and resolve them at the appropriate leadership level.

## **2–37. Reporting procedures**

Commanders must establish and rehearse commander's critical information requirements to identify and resolve facility issues as quickly as possible and at the appropriate leadership level. Report any degradation of or adjustments impacting the infrastructure or provision of medical care supporting Soldiers assigned or attached to a WTU, including Government owned or leased housing, clinical support (for example, SFAC) activities to MEDCOM as a Commander's Critical Information Requirement item.

## **Section VI**

### **Medical Command Medical Assistance Group Ombudsmen Program**

#### **2–38. Background**

The Ombudsman Program functions as an independent, neutral and impartial mediator for Soldiers and their Family members. Ombudsmen are located in, but not assigned to MTF and serve as a liaison between MEDCOM, the Soldier and Family member, the MTF commander, and the WTU commander, acting as a communicator, facilitator and problem solver. Ombudsmen have a collaborative relationship with the MTF Patient Advocacy Office and work closely with MEDCOM Medical Assistance Group, to assist with the resolution of issues that come through the Army Wounded Soldier and Family Hotline.

#### **2–39. Ombudsman Program**

*a.* The Ombudsman Program provides assistance to Soldiers assigned to a WTU and their Families as well as non-WTU Soldiers and their Family members with medical and non medical issues. Commanders should ensure Ombudsmen have access to town hall meetings and provide information that will facilitate the Soldier's awareness of the Ombudsman Program.

*b.* The Ombudsman Program provides the following services:

- (1) Resolve complaints, assist in obtaining accurate information, and act as a resource for Soldiers and their Families as well as any other Soldiers seeking assistance.
- (2) For Soldiers assigned or attached to a WTU, Ombudsman is expected to assist with any issue, medical and nonmedical, for which the WTU Soldier is seeking assistance.
- (3) Respect all requests for anonymity and maintain required HIPAA training.
- (4) Identify and document lessons learned for system improvement and communicate data to facilitate improvements.
- (5) Immediately report any issue that is beyond the scope of local resolution to the MEDCOM Medical Assistance Group to determine the appropriate staff for assessment and resolution.
- (6) Direct inquiries to appropriate staff for assessment and resolution.
- (7) Report situations to the leadership where regulations and policies are not consistent with the tenants of the WCTP.
- (8) Serve as a neutral, independent, and impartial source of information who will work to solve issues and disputes.
- (9) Evaluate processes and make recommendations for effective organizational change.
- (10) Maintain database to track and monitor issues, resolution, and outcomes.
- (11) Produce valid and timely reports. Ombudsman reporting procedures may change as the Ombudsman Case Tracking and Reporting System is implemented.
- (12) Attend meetings, conferences, and town hall sessions.
- (13) Keep local commanders informed as to the type of cases are being worked and how resolution was or will be achieved as well as any trend or pattern that has been identified. In cases where anonymity has been requested, Ombudsmen may share details regarding the issue but may not divulge the complainant's identity.

## **Chapter 3**

### **Comprehensive Transition Plan**

#### **3-1. Policy**

- a.* All Soldiers assigned or attached to a WTU will begin the CTP process upon assignment or attachment to a WTU. The CTP is a dynamic living plan of actions that focuses on the Soldier's future. The CTP uses six domains which includes career, physical, emotional, social, Family, and spiritual to establish goals that map a Soldier's transition plan. These six domains are further defined in paragraph 2-9 of this regulation.
- b.* As owners of the CTP, Soldiers are empowered to take charge of their own transition and are accountable for developing and achieving their goals while complying with all the medical and military responsibilities specified in paragraph 2-21.
- c.* The Triad of Care (see para 1-6c) will lead the interdisciplinary team in supporting the Soldier with training, guidance, and counseling.
- d.* The interdisciplinary team (Triad of Care, along with the OT or COTA, LCSW, AW2 advocate, TC, and an RC leadership representative as applicable. Other professionals may be invited by the Soldier, the Family, the interdisciplinary team, or the chain of command) in consultation with the Soldier will use the AWCTS, counseling records, the MODS-WT module, the PBH-TERM and AHLTA, as appropriate, to document all key aspects of the CTP. AWCTS is HIPAA compliant. However, entry of PHI into AWCTS should be limited to the absolute minimum necessary.
- e.* Commanders will ensure weekly Triad meetings are held to discuss individual Soldiers' needs, risk assessments, risk mitigation plans, and so forth (see chap 4, sec I for risk assessment and mitigation). Required tasks are detailed in paragraph 3-9.

#### **3-2. Comprehensive Transition Plan structure**

- a.* All Soldiers, regardless of CTP track, will complete six CTP processes that include: in-processing, goal setting, transition review, rehabilitation, reintegration, and post-transition. Each individual process has specific stand-alone requirements that all WTU Soldiers must meet. The processes serve as components of the CTP system which overlap, interrelate, and interconnect. Soldiers utilize assessments, goal setting, and transition review throughout their CTP, and receive support from the WTU interdisciplinary team to ensure that the plan is resourced and timely managed.
- b.* All Soldiers will complete in-processing within 30 days of arrival at a WTU that include an initial self-assessment, Phase I goal setting training, CTP track selection, and initial scrimmage. Documentary of these documents will be recorded using interdisciplinary team counseling records, AWCTS, PBH-TERM, and AHLTA. The initial self-assessment will be initiated within 24 hours of assignment or attachment in the WTU; completed and documented within the first 7 days of assignment or attachment in the WTU. WTU commanders may abbreviate the initial requirements of in-processing for Soldiers in an inpatient status or home bound status.
- c.* Redeploying Soldiers on Medical Readiness Processing-Evaluation orders that are not yet approved by the Triad

of Leadership for entry into the WCTP, may have their in-processing requirements abbreviated by their WTU commanders until Soldiers' attachments or assignments to the WTU are established.

*d.* Soldiers on Medical Readiness Processing–Evaluation orders will complete risk assessment and mitigation, as well as intake appointments with a PCM, NCM, and the LCSW. Further in-processing will continue upon formal acceptance into the WTU by the Triad of Leadership.

### **3–3. In-processing**

*a.* Immediately upon entry into a WTU, the interdisciplinary team begins clinical and non-clinical assessments and risk mitigation to ensure there is a plan in place to resolve the basic needs of Soldiers and their Family (see chap 4, sec I, for risk assessment and mitigation). If eligible, Soldiers will be supported by an AW2 advocate throughout the process, starting with in-processing. Assessments will be documented in AWCTS, PBH–TERM, AHLTA, and in counseling records.

*b.* The keys to success during in-processing include proper reception and orientation, setting expectations, completion of all in-processing requirements, and completion of Soldiers' Self-Assessments (within 24 hours of assignment or attachment in the WTU), culminating with the successful completion of the initial scrimmage.

*c.* Soldiers transferring from a WTU to a Community Care Unit must complete in-processing at the WTU. Community Care Unit commanders will ensure that all Soldiers attached to a Community Care Unit have a good understanding of their duties and responsibilities as well as of the capabilities and support they can expect from the Community Care Unit cadre.

*d.* WTU commanders will validate the completion of Soldiers' in-processing. Once in-processing is completed, WTU commanders will validate Soldiers' in-processing and transfer of the records to the gaining company (including a Community Care Unit). Transfer will happen as soon as possible or no later than 30 days.

### **3–4. Goal setting**

*a.* The goal setting process guides Soldiers and their Family in the development of sub-goals that support the overarching transition and outcome goal. Goal setting is made up of two parts, which are consistent throughout the process.

*b.* Phase I goal setting will be completed within 21 days, and facilitated by an OT or COTA. Phase I goal setting is more prescriptive than Phase II, because it helps WTU Soldiers create a foundation of functional and occupational goals, which will be reviewed during the initial scrimmage (on day 30).

*c.* Phase II goal setting will be facilitated after the initial scrimmage, between days 31 to 90, by Comprehensive Soldier and Family Fitness MRTs or performance experts. Phase II goal setting affords the Soldier the opportunity to expand his knowledge of the goal setting process, while providing the freedom to set bigger goals for the transition process and beyond. During this time, the Soldier will also create action statements that serve as an on-going roadmap to support healing and transition. Each action statement will be developed using the specific, measurable, actionable, realistic, and time bound criteria that ensures that Soldiers have a clear understanding of their goals and how to achieve them. Sub-goals will also be developed to address priority areas that support the Soldiers' career, physical, emotional, social, Family, and spiritual domains, and which facilitate successful achievement of their overarching transition and outcome goals.

### **3–5. Transition review**

Transition review provides the WTU commander and the interdisciplinary team with opportunities to ensure the Soldier's CTP is on track and Soldier's concerns are identified and resolved, and that the plan is resourced. Minimum attendees at all scrimmages will include: Soldier's SL and/or PSG, LCSW, OT or COTA, NCM, and AW2 advocate for assigned AW2 Soldiers unless directed otherwise as stated. The specific tasks of the Transition review are:

*a.* Review of completion of in-processing within 30 days of WTU orientation.

*b.* Completion of self assessments within the first 7 days and follow-up as directed by the commander (either weekly or monthly).

(1) The SL and NCM must validate each self assessment in AWCTS.

(2) The SL and NCM must document all action plans for red and amber items in AWCTS.

*c.* Quarterly execution of scrimmages that include—

(1) Initial scrimmage completed within 30 days of assignment or attachment which include the Soldier and his Family, HHC SL, and NCM, assigned line company SL and NCM (or Community Care Unit PSG and NCM), HHC LCSW, and the line company BLSW.

(2) 90 day scrimmage facilitated with company commander oversight to validate the transition plan.

(3) Quarterly interval scrimmage occurrences (180 days, 270 days, or 360 days, and so forth) and thereafter.

*d.* If MRDP is reached, the WTU commander will facilitate a FTR with battalion oversight to assess the Soldier's progress, status of the transition plan, and the proficiency of the interdisciplinary team's efforts. The FTR replaces the subsequent quarterly scrimmages and serves to provide Soldiers with a target transition date, finalize their transition plan, and to introduce the transition readiness process that will help map Soldiers' final tasks.

(1) The WTU battalion commander will lead an FTR for Soldiers that have been in the WTU for over 730 days. The battalion commander will determine what issues are delaying the Soldier's transition timeline and immediately address the barriers.

(2) The WTU commander, interdisciplinary team and the Soldier will document a plan to address the barriers, review and update scrimmage goals, and document the transition plan on a counseling statement and scrimmage worksheet to be signed by the company commander and the Soldier.

### **3–6. Rehabilitation**

The rehabilitation phase begins as early as possible, including during inpatient status immediately following injury, and provides appropriate clinical and non-clinical interventions (vocational rehabilitation, education, and adaptive reconditioning activities) that support the Soldier's transition goals. The rehabilitation progress and outcome provide the PCM with information to determine the Soldier's MRDP and substantiates the Soldier's ability to remain in the Army.

*a.* Selection of a Soldier's CTP track. Soldiers, in collaboration with their Family, indicate their preferred CTP track (remain in the Army and Transition or Separate from the Army) during in-processing, which will be validated by the chain of command and the interdisciplinary team. The initial track will be selected in conjunction with the career counselor and the OT who will counsel the Soldier on their likelihood of remaining in the Army based upon clinical condition and profile. However, final CTP track preference is based on medical prognosis and the Soldier's remaining service obligation after the Soldier meets MRDP, which may allow a Soldier to pursue tasks associated with both CTP tracks.

(1) *Remain in the Army.* This track is for all Soldiers who will continue military service. Although Soldiers identify their track preference, all Soldiers are presumed remain in the Army until the interdisciplinary team can verify the need to explore transition from the Army tasks, goals, and action plans. Remain in the Army track includes RTD, MAR2, and COAD. For RC Soldiers, dispositions also include REFRAD and COAR.

(2) *Transition from the Army.* This track includes all Soldiers who will not continue military service in either an active or reserve status. It can be reached through medical or nonmedical separation. Transition from the Army dispositions include medical separation (thru IDÉS) and nonmedical separation (thru UCMJ, Chapter, or Courts Martial).

*b.* Successful completion of transition readiness requirements that include Individual Transition Plan (ITP) prior to transition.

*c.* Adaptive reconditioning participation. All Soldiers must participate in a minimum of 150 minutes of moderate intensity exercise each week through adaptive reconditioning activities in accordance with chapter 11, section II, as well as their local command and their interdisciplinary team guidance. In addition, Soldiers will incorporate the performance triad of sleep, activity, and nutrition into their healing and transition plan to ensure they are maximizing recovery opportunities.

(1) Soldiers in WTUs may also participate in therapeutic events. Therapeutic events can be one of the many adaptive reconditioning activities used to help Soldiers achieve their short or long-term CTP goals.

(2) Therapeutic event must be a reasonable expectation of a specific beneficial effect on the Soldier's medical condition and outcome. The Soldier's PCM is the authority for designating whether a given activity is therapeutic (see chap 11, sec II).

*d.* CER participation. CER eligible Soldiers will participate in one or more CER activities. There are three categories of CER activity: (1) remain in the Army work assignments (RIAWA); (2) education and training; and (3) internships.

(1) The physical location where a CER activity is conducted is considered a CER work site. Work site is defined as "where a Soldier participates in a work activity that aligns with their CTP Track and long term goals." (See chap 6, sec III.)

(2) Eligibility for CER activity is based upon two distinct evaluations made by M2 and the WTU commander.

*(a)* The M2 evaluation must conclude that the Soldier is medically, emotionally, and physically ready to participate in a CER activity while continuing medical treatment. The NCM, in collaboration with the interdisciplinary team is responsible for coordinating the evaluation of CER eligibility with all members of M2; the NCM is also responsible for documenting the results.

*(b)* The commander's evaluation must conclude that the Soldier demonstrates the initiative and self-discipline required to participate in a CER activity. The company commander is responsible for the CER eligibility evaluation and the SL is responsible for documenting the results.

### **3–7. Reintegration**

This process is designed to specifically prepare each Soldier and his Family for successful transition back to the force or to civilian life as a Veteran.

*a.* Not later than 180 days prior to anticipated transition date, but not later than MRDP, cadre will ensure completion of WTC transition readiness (education, training, internships).

*b.* Not later than 90 days, cadre will ensure completion of Soldier for Life – Transition Assistance Program

requirements are documented on a DD Form 2958 (Servicemember's Career Readiness Standards/Individual Transition Plan Checklist); signed by the Soldier for Life – Transition Assistance Program counselor, Soldier, and commander.

*c.* Additionally, prior to Soldiers' transition from the WTU, cadre will review with Soldier to ensure all transition readiness requirements (ITP, Soldier for Life – Transition Assistance Program, and so forth) are completed and validated by the commander.

*d.* The NCM will ensure all eligible Soldiers are referred to VHA.

### **3–8. Post-transition**

Post-transition is the period after a Soldier exits the WTU, regardless of CTP Track. During this process, the Soldier is under the mission command of his or her follow on unit, or the care of the VA while participating in the AW2 program if eligible.

### **3–9. Triad meetings**

Interdisciplinary team coordination is paramount to the successful execution of the CTP. The weekly Triad meeting serves as a critical communication link for members of the interdisciplinary team. The weekly Triad meeting is a company-level meeting in which Soldiers in the company are discussed among the interdisciplinary team members. The weekly Triad meetings differ from scrimmage and FTR meetings, as these meetings are focused only on one Soldier.

*a.* The purpose of the Triad meeting is to foster team thinking in order to proactively organize and address Soldier issues, and to ensure a common operating picture for the Soldier's health care.

*b.* Triad meetings must be held weekly. High risk Soldiers will be discussed at every Triad meetings; lower risk Soldiers will be discussed at least monthly and ideally, more frequently.

*c.* The company commander is ultimately responsible for the successful execution of Triad meetings. At a minimum, the company commander, SL and/or PSG, PCM, LCSW, OT or COTA, NCM OIC, company NCMs and AW2 advocates for assigned AW2 Soldiers are required to attend all Triad of Care meetings, although not all need be present for the entire meeting. Other individuals such as TC, FRSA, VA liaison, career counselor, PEBLOs, Ombudsman, site coordinator, should attend as directed or invited by the company commander in order to accomplish the objective of effective communication and collaboration. In accordance with HIPAA rules and regulations, Soldier's HIPAA information is to only be discussed with those in a "need to know" status.

*d.* The interdisciplinary team will identify:

(1) Soldiers identified as high risk and risk mitigation plans with highlights of any significant life changes (martial separations, divorce, death in the Family, and ID of financial setbacks, and so forth).

(2) Any Soldier within 60 days of their transition date will be discussed weekly to ensure their follow on care is aligned, transition plans are in order, and any obstacles or barriers to transition are identified early and resolved prior to the Soldier's actual transition.

(3) The interdisciplinary team will discuss any Soldier receiving care at a civilian inpatient facility. For Soldiers receiving care at an inpatient BH facility, the NCM will report the length of time in the facility and the plans to transfer the Soldier to a MTF if the Soldier will require inpatient care for greater than 30 days.

(4) RC Soldiers with orders that will expire within the next 45 days (this can be accomplished by providing a list to the S-1 and company commander for their review and resolution).

(5) Soldiers with expired or expiring profiles (this can be accomplished by providing a list to the PCM and company commander for their review and resolution).

*e.* The following items should be discussed at least monthly:

(1) All Soldiers should be discussed at least monthly. In this discussion, the following must be addressed:

*(a)* Projected date a Soldier will meet MRDP. When a Soldier reaches MRDP, ensure all members of the interdisciplinary team know of the determination (specifically the Soldier's chain of command) prior to notifying the Soldier and his Family. Once MRDP is reached the chain of command should schedule a FTR to discuss the Soldier's transition plan and timeline.

*(b)* General assessment of Soldier's progress on their CTP track, and any needed adjustments.

*(c)* Career and education plans schedule and work site.

*(d)* The Soldier's Adaptive Reconditioning Program.

(2) Soldiers in the MEB process who have exceeded standard timelines or who may have potential issues.

(3) TRICARE enrollment issues; ensuring Soldiers are TRICARE enrolled to their WTU or Community Care Unit assignment.

(4) Soldiers with UCMJ actions, disciplinary actions, or administrative issues.

(5) Soldiers reaching 365 days without a MRDP. Interdisciplinary team will determine the issues delaying the Soldiers from reaching their MRDP and immediately address the barriers.

### 3-10. Transition program metrics

The WTC will monitor and report unit effectiveness and efficiency of the WCTP. A 90 percent requirement will be measured in areas such as the following:

- a. Self assessments completed and validated in AWCTS by SL and NCM within the first 7 days, and at least current within 30 days.
- b. Self assessments with red and amber items with action plan documented in AWCTS.
- c. Goal setting Phase I training completed within 21 days.
- d. Completion of in-processing requirements within 30 days.
- e. Transfers to Community Care Unit (for eligible Soldiers) within 30 days.
- f. Goal setting Phase II training with a MRT-performance experts specialist within 90 days.
- g. Completion of Soldier for Life – Transition Assistance Program requirements documented on a DD Form 2958, signed by the Soldier for Life – Transition Assistance Program counselor, the Soldier, and the commander, no later than 90 days prior to transition.
- h. Scrimmages completed by the WTU commander on each Soldier's transition plan (90 day scrimmage).
- i. MRDP reached or established no later than 365 days.
- j. Soldier scrimmages and FTRs that are current or within 90 days.
- k. Transition readiness requirements complete and validated by the WTU commander prior to transition from the WTU.
- l. Participation of Soldiers in Adaptive Reconditioning Program.
- m. Participation of eligible Soldiers in CER activities.
- n. Veteran Benefits Administration (VBA) and VHA referral rate for eligible Soldiers.

### 3-11. Accountability

Accountability and tracking is accomplished by using standard reporting requirements, AWCTS dashboard, manual CTP data calls, and MODS. Every leader shares responsibility to ensure all appointments and documents are accounted for after each meeting. This assists in de-conflicting appointments schedule and ensures Soldiers have the information they need to succeed in their individual CTP. The SL will ensure that the Soldier completes no less than 5 hours of adaptive reconditioning activities per week.

a. *Daily.* The SL will ensure Soldiers attend all formations conducted by the company, platoon, or squad. The only exceptions are those Soldiers with physical activity restrictions annotated on their profile DA 3349 or those with approval from their chain of command prior to formation. Unauthorized absences will be dealt with through administrative and/or UCMJ actions as deemed appropriate by the commander. If a Soldier is high risk, the Soldier must be contacted in accordance with the company commander's risk mitigation plan. Community Care Unit SL and/or PSG will make daily calls to Soldiers' work site or internship to verify that Soldiers are at their place of duty. This verification establishes accountability.

b. *Weekly.* The Soldier, with support from his or her SL and NCM, will maintain and refine his daily schedule and CTP accomplishments. This schedule is an inspectable item by SL and/or PSG. Changes to the Soldier's risk assessment and mitigation plan or the individual Soldier's CTP during periodic CTP scrubs with the Soldier, will be made in AWCTS by the SL and the company CTP management analyst. The NCM will inform all members of the key interdisciplinary team of these changes via email or telephone. The NCM or the appropriate interdisciplinary team member is responsible for entering the updates into AHLTA. The SL and or PSG will contact individual Soldier's internship, work, education, or training site supervisor to determine that the Soldier is actively engaged. During the first 30 days, the Soldier will enter his personal status in AWCTS self-assessment validated each week by the SL and NCM.

c. *Monthly.* PCMs will update the risk assessment and medical care plan for each Soldier. This will be accomplished at the Triad of Care meeting following the PCM's monthly contact with the Soldier; the Triad of Care will then discuss significant concerns and/or changes to the risk level. SLs and/or PSGs will contact each work site supervisor monthly to assess Soldiers' work performance and participation. When feasible, such contact will be accomplished by a visit. Additionally, the SL will counsel their Soldiers on their performance, review AWCTS self-assessment, and discuss transfer to Community Care Unit eligibility (if appropriate). This counseling will be documented on a DA Form 4856 (Developmental Counseling Form).

## Chapter 4 Risk Assessment and Mitigation Planning

### Section I General

#### 4-1. Purpose

Risk assessment and mitigation planning helps identify actions and processes to reduce high-risk behaviors which may result in harm to Soldiers and/or others.

#### 4-2. Background

The Army 2020 Report on Generating Health and Discipline in the Force Ahead, published in 2012 (<http://www.army1.army.mil/hr/suicide>), stated that stress on the Force, most often associated with combat-related wounds, injuries, and illness are increasingly placing Soldiers at risk. The report suggests that Soldiers suffering from physical and BH issues are in need of more vigilant leader oversight, risk mitigation, and medical health care. Risk is defined as the probability of harm or injury. Commanders will use SMEs at all levels and available tools and resources to identify and manage high risk Soldiers. The criteria used for determining a Soldier's risk level are based on input from experts representing MEDCOM's BH Staff, U.S. Army Public Health Command, and the DOD Risk Management Task Force.

#### 4-3. Policy

*a. Concept.* Risk assessment and mitigation management is a commander's responsibility, in collaboration with the Soldier's Triad of Care, interdisciplinary team, and the Soldier beginning with an initial screening risk assessment on the day the Soldier arrives at the WTU, followed by a complete assessment in the next 5 days, and continues with reassessments as needed, until the Soldier either returns to duty or separates from the Army.

*b. Process.* Each time a risk assessment is made, four people are typically involved in gathering the information: the Soldier's SL and NCM; BH provider (typically the Soldier's LCSW); and a medical provider (typically the Soldier's PCM). Each of the four will make an independent evaluation of the Soldier's risk level; the company commander will make a commander's risk assessment from these assessments. Once screening is complete, the commander, will decide upon and implement any necessary mitigation measures in collaboration with the Soldier's Triad of Care.

*c. Recording.* Risk assessments and mitigation actions are recorded in the AWCTS. AWCTS contains specific modules for risk assessment entries by the LCSW, NCM, SL, and the company commander. The AWCTS risk levels color codes include: low (green), moderate low (amber), moderate (red), and high (black). The NCM assessment includes input from the medical provider's assessment. The company commander uses the information from the LCSW, NCM, and SL assessments to prepare the commander's risk assessment and risk mitigation plan. The commander selects mitigation actions specific to the Soldier's level of risk and extenuating circumstances. The commander's mitigation plan contains recommended actions based on the risk level that the commander assigns. Completed assessments are maintained within the AWCTS risk module and may be viewed by specified cadre members.

*d. Special actions for evaluations of high risk.* Any provider or interdisciplinary team member assessing a Soldier as high risk in any category will notify the Soldier's company commander within 1 hour; such notification will be either in person or verbally over the telephone. No later than 24 hours thereafter, the company commander will notify the battalion commander, or the first O-5 in the chain of command, of the high risk new assessment.

*e. 24 hour screening assessment.* The initial screening risk assessment is completed within 24 hours of the Soldier's arrival at the WTU. This is done to ensure that the Soldier will be safe until the formal intake appointments occur, and that no emergent or urgent conditions are missed. In cases that involve urgent conditions, the Soldier's SL and NCM, and on-call BH and medical providers, will complete their assessments. If the urgent condition occurs after hours, Soldiers should be escorted to the on-call BH and medical providers by their WTU SL. WTU organic assets will enter their assessments into AWCTS. Non-organic BH and medical providers will document their findings in AHLTA and inform the Soldier's WTU NCM of their findings as soon as complete (the SL will provide the NCM's contact information). The NCM will inform the commander of the findings and annotate identified risks an AWCTS entry to assist company commander in preparing the Soldier's first commander's risk assessment and mitigation plan.

*f. The full intake assessment.* Not later than 5 days after the Soldier's arrival, PCM, NCM, and LCSW conducts comprehensive intake evaluations of the newly arrived Soldier. The information gathered at these visits builds upon the assessments in the first 24 hours. If necessary, the LCSW, NCM, and SL update risk assessments in AWCTS. The NCM's assessment includes any pertinent information from the PCM evaluation. The commander uses this new information to update the Soldier's risk assessment and mitigation plan as appropriate.

*g. Regularly scheduled assessments.* The company commander and the interdisciplinary team review all WTU Soldier risk assessments and mitigation plans monthly, and all high-risk WTU Soldiers at the weekly Triad meetings. The PCM and NCM are responsible for communicating information findings from specialty providers. For Soldiers identified as high risk by the WTU, the WTU LCSW is responsible for informing the Department of BH of the high risk finding and ensuring the Department of BH's assessments and treatment plans for the Soldier are communicated to

the WTU team on a weekly basis. If the Soldier is seen by a network provider, the LCSW will communicate with the network provider on a weekly basis as well.

*h. Oversight responsibilities.*

(1) The LCSW meets with all high risk WTU Soldiers weekly and conducts ongoing BH risk assessment, care management, and provides support to the Family or caregivers regarding behavioral health care.

(2) WTU battalion commanders, or the first O-5 in the chain of command, approves all high risk Soldier mitigation plans within 24 hours, and reviews them weekly. For separate companies, the MTF commander may designate the DCCS to approve and review.

(3) MTF commanders, or the first O-6 in the chain of command, reviews all high risk Soldier mitigation plans monthly.

(4) Within 30 days of each WTU Soldier and cadre member's arrival, commanders ensure the U.S. Army Soldier and Leader Risk Reduction Tool (USA SLRRT) is completed. The USA SLRRT is used during initial and developmental counseling and leaders ensure it is reviewed annually.

#### **4-4. Management and mitigation**

*a.* The commander should select risk mitigation actions specific to the level of risk and presence of specific risk factors. Completed commander assessments are maintained within the AWCTS risk module and viewable to specific cadre members. The AWCTS risk module pre-populates the mitigation plan for all Soldiers evaluated as high risk with the following mitigation actions:

- (1) Command's contact with Soldier two times per day, 7 days per week.
- (2) Medication reconciliation at least weekly and each time there is a change in medication regimen.
- (3) Issue a no alcohol order.
- (4) Roommate, NMA, or Family member as Soldier battle buddy.
- (5) Require battle buddy to travel off post (sign in or out with staff duty NCO).
- (6) Refer to the chaplain.
- (7) Initiate safety counseling.
- (8) Consider BH referral for evaluation and follow-up.

*b.* Additional mitigation actions that the commander deems necessary can be added to the risk mitigation plan.

*c.* All Soldiers assessed by any member of the cadre as being at risk for suicidal or homicidal ideations should be escorted to the emergency department (ED) or BH team.

#### **4-5. Reassessment**

*a.* The cyclic process of risk assessment, mitigation, and re-assessment repeats whenever significant changes or new information for a Soldier occurs, and continues as long as the Soldier remains in the WTU. This naturally occurs at milestones in the Soldier's transition process, such as scrimmages (see glossary for definition) or the FTR, but may also occur at other times. Events in a Soldier's life that cause consideration of immediate reassessment include—

- (1) Broken relationship (divorce, death of family member, spouse, or partner).
- (2) Pending UCMJ action.
- (3) Significant financial difficulties.
- (4) Alcohol and drug abuse and/or misuse (including prescription medications).
- (5) Acting out behaviors (absent without leave (AWOL), positive urinalysis, driving under the influence).
- (6) Social withdrawal or isolation, giving away belongings.
- (7) Milestones (MEB and PEB results, pending separation from Army).
- (8) News of significant combat in the Soldier's unit, or anniversary of past action.
- (9) Change in level of BH care, release from inpatient BH program, and significant medication changes.
- (10) Suicidal or homicidal thinking or statements by the Soldier.

*b.* Battle drill. Commander should institute a battle drill whenever a member of the interdisciplinary team feels the Soldier's risk level has undergone an elevated change. Any interdisciplinary team member can identify a change in risk indicators and notify the commander. Once the drill is complete, the commander ensures the new risk level and mitigation plan are disseminated to the Triad of Care and recorded in AWCTS.

#### **4-6. Responsibilities**

*a.* WTC as the proponent will share feedback and best practices with RMCs.

*b.* RMCs will monitor policy execution and track risk levels and appropriate mitigation plans across their commands.

*c.* Military treatment facility commanders will—

- (1) Implement the risk assessment and mitigation policy.
- (2) Follow OTSG guidance and directives for high-risk medication management and education, and implement procedures for enrolling high risk Soldiers into the SPP (see chap 4, sec II).

(3) Ensure pharmacists provide training to Soldiers and cadre on medication reconciliation. Training should focus on group and individual level and should specifically address the dangers associated with polypharmacy, narcotics, and the use of alcohol.

(4) Execute recommended actions provided by the Office of the Vice Chief of Staff Memorandum, Deputy Assistant Chief of Staff, Establishment of the Army Campaign Plan for Health Promotion & Risk Reduction Fiscal Year 2011 (HP&RRFY11) and in the Army 2020: Generating Health and Discipline in the Force Ahead of the Strategic Reset, Report.

*d.* WTU commanders will—

(1) Ensure compliance with the risk assessment and mitigation policy.

(2) Complete Soldiers' risk assessments and mitigation plans within 24 hours of attachment or assignment to the WTU, and ensure WTU staff maintains a current risk assessment and mitigation plan based on Soldiers' reassessments.

(3) Designate the Soldier's risk level as low (green), moderate low (amber), moderate (red), or high (black) (BH risk assessment of severe or high (black) is equivalent to commander's risk level of high (black)). In the event where risk assessments differ between the Triad of Care and/or LCSW risk assessments, WTU commander will determine the appropriate risk level.

(4) Determine the overall risk designation based on the assessments of the designated WTU staff and identify an appropriate mitigation plan.

(5) Counsel each Soldier on the risk mitigation plan and validate the Soldier's understanding by documenting the counseling in the AWCTS case log after making a risk designation.

(6) Ensure compliance with chain of command safety programs (MTF and MEDCOM).

(7) Ensure PSGs and SLs and other cadres are trained in Basic Life Support and Automatic External Defibrillation training and are provided pocket masks and gloves.

(8) Ensure units report all attempted suicides, medication overdoses, and all situations that merit command attention in accordance with the current IMCOM policy.

(9) Provide training to cadre, Soldiers, and Families on the roles, responsibilities, programs, and services available to support Soldier and Family wellness.

(10) Develop unit battle drills to provide action steps for personnel to respond quickly and appropriately to potential or actual risk events. Battle drills will include plans for expediting assistance to Soldiers with behavioral difficulties commonly associated with suicide or accidental death.

(11) Provide ongoing risk assessment and ensure annual suicide education to cadre, Soldiers, and their Families. Track and manage mandatory suicide prevention training of individual Soldiers in accordance with AR 350-1.

(12) Ensure that security procedures regarding privately owned weapons on Army installations are current and in accordance with AR 190-11 and HQDA physical security directives. In addition, commanders—

*(a)* Counsel and encourage moderate and high risk Soldiers residing off the installation to disclose possession of privately owned weapons and store personal weapons in the unit's arms room.

*(b)* Seek legal advice from the servicing office of the staff judge advocate on appropriate actions to take in cases involving moderate or high risk Soldiers refusing to relinquish possession of privately owned weapons.

*(c)* Ensure SLs and the key interdisciplinary team members discuss with Soldiers' spouses or Family members about the dangers of privately owned weapons in the home and encourage them to store their privately owned weapons in the unit's arms room.

(13) Ensure redeployed or transferred Soldiers assigned or attached to the WTU have a current DD Form 2796 within 30 days of redeployment in accordance with AR 40-66. WTU Soldiers assigned or attached to the WTU without a completed DD Form 2796, and whose redeployment exceeds 30 days must complete one within 5 days of their assignment or attachment to the WTU. Additionally, redeployed Soldiers assigned or attached to the WTU will receive a mandatory PDHRA (DD Form 2900) within 90 to 180 days of redeployment in accordance with AR 40-66. The completed PDHRA will be filed in the Soldier's medical records and Medical Protection System.

(14) Designate the WTU barracks, to include rooms and indoor and outdoor common areas, as alcohol free zones. Ensure Soldiers are counseled in writing to ensure they understand the alcohol free zone policy and that violation of the policy may subject to UCMJ actions. If it is determined by the PCM that consumption of alcohol poses an unacceptable risk to the Soldier, a no alcohol order will be initiated and reviewed as needed.

(15) Ensure Soldiers are counseled in writing about the requirement to disclose to their PCM and NCM the names of all medications, to include prescription and over-the-counter medications, dietary supplements, and herbal products. The written counseling will include that the Soldier are only authorized to take prescription medications prescribed by military authorities (MTF and/or TRICARE network providers).

(16) Develop medication review process immediately when the Soldier is attached or assigned to the WTU. Soldiers designated as high risk and/or enrolled in the SPP will undergo a minimum of weekly medication reviews or when a change in medication regimen occurs. The clinical pharmacist or member of the clinical pharmacy should be involved in medication reviews.

*(a)* In coordination with the PCM and MTF commander, restrict refilling prescribed medications, including schedule

II drugs (both MTF and TRICARE retail network) to the MTF pharmacy unless in an emergency situation or if the WTU is not located in an area with a MTF pharmacy. Commanders will provide MTF EDs with a current roster of Soldiers ensure medications are only issued with PCM and NCM knowledge. MTF commanders will request that local civilian EDs that may treat WTU Soldiers contact designated MTF POC to ensure that the WTU commander may conduct proper oversight of the Soldiers health and necessary coordination of care and treatment in accordance with HIPAA requirements.

(b) In coordination with the PCM, interdisciplinary inpatient staff and the WTU interdisciplinary team, implement a comprehensive discharge plan that assesses the Soldier's risk and mitigate plan that address risk. A transition of care plan will be communicated between inpatient interdisciplinary team and WTU Triad of Care. To the extent possible, Soldiers should not be released on a day before a weekend or holiday.

(c) Ensure Soldiers and their spouses or Family members receive education and training to address the dangers associated with poly-pharmacy, narcotics, and mixing of alcohol with medications.

(17) Ensure Soldiers are informed adverse actions in the morning, except for Fridays and before long-weekends, to permit adequate time for the staff to manage possible adverse reactions. Inform all members of the Triad of Care, the LCSW, and the chaplain when any adverse action is initiated to ensure the Soldier's risk level is reassessed and the mitigation plan is updated if necessary. Soldiers will be referred and escorted to the LCSW for a reassessment.

(18) Ensure Soldiers considered for transfer to WTU have a risk assessment and mitigation plan completed prior to transfer. Soldiers designated as high risk are not eligible for transfer except for Soldiers assigned or attached to the Community Care Unit whose medical care exceeds that which the Community Care Unit is capable of providing. In such cases, the Community Care Unit commander will coordinate a transfer to the WTU.

(19) Utilize the BH risk assessment of the WTU LCSW, on-call, and BH providers to support risk management and mitigation plans.

(20) Include the USA SLRRT assessment when conducting periodic performance counseling for WTU Soldiers and cadre in accordance with AR 623-3.

(a) The USA SLRRT will be used to facilitate dialogue between the Soldier and leader and ensure referrals to appropriate resources, when necessary.

(b) During permanent change of station (PCS), complete the following:

1. Identify the POC for the gaining unit or organization.
2. Ensure the gaining command's POC is informed about the transferring Soldier's level of functioning based on the last developmental counseling session. A guide ("Guide for Use of the U.S. Army Soldier and Leader Risk Reduction Tool") located in the 2012 Army Suicide Prevention Month Web site, to assist commanders to determine Soldier's level of functioning can be obtained at [http://www.armyg1.army.mil/hr/suicide/spmonth/risk\\_assessment\\_tool.asp](http://www.armyg1.army.mil/hr/suicide/spmonth/risk_assessment_tool.asp).

(c) Counseling sessions, using the USA SLRRT should be conducted—

1. Within 30 days of arrival to the WTU.
2. Approximately 90 days prior to reassignment.
3. Within 30 days of returning to duty after deployment.
4. When Soldiers are administratively removed from a school and returned to the unit or organization.
5. Within 120 days of Soldiers' PCS, when identified as moderate to high risk.
6. When leaders determine the Soldier would benefit from an assessment because of changes or transitions in the Soldier's personal or professional life or when the leader identifies a risky behavior.

e. The PSG and/or SL will—

- (1) Assess Soldier's basic needs and risk assessment within 24 hours of the Soldier's arrival.
- (2) Implement increased risk mitigation plans for Soldiers based on acute changes in the Soldier risk indicators as described in paragraph 4-5 of this regulation, and/or upon the request of any member of the Triad of Care and/or WTU LCSW.

- (3) Work with the WTU finance NCO to review Soldier's pay to determine if there are any indicators of financial issues to corroborate SL, NCM and/or LCSW risk assessment.

- (4) Notify the company commander within one hour of any increase to high risk or an initial assessment of high risk.

f. The PCM will—

- (1) Inform the WTU commander and the interdisciplinary team of Soldiers' medical risk assessments at or before the next weekly Triad meetings. The subjective risk assessment is based on each Soldier's cognitive impairment, BH history, medication regimen, history of substance abuse, compliance with treatment.

- (2) Review the 24 hour risk assessment in AHLTA and complete a one-hour PCM appointment no later than 5 days after arrival.

- (3) Ensure medical, BH, and rehabilitation plans are in synergy and are consistent with risk mitigation.

- (4) In coordination with LCSW and BH providers, ensure BH assessment and safety and treatment plans are in place for Soldiers.

- (5) Ensure the plans are understood and agreed upon by the Triad of Care and appropriate members of the interdisciplinary team.
- (6) Where clinically appropriate, initiate entry of high-risk Soldiers into the SPP.
  - g. The NCM will—
    - (1) Initiate a risk assessment and a medication review within 24 hours of assignment or attachment.
    - (2) Document the risk level in AHLTA.
    - (3) Inform the WTU commander within one hour of any high risk determination.
    - (4) Include Family and social support assessment during in-processing and during weekly NCM contacts in order to determine potential broken relationships.
    - (5) Annotate this discussion in AHLTA and educate Families regarding risk mitigation measures when developing the plan of care.
    - (6) Validates self assessments and appropriately assigns tasks within AWCTS.
  - h. The WTU LCSW will—
    - (1) Conduct the preliminary BH needs and risk assessment during duty hours and as assigned on-call within 24 hours of attachment or assignment of the Soldier to the WTU and complete the assessment within 5 days.
    - (2) At locations where the Soldier arrives during non-duty hours and/or WTU LCSW on-call support is limited, the on-call provider designated to cover BH will meet with the Soldier to conduct the preliminary BH needs and risk assessment.
    - (3) In coordination with the Triad of Care, conduct the comprehensive BH assessment, ongoing BH risk assessment, care management, and support to the Family or caregivers regarding behavioral health care. The WTU commander is the final decision authority in risk determination and mitigation.
    - (4) Complete the risk assessment in AWCTS and document the corresponding risk level in AHLTA. Paragraphs 2–24f, 2–25h, and chapters 4 and 5, section III, further outline the duties and responsibilities of the LCSW.
    - (5) Inform the company commander within one hour of any of high risk determinations.
    - (6) Validate self assessments and assign tasks appropriately.

## **Section II**

### **High-Risk Medication Review and Sole Provider Program**

#### **4–7. Policy**

A baseline medication review and reconciliation must be completed on every assigned or attached WTU Soldier within 24 hours of arrival by a qualified health care provider. A deliberate review must be completed, as a part of the PCM exam, within 5 days. Purpose is to identify potential adverse medication interactions, side effects or potentially lethal medication combinations. The Soldier's PCM, must lead this effort, in collaboration with WTU NCM, MTF clinical pharmacists, and other MTF privileged providers involved in the care of the WTU Soldiers. These reviews must be documented in the electronic medical record or AHLTA.

#### **4–8. Responsibilities**

The PCM will consider all WTU Soldiers deemed high risk for BH or medication misuse for entry into the High-Risk Medication Review and SPP.

*a.* The PCM may refer a Soldier to the SPP at any time, and will follow local MTF procedures to determine who will become the patient's sole provider. The designated sole provider and designated alternate are the only providers authorized to prescribe, countersign, or telephonically approve prescriptions for the high-risk Soldier. The sole provider may be the Soldier's PCM, but could be a specialist, sub-specialist, or other provider.

(1) Only a Soldier's PCM, sole provider, or authorized alternate is authorized to modify an existing sole provider medication management. Providers will coordinate changes to the SPP through the MTF pharmacy.

(2) WTU Soldiers enrolled in SPP will receive a maximum of a 7-day supply of controlled or non-controlled medications, except at the Soldier's military provider discretion. In such cases, non-refillable prescriptions for antimicrobials may be written for up to 14 days. WTU Soldiers in a SPP are restricted to refilling prescriptions at one pharmacy (for example, MTF pharmacy or TRICARE retail network pharmacy, if enrolled in remote care). Dispensing restrictions apply to WTU Soldiers in the SPP.

(3) For MTF-based WTUs, the Soldier's sole provider will coordinate enrollment with the supporting MTF pharmacy according to the SPP policy. The MTF pharmacy will coordinate sole provider restrictions through the pharmacy operations center. The designated SPP will forward monthly a summary report of the Soldier's medications to the MTF Pharmacy and Therapeutics Committee.

*b.* The MTF directors of pharmacy will assign clinical pharmacist(s) to provide dedicated support to WTUs. They will perform a medication review for high-risk or sole provider Soldiers at least weekly and, as needed, when the medical staff identifies new high-risk Soldiers. Clinical pharmacist will assist in the delivery of safe and appropriate medication therapy for WTU Soldiers (such as provide medication management services to prevent, identify, and

resolve medication-related problems; and conduct medication reviews of prescription and over-the-counter medications, dietary supplements, and herbal products).

(1) The pharmacy will place a sole provider prescription in the high-risk or in the Sole Provider Soldier's Composite Health Care System medication profile listing the name of the sole provider and alternate who may act on their behalf. The MTF pharmacy will contact the pharmacy operations center to initiate the change.

(2) MTF pharmacists designated to support WTUs will request Pharmacy Medication Analysis and Reporting Tool (P-MART) report weekly for all high-risk WTU Soldiers. The P-MART tool, which can assist providers performing medication reviews, is available on the Pharmacoeconomic Center Web site. The P-MART contains outpatient prescription data from MTFs, the TRICARE mail order pharmacy and retail network pharmacies.

(3) The MTF Pharmacy and Therapeutics Committee will receive and review summary reports from the SPP monthly.

c. Commanders of Soldiers in community-based care, in consultation with clinical authority, will strongly consider returning high-risk Soldiers to an MTF-based WTU. If the Soldier is retained in community-based care, the Soldier's clinical team will initiate and complete the appropriate process restricting the Soldier to one retail network pharmacy. The NCM will coordinate restriction of the Soldier to the retail network pharmacy with the pharmacy operations center.

## **Chapter 5 Medical Care Management**

### **Section I Primary Care**

#### **5-1. Primary care manager**

The PCM will be a physician, family nurse practitioner, or physician assistant trained in the delivery of primary care medicine. Soldiers assigned or attached to a WTU or will be assigned a PCM. The PCM provides primary oversight and continuity of the Soldier's health care, and lays the foundation and direction of the care plan used by the Soldier's health care team. This is accomplished through PCM's initial comprehensive assessment, leading, and facilitating the clinical discussion at Triad meetings, and ensuring clear and continuous two-way communication of health care plans and issues with the NCM, SL and/or PSG, BH providers, and other members of the interdisciplinary team. The PCM is responsible for assessing when each Soldier has reached the MRDP and is the primary authority for determining whether a Soldier is returned to the Force after care is complete or referred to a MEB. Key roles and responsibilities of the PCM are outlined in paragraphs 2-22, 2-25, 3-11, chapter 4, and throughout the regulation.

#### **5-2. Medical retention determination point**

a. The MRDP is the point in time in which a determination can reasonably be made whether or not further medical care will cause the Soldier to meet medical retention standards or render them capable of performing the duties required by their office, grade, rank, or rating. Except as noted in paragraph 5-2b, the MRDP will occur within 1 year of the initial diagnosis of a potentially disqualifying medical condition. The MRDP should generally be reached earlier than 1 year, as the Soldier's clinical course and the PCM's assessment permits. At the MRDP, Soldiers with one or more condition(s) that fail to meet medical retention standards outlined in AR 40-501 will be referred into the IDES by the profiling approval authority.

b. Extension of temporary profiles beyond 1 year requires approval by the SC or the first general officer in the Soldier's chain of command in consultation with the senior medical officer. Once the MRDP is met for one potentially unfitting condition, regardless of the status of the other co-existing conditions, referral into the IDES is mandatory.

#### **5-3. Medical evaluation board referral**

a. Conditions discovered by a medical physician after ID of the initial medically disqualifying condition will not delay referral into IDES.

b. The WTU commanders will provide a monthly by-name report on Soldiers who have 6 months assigned and attached to a WTU without a MEB referral to the SC.

c. The MTF commanders will provide a by-name report on Soldiers who have 1 year assigned or attached to the WTU without a MEB referral to the SC.

d. The SC will provide a numerical installation summary report to ACOMs, ASCCs, or DRUs commander on Soldiers who have 18 months assigned or attached to the WTU without a MEB referral and the RMC commanders will provide a Community Care Unit numerical summary report to the MEDCOM commander.

e. The WTC will provide the Vice Chief of Staff of the Army (VCSA), a consolidated ACOM, ASCC, or DRU numerical summary report utilizing the MODS-WT module as the data source.

f. The MODS-WT module will be the data source to support all reporting requirements.

g. AR 40–400 governs the MEB policy. AR 635–40 governs the policy for the PEB.

#### **5–4. Transition standards**

a. Soldiers exceeding 12-month assignments or attachment to a WTU without an MEB referral will require the SC (his or her designated general officer representative) endorsement, a medical treatment plan, including a rationale for not referring the Soldier to an MEB, the barriers impacting MRDP, and the expected MRDP date. The SC, or his or her designated general officer representative, will revalidate the treatment plan at a minimum of every 6 months or when deemed appropriate. Treatment plan endorsements may not be delegated below a general officer.

b. Conditions discovered by the PCM or another provider after ID of an initial medically disqualifying condition will not delay referral into the IDES unless it is a condition that must be fully addressed and documented for adjudication in the MEB process (see AR 40–501).

c. At the end of each month, a report will be submitted identifying Soldiers assigned or attached to a WTU without a MEB referral, MEB was stopped, or do not have an endorsed treatment plan as required by paragraph 5–4a:

(1) WTU commanders will submit a by-name report to the MTF commander on Soldiers reach for 6 months in the WTU.

(2) MTF commanders will provide a by-name report to the SC on Soldiers exceeding 12 months in the WTU.

(3) SCs will provide a numerical installation summary report to ACOM, ASCC, or DRU commander on Soldiers remaining in the WTU for 18 months. RMC commanders will provide a Community Care Unit numerical summary report to the MEDCOM commander.

(4) WTC will provide the VCSA a consolidated ACOM, ASCC, or DRU numerical summary report on Soldiers remaining in the WTU for 24 months or more.

d. The MODS–WT module is the data source that support all reporting requirements stated. Commanders will ensure MODS–WT module is maintained to allow all installations with WTU or Community Care Unit to pull by-name reports to meet this requirement.

e. Procedural guidance for the MEB process is located in AR 40–400.

#### **5–5. Medically optional surgeries, procedures, and treatments**

a. The definition of a medically optional surgery, procedure, or treatment is one that may be beneficial, but is not required to preserve life, limb, or eyesight, to prevent the loss of function, improve pain levels, or to return the Soldier to fit-for-duty status. Optional surgical procedures or treatments may include those that are purely cosmetic, those whose beneficial outcome is uncertain, and those which may be performed at a later time without losing effectiveness. A specific or patient-preferred type of procedure or treatment, where a reasonable alternative is offered to and refused by the Soldier, may also be considered optional.

b. Surgeries, procedures, or treatments that may be reasonably expected to give relief of significant pain or disability and those that are part of the normal plan of care for condition(s) leading to WTU admission, will not be considered optional.

c. The mission of a Soldier in the WTU is first, to heal, and second, to achieve a successful transition, either back to the Force, or to civilian life as a Veteran. All surgeries, procedures, and treatments provided for the Soldier must be clearly connected with the achievement of one or both of those two goals. Medically optional surgeries, procedures, and treatments may only be performed when there is a reasonable expectation by competent medical authority that such procedure will have a beneficial effect, and will in no way delay or impede the Soldier's process toward healing or successful CTP completion.

d. An algorithmic summary of the management of optional surgeries, procedures and treatment can be found in figure 5–1.

e. Cases that cannot be adequately resolved at the WTU level will be referred to the MTF commander, with the MTF DCCS or designee serving as medical SME.

#### **5–6. Service animals in Warrior Transition Units and Community Care Units**

a. A service dog is a dog individually trained to do work or perform specific tasks for the benefit of an individual with a disability. Generally, Soldiers requiring a service dog are expected to require the dog for an extended period of time, often for life. To be recognized by the Army, service dogs obtained after 28 January 2013 must be obtained by eligible Soldiers from a source accredited by an organization recognized by the VA. Emotional support dogs and other privately-owned animals not meeting the requirements for a service dog will be subject to installation pet policies and rules. Soldiers will generally not be permitted service dogs until they have achieved a sufficient level of independence to reside off post in private housing. On a case-by-case basis, a Soldier's interdisciplinary team may approve the Soldier to begin training with a service dog while residing at a WTU in coordination with WTU command and the non-governmental organization providing the training.

b. The Army does not provide service dogs. Service dogs are obtained from sources accredited by organizations recognized by the VA, and only after recommendation by the Soldier's PCM and interdisciplinary team, with approval by the first O–6 in the Soldier's chain of command.

c. Service dogs and service-dogs-in-training are not permitted to reside in the barracks with Soldiers assigned to the WTU.

d. Service-dogs-in-training may be granted access to barracks facilities associated with WTU or MTFs on a case-by-case basis in order to facilitate goal-oriented therapy for Soldiers anticipating discharge.

## **Section II**

### **Case Management**

#### **5–7. Nursing case management**

a. In accordance with the Defense Health Agency “Medical Management Guide”, Version 3.0, case management is a critical component of the comprehensive M2 process. The purpose of case management is to support the Soldier through transitions of care, increase coordination, and support patient safety, education and self-determination by establishing an active partnership with patients, their families and the entire health care team to achieve optimal health care outcomes.

b. Case management is defined as a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes.

#### **5–8. Education and training and certification**

a. WTU NCMs, as licensed registered nurses, must maintain licensure standards in accordance with State licensure boards and AR 40–68.

b. In addition to certification, WTU NCM must complete the following education and training modules located on the Medical Health Services Learn training platform:

- (1) Case Management module 1.
- (2) TRICARE Fundamentals.
- (3) Military Medical Support Office.
- (4) Veterans Health Initiative on Traumatic Brain injury for clinical case managers.
- (5) Post-Traumatic Stress Disorder.
- (6) Psychological Impacts of Deployment.
- (7) VHA Overview.
- (8) Introduction to the DOD Disability Evaluation System (DES) for Case Managers.
- (9) DOD Recovery coordination Program.
- (10) 15th Edition Ambulatory Care Training Plan.
- (11) 15th Edition Behavioral Health Guidelines Training Plan.
- (12) Completion of the NCM course before accepting a patient for case management services, and must complete the course within 90 days of assignment to the WTU.

c. It is highly recommended that NCMs obtain certification by either the American Nurse Credentialing Center or the Commission for Case Manager Certification.

#### **5–9. Case management process**

Case managers will adhere to the standards of case management practice defined by the Case Management Society of America and further delineated in the Defense Health Agency, “Medical Management Guide”, section III. Case managers will serve as the lead coordinator for all medically-related transition activities. As the lead coordinator, the NCM will establish communication with the receiving facility, organization, or unit level lead coordinator and use the handoff tools to ensure all Soldier and Families needs are communicated to the receiving team prior to the Soldier’s departure. This includes handoffs to the VA, a M2 team at the Soldiers installation, and/or a civilian care team.

a. All case management services for Soldiers evaluated for, or enrolled in, case management will be documented in AHLTA using a standardized case management alternate input method.

b. All case managers will code their services in AHLTA using DOD established provider specialty codes, HIPAA taxonomy codes, Medical Expense and Performance Reporting System codes, International Classification of Diseases Revision-10 diagnosis codes, evaluation and management procedure codes, and Health care Common Procedure Coding System codes outlined in the TRICARE Business and Economic Analysis Division Unified Biostatistical Utility Coding Guidelines, appendix E, Coding Case Management Services. These guidelines can be accessed online at [http://www.tricare.mil/ocfo/bea/ubu/coding\\_guidelines.cfm](http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm).

c. Case managers will use a six step process to deliver care to Soldiers: assessment, planning, implementation, coordination, monitoring, and evaluation. Working through these processes with the Soldier results in a comprehensive care plan that supports the Soldier’s goal to heal and transition. In the WTU, the comprehensive care plan supports the CTP and identifies specific goals and actions designed to meet the Soldier’s identified needs. The purpose of the

comprehensive care plan is to address problems, set shorthand long-term health and transition-related goals, identify barriers to reaching goals and identify actions that can be taken to resolve barriers to achieving goals.

(1) The plan of care should address all six domains of strength within the Comprehensive Soldier and Family Fitness model.

(2) The plan of care must include goals that promote cost-effective, quality outcomes in accordance with the Defense Health Agency, "Medical Management Guide".

*d.* Termination of case management services. Normally, case management services will continue until the Soldier completes his or her medical care and has RTD, or completes the IDES processes and is discharged from the military. However, due to the unique nature of military operations or other circumstances, there will be situations when case management services will need to be terminated. For example, cases may be closed due to geographical relocation, termination, or ineligibility for TRICARE benefits. Case managers will plan and facilitate transition of care and services for these case managed patients.

(1) Upon termination of case management services, the case manager will complete all necessary actions referenced previously in this regulation to include notification of the PCM and specialty providers.

(2) At a minimum, NCMs will document case closure in AHLTA and in AWCTS as well as any other patient tracking systems of record.

*e.* The NCM will validate the Soldiers self assessment and assign tasks appropriately to meet the needs of the Soldier and Family (see paras 2–22, 2–24, 2–25, and chaps 3 and 4 for roles and responsibilities of the NCM).

### **Section III**

## **Clinical Social Work Care Management**

### **5–10. Purpose**

This section establishes policy and standards for WTU LCSWs and/or BH providers conducting intake, assessment, treatment, supportive services, and care management at WTUs.

### **5–11. Policy**

The WTU LCSWs and designated BH providers will abide by the policies and procedures outlined in this chapter and throughout this regulation, in assessing, supporting, treating, and managing individual Soldiers and their Family or caregiver.

### **5–12. Responsibilities**

WTU LCSWs will work cooperatively and collaboratively with others involved in the care of their Soldiers and Families or caregivers. The WTU LCSW's responsibilities include, but are not limited to—

*a.* Communicate routinely with the Triad of Care team and other WTU medical staff and ensure BH care is coordinated with the medical treatment plan.

*b.* Attend interdisciplinary and treatment team meetings.

*c.* Provide input into the CTP.

*d.* Advise command on BH issues.

*e.* Interface with and coordinate with other BH assets on and off the installation.

*f.* Conduct briefings.

*g.* Train staff and cadre.

### **5–13. Provision of behavioral health care standards and timelines**

*a.* Preliminary BH needs and risk assessment. The Soldier, within 24 hours of the attachment or assignment to the WTU, will complete a preliminary interview with a WTU LCSW or designated on-call provider and complete the WTU BH Social Work Risk Assessment–Questionnaire (SWRA–Q) worksheet.

*b.* The WTU LCSW will—

(1) Within 24 hours of the Soldier's attachment or assignment to the WTU, meet and welcome the Soldier; ensure Soldier completes and signs DA Form 4700 (Medical Record–Supplemental Medical Data) to record the Limits of Confidentiality and Informed Consent to Care (BH clinics); conduct the preliminary BH needs and risk assessment; and complete a safety plan (as appropriate). In the absence of the WTU LCSW, this function may also be performed by an on-call MTF BH provider.

(2) Within 5 days of the Soldier's attachment or assignment to the WTU, schedule an appointment for the Soldier to meet with the WTU LCSW for the initial BH risk assessment and comprehensive assessment, and provide to the Soldier, the Behavioral Health Intake–Psychosocial History and Assessment (BHI–PHA) worksheet to complete prior to the scheduled appointment.

(3) Complete appropriate referrals, consults, and collateral contacts or notifications required to address the Soldier's needs and mitigate the BH risk.

- (4) Enter the Soldier's responses on the SWRA-Q worksheet into the automated BH risk assessment tool entitled PBH-TERM to estimate the Soldier's BH risk (severe, high, elevated, guarded, or low).
- (5) Enter results of BH needs and preliminary risk assessment into AHLTA. In the patient encounter note, enter the risk assessment in the "Objective" section and the safety and treatment plan in the "Plan" or "Add Note" section.
- (6) Convert the BH risk assessment into the WTC BH Social Work Risk Assessment (SWRA) four-point scale (high, moderate, moderate-low, or low) using AWCTS. The LCSW will select the appropriate radio buttons within AWCTS and add any additional comments. Following submission, the results of the SWRA will be displayed on the WTU commander's dashboard for final determination of risk assessment and risk mitigation, as necessary. In general, the paper-based WTU SWRA will be provided to the commander only when AWCTS is down or not available.
- (7) Notify the WTU commander or designee immediately, by telephone or in person, if the Soldier is assessed as "severe" or "high" BH risk.
- (8) Act as a consultant to the WTU commander to implement a BH safety and risk mitigation plan for the Soldier.
- (9) At locations where the Soldier arrives during non-duty hours and WTU LCSW on-call support is limited, the designated on-call provider will—
- (a) Meet with the Soldier to assess BH immediate needs, provide the Soldier the SWRA-Q and the Limits of Confidentiality and Informed Consent to Care to complete; assess the risk on the SWRA; and complete safety and treatment plans, as appropriate.
  - (b) Complete appropriate referrals, consults, collateral contacts or notifications to mitigate risk and facilitate the provision of appropriate BH care.
  - (c) Provide the results of the needs assessment and the BH and WTU risk assessment to the WTU commander or designee via AWCTS or direct notification.
  - (d) Notify the WTU commander or designee immediately, by telephone or in person, if the Soldier is assessed as "severe," "high," or "moderate" BH risk.
  - (e) Act as a consultant to the WTU commander to implement a BH safety and risk mitigation plan for the Soldier.
  - (f) Enter the BH risk assessment (severe, high, moderate, guarded, or low) into AHLTA in the patient encounter note in the "Objective" section, safety, and treatment plan in the "Plan" or "Add Note" section.
  - (g) In instances where an on-call provider completes the preliminary BH needs and risk assessment, the WTU LCSW will (on the next duty day)—
    1. Review the care provided and the BH needs of the Soldier; ensure the Soldier completed the SWRA-Q and Limits of Confidentiality and Informed Consent to Care forms; the on-call provider completed the SWRA; enter risk assessment in AHLTA; and implement safety and risk mitigation plans, if provided by the WTU commander.
    2. Obtain the responses to the initial SWRA-Q from the on-call provider and enter them into PBH-TERM.
    3. Meet and welcome the Soldier and review the current SWRA-Q and update, if needed; address any additional BH needs; schedule an appointment for the Soldier to meet with the WTU LCSW within 5 days of the Soldier's attachment or assignment to the WTU for the initial BH risk assessment and comprehensive assessment; and provide the Soldier with the BHI-PHA worksheet and the Limits of Confidentiality and Informed Consent to Care (recorded on a DA Form 4700) to complete prior to the scheduled appointment.
    4. Document the encounter and enter the current BH risk assessment (as assigned by the on-call provider or adjusted by the WTU LCSW) in AHLTA; enter the WTU SWRA current risk assessment (as assigned by the on-call provider or adjusted by the WTU LCSW) into AWCTS. If AWCTS is not available, ensure that the SWRA is provided to the WTU commander and the Triad of Care.
  - (h) The WTU commanders will develop and implement risk management and mitigation plans for Soldiers as necessary and required; and initial ongoing BH risk assessment and comprehensive assessment.
  - (i) The Soldier will—
    1. Bring the completed BHI-PHA worksheet and DA Form 4700 (signed Limits of Confidentiality and Informed Consent to Care) to their scheduled appointment with the WTU LCSW.
    2. Review and sign DD Form 2005 (Privacy Act Statement – Health Care Records), if not previously signed.
    3. Review and sign DD Form 2870 (Authorization for Disclosure of Medical or Dental Information), as applicable. The WTU LCSW will use this form for release of medical information (for example, information released from a military provider to a civilian provider, facility, Families, or caregivers).
    4. Review and sign authorization to send and receive medical information by electronic mail, as applicable.
    5. Complete ongoing BH interviews and risk assessments, as requested or required.
    6. Comply with risk mitigation and BH safety and treatment plans.
  - (j) The WTU LCSW, at the first scheduled appointment with the Soldier, will—
    1. Meet with the Soldier and re-assess the BH needs; review and obtain the Soldier's signature on all required documentations and complete WTU LCSW BH steps for safety and treatment plan as appropriate.
    2. As indicated by interview and assessment, have the Soldier complete the appropriate screening assessment and intervention tools.

3. Review AHLTA to identify others involved in the Soldier's care, and consult with them to ensure a comprehensive clinical assessment has been completed, safety concerns have been addressed, and care coordination has been completed.

4. Enter and complete the BH risk assessment in PBH-TERM. From the Soldier's responses on the BHI-PHA worksheet and from the relevant facts derived from the WTU LCSW's clinical interview and judgment, input "factors" data (that is, depression – Factor 1; mental status – Factor 2) and case complexity data into the PBH-TERM. The PBH-TERM will assist the WTU LCSW in estimating the immediate risk level (low, guarded, elevated, high, or severe). The WTU LCSW will provide the results of the BH risk assessment SWRA to the WTU commander and/or the Triad of Care by entering the SWRA results into AWCTS. If the Soldier is assessed as "high" or "severe" risk, the LCSW will notify the WTU commander immediately—in person or by telephone—to facilitate a safety and risk mitigation plan for the Soldier.

5. Enter the BH risk assessment, the results of the comprehensive BH assessment, and the plan for the Soldier into AHLTA in the prescribed template for WTU LCSWs entitled "Behavioral Health Social Work-Case Management" as soon as possible, but no later than 10 duty days after the initial interview with the Soldier. Complete the subjective, objective, assessment, and plan sections in accordance with the structure provided in the template. Additional comments and care management notes may be placed in the "Add Note" section of the encounter. The risk estimate or assessment will be entered in the patient encounter note in the "Objective" section and the treatment and safety plan in the "Plan" or "Add Note" section. The PBH-TERM risk estimate will be "cut and pasted" into the "Add Note" section of the AHLTA encounter.

6. Enter the diagnosis in the "Assessment" section of the AHLTA Enterprise template "Subjective Objective-Behavioral Health Social Worker-Care Manager." The WTU LCSWs may diagnose a Soldier's BH condition (for example, Adjustment Disorder 309.0, Acute Reaction to Stress 308.0, Post-Traumatic Stress Disorder 309.81) in accordance with their clinical license to practice independently. The WTU LCSW will annotate all five axes of the Diagnostic and Statistical Manual of Mental Disorders-IV multi-axial classification. If there is no diagnosis, the WTU LCSW may code "no diagnosis or condition" on Axis I and/or Axis II as V71.09. If the diagnosis is deferred, the WTU LCSW may code "diagnosis or condition deferred" on Axis I and/or Axis II as V799.9. For Axis III, if the medical conditions are unknown, annotate as "unknown." Axis IV will include the psychosocial and environmental problems, and Axis V will include the Global Assessment of Functioning.

7. Enter the Soldier's management plan into the "Plan" section of the encounter note in AHLTA. The management plan from PBH-TERM will be "cut and pasted" into the encounter as an "Add Note." The goals and progress toward the goals will be annotated in PBH-TERM and reflected in the "Plan" or "Add Note" section of the encounter.

(k) The WTU LCSW will conduct ongoing BH risk assessments. Soldiers assessed at a BH risk of "severe" or "high" risk will be re-assessed on a weekly basis; those assessed as "moderate" or "elevated" on a monthly basis; and those assessed as "moderate-low," "guarded," or "low" on a quarterly basis. The LCSW will use the SWRA-Q to conduct the ongoing risk assessments and enter the risk assessment data into PBH-TERM at each risk assessment encounter. The LCSW will document the BH risk assessment and update the WTU commander and/or Triad of Care regarding current risk assessments using AWCTS and during Triad meetings.

1. A Soldier considered as "severe" or "high" risk for BH concerns on any risk screen or assessment will be re-assessed for risk level on a weekly basis using the SWRA-Q and the PBH-TERM risk estimate. This reassessment will be conducted in-person with the Soldier until the BH risk level is determined to be "elevated," "guarded," or "low."

2. A Soldier considered "severe" or "high" risk, will not be transferred to a Community Care Unit. LCSWs with "severe" or "high" risk Soldiers will coordinate with the community BH providers, the Triad of Care, and the chain of command to assess if the Soldier may need to return to the installation for WTU installation level of care.

3. Any Soldier admitted to an inpatient BH facility (including substance abuse rehabilitation) or day program for BH care will be considered "severe" or "high" risk. A BH provider will conduct a risk assessment within 24 hours after discharge.

4. Soldiers estimated as "elevated" BH risk will be evaluated by the WTU LCSW on a monthly basis, using the SWRA-Q and PBH-TERM for the risk estimate, until the risk level is estimated to be "guarded" or "low." The WTU LCSW will conduct an in-person risk assessment at a minimum of every 30 days for each Soldier at "elevated" risk until the risk level is determined to be "guarded" or "low." LCSWs may conduct the ongoing monthly risk assessments by telephone; WTU LCSWs will conduct the assessment in person.

5. Soldiers estimated as "guarded" or "low" BH risk will receive a risk estimate using the SWRA-Q and PBH-TERM on a quarterly basis. Community Care Unit LCSWs may conduct the ongoing monthly risk assessments by telephone; WTU LCSW's will conduct the assessment in person.

6. Based on the estimated risk level, the LCSW will take appropriate action to support Soldiers and their Family or caregiver (for example, consult with the physician and/or NCM, contact the command, and/or assist in coordinating the safety plan (including protective measures like inpatient care, weapons removal, and safe shelter from abuse)).

7. The LCSW will conduct BH risk reassessment as soon as possible, but no later than 24 hours, on Soldiers experiencing warning signs as noted in paragraph 4-5. Risk estimates may be completed at any time. AWCTS will be

updated (notifying the risk estimate level of the Soldier when a risk estimate is completed; this may be done via AWCTS).

8. If the Soldier is unavailable to complete a risk assessment due to leave status, the WTU LCSW will contact the Soldier and assess the risk level via telephone.

9. The Soldier will have a PBH-TERM risk estimate completed for consideration of closure of PBH-TERM record 14 days prior to discharge from the WTU. The closing risk estimate from PBH-TERM will be entered into the "Add Note" section of the AHLTA encounter.

10. For each BH risk assessment, the LCSW will enter the responses to the SWRA-Q into the automated BH risk tool (PBH-TERM) at <https://health-terms.army.mil>. (Note: this Web site is restricted and requires an individual provider code.) The WTU LCSW will enter the BH risk assessment into AHLTA in the "Objective section" of the patient encounter note or as an "Add Note" and the SWRA WTU risk assessment into AWCTS.

11. The WTU LCSW will enter the estimated risk level of the Soldier into the AWCTS.

(l) The WTU LCSW will coordinate with Family members, Triad of Care and BH providers, and other members of the interdisciplinary team as needed to ensure appropriate BH risk estimation, risk mitigation, and care management.

(m) WTU commanders will adjust risk management and mitigation plans based on assessed risk and the BH comprehensive assessment of Soldiers, as necessary or when required.

#### **5-14. Case complexity estimate**

a. The LCSW will (upon initial interview, at 90-day intervals, and at case closure) complete the Case Management Complexity Worksheet (CMCW) in PBH-TERM at <https://health-terms.army.mil>. The case complexity is completed at each risk estimate within the PBH-TERM. The LCSW will indicate the level of case complexity (low, moderate, or high) in the "Objective" section of the "subjective, objective, assessment, and plan" and note in the Soldier's AHLTA encounter.

b. If PBH-TERM is not available, the LCSW will use the paper-based CMCW to determine the case complexity and place the CMCW in the service treatment record (STR).

#### **5-15. Supportive counseling, brief treatment intervention, and referral**

a. The WTU LCSWs will provide crisis intervention and/or brief, solution-focused counseling to meet the needs of Soldiers, their Families, or caregivers as determined by their assessment.

b. If more than a brief intervention is required (generally, greater than six sessions), the Soldier will be referred to other appropriate services and for follow-up to ensure continuity of care; however, the LCSW will continue to provide BH care management of the Soldier.

c. Installations with WTU LCSW staffing levels that support more expansive clinical interventions and programs may provide brief interventions, including inpatient and outpatient groups for Soldiers, their Families, or caregivers. Individual, marital, and family counseling are also available when needed.

d. If the WTU LCSWs identify that Soldiers' BH needs are beyond their privileging and scope of practice, LCSWs will, in coordination with the PCM and NCM, refer the Soldier and Family to the appropriate health care discipline for further assessment and intervention. Mandatory referral programs include the ASAP for alcohol and/or drug problems and the Family Advocacy Program (FAP) for suspicion of child or intimate partner abuse and/or neglect. Other supportive referral programs for Family members include the Exceptional Family Member Program (EFMP).

e. The LCSW will conduct a Family needs assessment to ensure that the Family's or caregiver's needs and goals are addressed. The LCSW may use WTU BH-Family Needs Assessment to assist in ID and management of the Family's or caregiver's goals.

f. The LCSW will document all interventions into AHLTA.

#### **5-16. Care management**

The LCSW will—

a. After inputting data into all the "Factor Groups" of the PBH-TERM, complete the management and intervention treatment plan and "cut and paste" the PBH-TERM management plan into the "Add Note" section of the AHLTA encounter.

b. Manage caseload in accordance with the risk level indicated by the PBH-TERM and the WTU LCSW's clinical judgment.

c. Monitor and/or manage all Soldiers requiring BH care to ensure participation in appropriate care and to monitor compliance with treatment recommendations (even if the Soldier is being treated by another BH provider).

d. Manage the BH needs of Soldiers and their Family or caregiver and refer them for clinical care and resources, as indicated. Ensure that contacts and subsequent encounters are entered into AHLTA. The WTU LCSW may use the "Add Note" functionality within the Soldier's last AHLTA encounter to enter care management notes (for example, attempts to contact the Soldier and care coordination efforts).

e. Attend treatment and interdisciplinary team meetings and regularly interface with the Triad of Care and the chain

of command. Provide input into the CTP. Update management and intervention treatment plans so that they are in agreement with team meeting recommendations and the CTP.

f. Educate, advocate, and conduct ongoing assessments to monitor BH, medical, and psychosocial needs of the Soldier, the Family, or caregiver throughout the transition process.

g. In the Community Care Units, if the Soldier does not respond to contact attempts (that is, email and at least three phone calls), the WTU LCSW will contact the Soldier's SL or PSG. If the SL is unable to reach the Soldier, the Community Care Unit LCSW will mail the letter entitled, "Letter Requesting Contact" located in the Resources-Behavioral Health Social Work-Case Management resource list at [www.nationalresourcedirectory.gov](http://www.nationalresourcedirectory.gov), and annotate in the STR the response or lack of response.

#### **5-17. Clinical documentation in the medical record**

a. *Behavioral health records.* The BH records will be maintained in the STR in accordance with AR 40-66 and entered into all required medical and BH systems.

b. *Closing note.* The standard format for closing summary notes is located at the provided Web site in paragraph 5-20. The closing summary note is used when services have been discontinued or are no longer required. The closing note should include a brief summarization of the Soldier's condition, diagnosis, treatment, services, resources provided, closing risk level (based upon the PBH-TERM risk estimate), and case complexity.

c. *Transfer note.* The transfer note is used when the Soldier is transferred to another WTU or provider within the WTU. The transfer note should include a brief summarization of the Soldier's condition, diagnosis, treatment, services, resources provided, transfer risk level (based upon the PBH-TERM risk estimate), and case complexity.

#### **5-18. Limits of confidentiality for clinical information and consent to assessment and/or treatment**

Providers will inform Soldiers regarding limits of confidentiality. Providers will use the limits of confidentiality and informed consent to care to document that Soldiers understand the limits of confidentiality and are providing informed consent regarding their assessment, treatment, and care.

#### **5-19. Behavioral health information release**

The Soldier's BH release information will be handled in accordance with AR 40-400.

#### **5-20. Resources**

a. The BH care manager resource list and the Web site for the National Resource Directory ([www.nationalresourcedirectory.gov](http://www.nationalresourcedirectory.gov)) should be provided to all Soldiers, their Families, or caregivers.

b. The BH International Classification of Diseases coding guide.

c. Forms, letters, templates, worksheets, instructions, screening tools, the patient satisfaction survey, checklists, case notes, telephone contacts and closing note standard formats, resource lists, and references noted in this regulation are available at <https://www.us.army.mil/suite/page/517>.

d. AWCTS access. For access to AWCTS for Soldiers in a designated WTU, contact the local CTP management analyst.

### **Section IV**

#### **Occupational Therapy**

##### **5-21. Purpose**

This section establishes policy and standards for WTU OT and COTA conducting intake, assessment, supportive services, and care management at WTUs.

##### **5-22. Policy**

The WTU OT and Certified Occupational Therapy Assistants will abide by the policies and procedures outlined in this chapter and throughout this regulation, in assessing, supporting, and managing individual Soldiers, their Families, or caregivers.

##### **5-23. Responsibilities**

WTU OT or COTAs will work cooperatively and collaboratively with others involved in the care of the Soldiers and their Families or caregivers. The WTU OT or COTA's responsibilities include, but are not limited to—

a. Communicate routinely with the interdisciplinary team and other WTU medical staff and ensure CER activity is coordinated with the medical treatment plan.

b. Complete initial Phase I goal setting training for all new Soldiers in transition during in-processing phase.

c. Attend interdisciplinary and treatment team meetings, as needed.

d. Assist the medical team in Traumatic Servicemember's Group Life Insurance ADL assessment, as needed.

e. Assist the medical team in SCAADL ADL assessments, as needed.

- f.* Assist the medical team with the determination of the need for a NMA.
- g.* Provide input towards the CTP by communicating the effects Soldiers' conditions may have on their career goals and keep the NCM informed of all clinical conditions that may affect the recovery plan.
- h.* Act as SME for referral for assistive technology, and provide consultation for Americans with Disability Act requirements.
- i.* Interface with and coordinate with other OTs on and off the installation.
- j.* Train staff and cadre on areas within the OT or COTA's scope of practice to include, but not limited to, goal setting, mobility challenges, and/or assistive technology.

**5–24. Provision of occupational therapy registered care standards and timelines**

- a.* The HHC OT will—
  - (1) Conduct all intakes as the Soldier in processes.
  - (2) Complete an initial assessment within 14 days of Soldiers' arrival at the WTU to determine Soldiers' functional ADL status and areas of interest for work reintegration (see chap 11, sec II for makeup and responsibilities of the adaptive reconditioning team). This will be charted in AHLTA. Initial assessment may include, but not be limited to—
    - (a) Pain assessment.
    - (b) Fatigue assessment.
    - (c) Perceived deficits questionnaire.
    - (d) Leisure skill index.
    - (e) Functional status questionnaire.
    - (f) Modified occupational self assessment.
    - (g) Musculoskeletal screen.
    - (h) Learning style.
    - (i) Barriers to learning.
    - (j) Assessment and functional deficits.
  - (3) Plan of care should include, but not be limited to—
    - (a) Phase I goal setting training.
    - (b) Phase II goal setting training.
    - (c) Life skills groups and CER preparatory activities which include classes or group sessions based on Soldiers' functional need and achievement of CTP goals.
    - (d) Request to PCM for referral for MTF OT intervention, if needed.
    - (e) Request to PCM for referral any care or discrepancies found during evaluation, as needed.
    - (f) Request to PCM for referral for any procurement of equipment if needed.
    - (g) Computer/Electronics Accommodations Program Assessment as needed.
    - (h) Military occupational specialty (MOS), professional qualification skills, and functional work assessments if needed.
  - (4) Consult and collaborate with other clinical and non-clinical team members to establish an appropriate plan within all six domains to help facilitate a successful transition for Soldiers and their families.
  - (5) Prepare Soldiers for the CTP process by providing Phase I goal-setting training no later than 21 days after arrival and coordinating an introduction to Phase II Comprehensive Soldier and Family Fitness – goal setting no later than 90 days after the arrival date. The HHC OT may delegate the Phase I goal-setting to the COTA. The OT (or COTA if designated) will enter the Soldier's career domain goal into AWCTS upon completion of the Phase I goal-setting training.
- b.* The battalion OT (BN OT) will provide supervision and oversight to the line company COTA to implement the plan of care. The battalion OT will conduct all reassessments, coordinate CER with the TC, assist with planning and implementing adaptive reconditioning programs and provide supervision of the certified OT as required by their State licensure.
  - (1) Assist the PT and other members of the adaptive reconditioning team (brigade surgeon, site coordinator, company commander, and others designated by the WTB commander) in developing and implementing the Adaptive Reconditioning Program across all six domains related to the Soldier's transition goals. The OT or COTA will work with members of the interdisciplinary and adaptive reconditioning teams to grade and modify Adaptive Reconditioning Programs to ensure the program addresses the Soldier's transition goals.
  - (2) The BN OT will communicate with the NCM on the Soldier's clinical CER eligibility status. The OT is the SME for the career goal and may engage the Soldier in CER prep activities as related to the Soldier's transition goals. The OT will complete a functional assessment to assist the interdisciplinary team with CER eligibility determination, as well as recommendations based on appropriate and supportive work assignments. This is communicated via the CER eligibility and the work site limitations documents, as well as documenting in AHLTA, AWCTS, or other platforms. The OT will use objective measures in determining the Soldier's readiness to include, but not limited to the Soldier's to—

- (a) Keep his or her own medical and nonmedical appointments independently.
- (b) Demonstrate good self-management organization, communication, and analytic skills to positively contribute to a work environment.
- (c) Review of the functional demands of the proposed work site—
  - 1. Understand verbal instructions.
  - 2. Understand written instructions.
  - 3. Determine suitable work environment.
- (d) Soldier's ability to get to and from CER work site.
- (e) If the BN OT, along with the interdisciplinary team, determine that a functional assessment is required for either physical and/or mental or emotional capacity, the BN OT will coordinate the assessment. The functional assessment will include, but not be limited to—
  - 1. RTD track assessment, in consultation with the career counselor.
  - 2. Review of the physical demands of the Soldier's MOS and area of concentration.
  - 3. Review the critical tasks related to the Soldier's MOS and area of concentration.
  - 4. For transition out of the Army, review the physical and mental demands of the potential job description with the TC.
  - 5. The BN OT or COTA will reassess the Soldier's progress toward their CER goals every 30 days to ensure successful transition. The BN OT will work with the TC for referrals to VA VR&E counselors for vocational testing and counseling. The OT will work with the interdisciplinary team to assist in facilitating Soldier's successful completion of the WCTP requirements to include referrals to ACES for education assistance.
- c. The COTAs, under the supervision of the BN OT will conduct life skills groups.
  - (1) The Life Skills Groups will be functional and goal oriented involving interaction between Soldiers and instructors. The Soldier will complete a written survey to evaluate each group session's effectiveness toward achieving transition goals.
  - (2) Life skills groups include, but are not limited to, the following areas:
    - (a) Stress management.
    - (b) Sleep hygiene.
    - (c) Energy conservation.
    - (d) Financial management.
    - (e) Time management.
    - (f) Anger management.
    - (g) Conflict resolution.
    - (h) Instrumental ADL.
    - (i) Self esteem building.
    - (j) Leisure skill exploration.
  - (3) The CER prep skills may be conducted either one-on-one or group pending the needs of the individual Soldier. The COTA, under the guidance of the BN OT, may provide preparatory skills related to either the career or education track. These activities will not replace Soldier for Life – Transition Assistance Program transition requirements. Included in the CER prep skills will include, but is not limited to—
    - (a) Resume writing, traditional, and online versions (database).
    - (b) Interview skills.
    - (c) How to “Dress to Impress.”
    - (d) Converting Army speak.
    - (e) Relationship building.
    - (f) Study skills, including assistive technology, if needed.

## **Section V**

### **Physical Therapy**

#### **5–25. Purpose**

This section establishes roles and responsibilities of WTU PT and PTAs.

#### **5–26. Policy**

The WTU PTs and PTAs will abide by the policies and procedures outlined in this chapter and throughout this regulation, in assessing, screening, supporting, and managing individual Soldiers, their Families, and caregivers.

## **5–27. Responsibilities**

The WTU PT or PTAs will work cooperatively and collaboratively with others involved in the care of their Soldiers and Families or caregivers. The WTU PT or PTAs responsibilities include, but are not limited to—

- a. Complete the initial physical conditioning assessment screen for all new Soldiers while assigned to HHC during in-processing no later than 21 days.
- b. Communicate routinely with the Triad of Care team and medical staff and ensure adaptive reconditioning activity is coordinated with the medical treatment plan.
- c. Attend interdisciplinary team meetings, as needed.
- d. Provide input into the CTP physical domain goal setting process.
- e. Advise command on adaptive reconditioning issues in conjunction with the site coordinator.
- f. Interface with and coordinate with other PTs on and off the installation.
- g. Conduct briefings, as needed.
- h. Train staff and cadre on physical reconditioning and other training needs related to the physical domain as requested or directed by the commander.

## **5–28. Provisions of physical therapy care standards and timelines**

a. The PT will complete an initial physical conditioning assessment and screening within 21 days of entering the WTU and evaluate the Soldiers' abilities and limitations for participation in an adaptive reconditioning. In addition, the PT will—

- (1) Include an initial review of the Soldier's physical fitness and adaptive reconditioning activity interests for the development of the CTP short and long-term goals.
- (2) Assign an ability group in accordance with the Building the Soldier Athlete (a Profile Physical Training Supplement) and establish goals for physical fitness and health maintenance.
- (3) Initiate the development of an Adaptive Reconditioning Program for the Soldier, specifically as it pertains to the physical domain. The PT is the SME for physical fitness for the command.
- (4) Provide input to the Soldier and interdisciplinary team for the development of sub-goals, in any of the six CTP domains, and the Soldier's transition outcome goal.
- (5) Ensure the Soldier's eProfile is appropriate to the Soldier's abilities and limitations.
- (6) Modify the Soldier's eProfile, or consult with the physical profile's originating provider for modifications or changes when appropriate.
- (7) Assist with the neuro-musculoskeletal care coordination, as appropriate.
- (8) Provide ongoing consultation with all interdisciplinary team members to ensure completion of all physical therapy requirements.
- (9) Communicate initial assessment and screen results to the interdisciplinary team members prior to the initial scrimmage.
- (10) Reassess the Soldier's physical fitness health every 90 days and revise the Soldier fitness plan based upon their current progress.

b. The PT's initial assessment and screening may include, but not limited to—

- (1) Soldier goals while assigned to WTU.
- (a) Return to current MOS.
- (b) Change MOS.
- (c) Transition from the Army.
- (2) Soldier goals for physical domain.
- (3) Pain assessment.
- (4) Musculoskeletal screen.
- (5) Current exercise plan and level.
- (6) Most recent Army physical fitness training score.
- (7) Height and body composition.
- (a) Body mass index.
- (b) Army body composition standards.
- (c) eProfile.
- (8) Plan of care may include—
  - (a) Request to PCM for referral for physical training assessment at MTF for orthopedic concerns, if needed.
  - (b) Referral request to PCM for physical training assessment or concussion care, if needed.
  - (c) Physical reconditioning ability group.
- (d) List the activities related to the Adaptive Reconditioning Program that the Soldier may participate in, to address interests and goals pertaining to the physical domain.

c. The PTA will—

- (1) Carry out the Soldier's plan of care as per the PT's guidance.
- (2) Assist the adaptive reconditioning team, as required.
- (3) Assist the PT in reassessing the Soldier's physical fitness health.

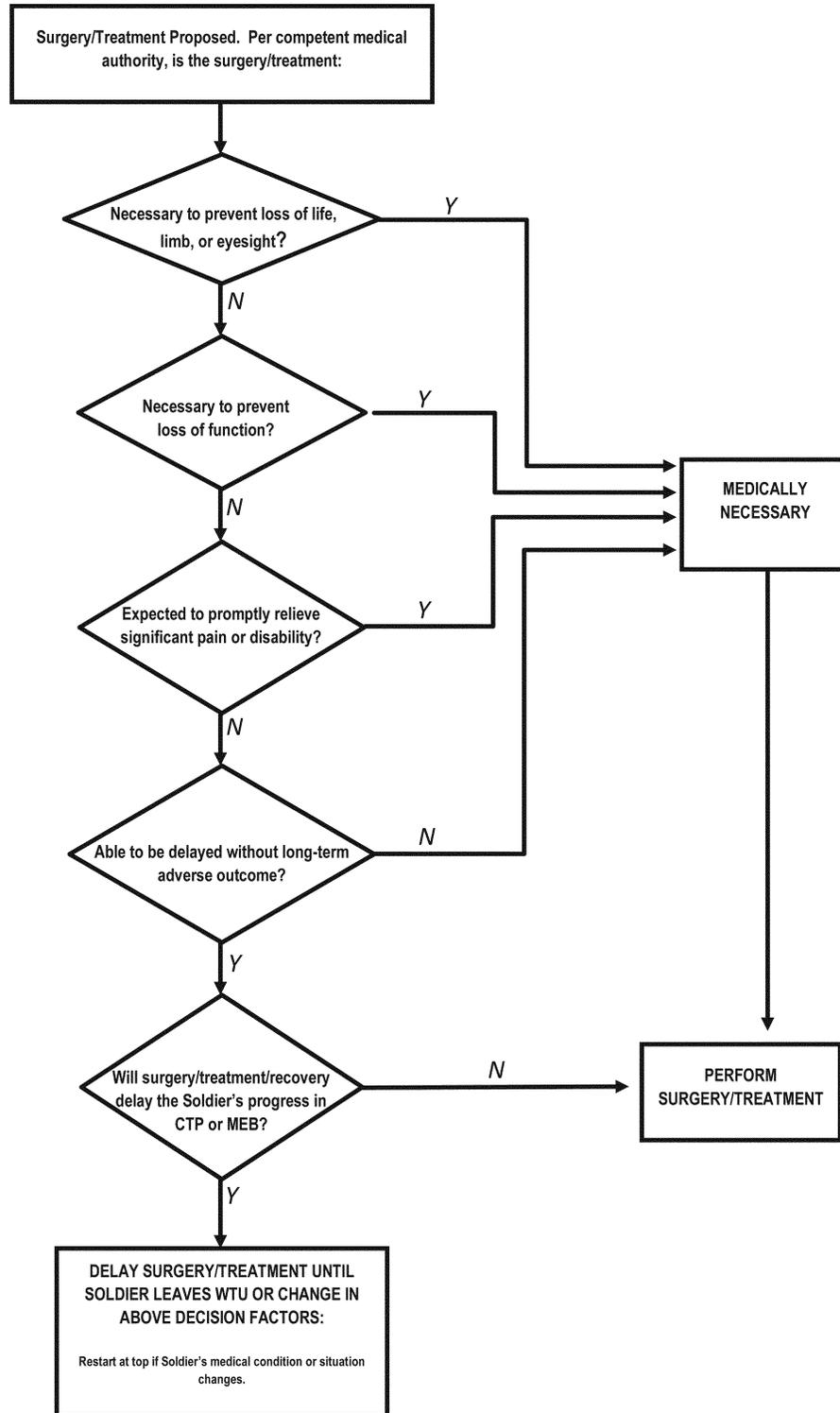


Figure 5-1. Algorithmic summary of the management of optional surgeries

## Chapter 6 Human Resources and Administrative

### Section I

#### Entry, Exit, and Transfer into the Warrior Care and Transition Program

##### 6-1. General

*a.* The mission of a WTU is to successfully transition wounded, ill, or injured Soldiers either back to the Force or to Veteran status, through a comprehensive program of medical care, rehabilitation, and professional and personal goal development. A WTU Soldier falls under the command and control and M2 of a WTU. A WTU Soldier's primary mission is to heal and transition.

*b.* The Triad of Care works in concert with the Triad of Leadership (see glossary) to ensure advocacy, continuity of care for WTU Soldiers, and a seamless transition of WTU Soldiers either back to the Force or to Veteran status.

*c.* Assignment or attachment to a WTU will not be performed solely to facilitate the early requisitioning of replacement personnel or for purely compassionate reasons.

*d.* A SC with a WTU on their installation, the MTF commander, and the WTU commander comprising the Triad of Leadership, is responsible for establishing processes to review and decide Soldiers eligibility to enter their respective units based on criteria stated in this section of this regulation. Ultimately, the SC will ensure Soldiers who are approved for assignment or attachment to a WTU meet the entrance criteria specified in this section.

##### 6-2. Eligibility

*a.* Active component (COMPO 1) and Active Guard Reserve (AGR) Soldiers must meet one of the following:

(1) A Soldier has, or is anticipated to receive, a profile of more than 6 months duration, with duty limitations that preclude the Soldier from training or contributing to unit mission accomplishment, and the complexity of the Soldier's condition requires clinical case management.

(2) Soldier's psychological condition is evaluated by a qualified medical or BH provider as posing a substantial danger to self or others if the Soldier remains in the unit.

*b.* RC Soldiers (COMPO 2 and 3 not in AGR status) must meet all of the following:

(1) The Soldier's medical condition(s) incurred or aggravated in the LOD during an active duty status (contingency or non-contingency) or inactive duty status (inactive duty training, funeral honors duty) may qualify for evaluation, treatment, and/or disability evaluation processing while in an active duty status; and,

(2) The Soldier's condition(s) require(s) definitive care. Definitive care is defined as a specific treatment or a sequence of treatments lasting 30 days or more, as determined and appropriately documented by military medical authority. Treatment is expected either to return the Soldier to duty or reach MRDP and begin the IDDES process. This treatment plan will require a major time commitment from the Soldier (for example, three or more medical appointments per week).

*c.* Soldiers who do not meet the specific eligibility criteria stated will remain in their units and utilize the standard health care system and access-to-care standards. RC Soldiers on AD orders specifying a period of more than 30 days will, with their consent, be kept on AD for disability evaluation until final disposition by the PDES process. Soldiers in the PDES process will not be automatically assigned or attached to the WTU; they must meet the entry criteria stated for assignment or attachment into the WTU.

##### 6-3. Ineligibility

The following Soldiers, regardless of component, are ineligible for entry into the WCTP:

*a.* Pregnancy alone is not a criterion for attachment or assignment to a WTU. However, pregnant Soldiers who meet WCTP entrance criteria in paragraph 6-2*a* or 6-2*b* may enter the WTU if the treatment for qualifying conditions can be conducted without interfering with the pregnancy.

*b.* Soldiers in initial entry training, advanced individual training, or one station unit training. The Triad of Leadership, or designated authority may approve, by exception, initial entry training Soldiers into the WTU.

*c.* Soldiers are pending MAR2.

*d.* Soldiers in temporary disability retirement list status.

*e.* Mobilized COMPO 2 and 3 Soldiers whose condition(s) existed prior to mobilization, were not aggravated by mobilization, and were not discovered prior to day 25 of the current mobilization.

*f.* Soldiers approved for COAD or COAR status.

*g.* Soldiers who are pending or undergoing UCMJ, or legal actions (prohibiting a PCS move), investigation, and/or

LODs require GO member of the Triad of Leadership approval for assignment or attachment to the WTU. Approval for RC Soldiers in ADME status or MRP2, is the WTC commander.

#### **6-4. Procedures for medical retention processing for Reserve Component Soldiers**

a. COMPO 1 and AGR Soldiers will not be in an attached status for longer than 180 days, unless approved as an exception to policy (ETP) by Army G-1 (DAPE-PRC). Attachment and assignment of AGR Soldiers to a WTU resides with WTU S-1.

b. COMPO 2 and 3 Soldiers meeting the eligibility criteria in paragraph 6-2b may voluntarily apply for 10 USC 12301(h) orders under one of the following medical care processing programs:

(1) *Medical retention processing-evaluation*. Medical readiness processing-evaluation orders voluntarily extend demobilizing RC Soldiers on active duty for a short term (normally less than 60 days) for a medical evaluation to determine eligibility for medical readiness processing orders.

(2) *Medical retention processing*. Medical readiness processing orders voluntarily retain RC Soldiers on active duty who incur a wound, injury, or illness, or who aggravate a pre-existing medical condition while on active duty in support of a contingency operation.

(3) *Medical retention processing 2*. Medical readiness processing 2 orders voluntarily return RC Soldiers to active duty, who were released from active duty, with a LOD for unresolved injuries or illness incurred while on active duty in support of a contingency operation.

(4) *Active duty medical extension*. ADME orders voluntarily place RC Soldiers on temporary active duty to evaluate and treat an injury or illness incurred in the LOD during other than in a contingency operation.

#### **6-5. Senior grade entry approval to Warrior Transition Units**

a. Commissioned officers in the grade of O-4 and above, warrant officers in the grade of CW3 and above, and NCOs in the grade of E-8 and above are considered for assignment and attachment by the WTU Triad of Leadership. The first GO in the WTU Triad of Leadership is the approval authority, with the following exception: the WTC commander is the approval authority for Soldiers who enter under MRP2 or ADME orders.

b. General officers will not be relieved from duty assignment and assigned and attached to a WTU without the approval of the DCS, G-1. Requests for such approval will be routed through the WTC commander prior to consideration by HQDA.

#### **6-6. Location of care determination**

The overriding concept is to provide necessary care and services as close to the Soldier's home or support system as possible. In most cases, this will be the home station for AC Soldiers and the home of record for RC. RMC in coordination with the MTFs will assist in determining the WTU location based on the ability to provide necessary evaluation for treatment, the available capacity, and the proximity to the Soldier's duty station or home for RC Soldiers. All transfers and movement of Soldiers between losing and gaining units will be managed, coordinated, and verified by the STARTC, and information verified in the patient movement request (PMR) (see paras 6-11 and 6-12).

a. COMPO 1 Soldiers will primarily be assigned to the WTU closest to their duty station that has the medical capability and functional capacity to meet their care needs. As an ETP, COMPO 1 Soldiers may be attached to a Community Care Unit on a case-by-case basis depending on their medical needs, Family location, and support needs. The Triad of Leadership, with the consensus of the Triad of Care, will make the determination and recommendation if a COMPO 1 Soldier will be assigned to a Community Care Unit (see para 6-12 for the ETP criteria).

b. For RC Soldiers returning through demobilization stations requiring WTU placement, the STARTC will directly arrange placement at the WTU closest to the Soldier's home that has the medical capability and capacity to care for the Soldier. The selected WTU should take into consideration whether the Soldier's home is within its assigned geographic area.

c. RC Soldiers will primarily be attached to a Community Care Unit to receive M2 and transition services. As noted, the Soldier's home must be within the selected unit assigned geographic area. Such attachment allows Soldiers to live at home and perform duty at a location near home while receiving medical care from the TRICARE network, VA, or MTF providers in or near their community.

(1) RC Soldiers will initially be attached to a WTU and undergo evaluation and development of treatment plan prior to transfer to another WTU or a Community Care Unit for mission command and M2.

(a) RC Soldiers should be screened for eligibility to enter the Community Care Unit within the first 30 days of attachment to the WTU. Soldiers residing within 50 miles of the WTU, or those requiring medical resources that are unavailable in their home communities, should be managed from the WTU.

(b) The RC Soldiers considered high risk for safety or BH should remain attached to a WTU.

(2) RC Soldiers physically capable of working will perform duties primarily in support of 10 USC missions or other suitable alternatives, such as, internships in conjunction with VA Coming Home Work Program, DOD OWF, or education that is within the limitation of their profile. The Soldier's SL or PSG in the Community Care Unit will

determine duty location. When a Soldier's medical condition precludes performance of military duties (severely limiting conditions or terminal illness), the Soldier may have their residence designated as their duty location.

d. All initial orders and extensions will be coordinated with HRC for processing.

#### **6-7. Exit criteria for component 1, and component 2 and 3 Active Guard Reserve Soldiers**

a. *Return to duty.* Soldiers may be returned to duty if any of the following criteria are met:

(1) The PCM determines that the Soldier can RTD, generally with all profile designators of 1 or 2 in accordance with AR 40-501.

(2) Soldier is found fit for duty by a PEB.

(3) Soldier is accepted for COAD or COAR in accordance with AR 635-40.

b. *Separation or retirement.*

(1) Soldiers who do not meet Army medical retention standards described in AR 40-501 may remain assigned or attached to the WTU until a final PDES determination is rendered and the Soldier is retired or separated.

(2) Soldiers receive final determination on UCMJ or adverse administrative actions in accordance with ARs.

(3) Soldier's eligibility for, and election to accept, a nonmedical retirement.

#### **6-8. Exit criteria for component 2 and 3 Soldiers not in Army Guard Reserve status**

a. A RC Soldier should be recommended to the DCCS for REFRAD when any one of the following situations exists:

(1) Soldier's written, voluntary election to REFRAD after being counseled on his or her right to PDES or IDES processing and the associated benefits of a medical discharge should the PEB find the Soldier unfit for duty.

(2) Permanent or temporary profiles with a designator of 1 or 2 in all categories (medical readiness classes 1 and 2).

(3) Soldiers with a single temporary profile designator of 3 reasonably expected to resolve to a profile designator of 1 or 2 within 30 days.

(4) Incarceration expected to exceed 30 days in duration which prevents the Soldier from participating in the CTP.

(5) Completion of the PDES process with a finding of fit for duty or COAR status.

b. *Separation or retirement.* Recommendation for retirement or separation should be used when one of the following situations exists for an RC Soldier:

(1) Completion of the PDES process with a finding of not fit. COMPO 2 and 3 Soldiers who do not meet Army retention standards described in AR 40-501 will remain attached to the WTU until a final PDES determination is rendered and the Soldier is retired or separated.

(2) Administrative or UCMJ actions recommending separation or discharge from the Army. (See AR 135-175 and AR 600-8-24 for separation, transfer, or discharges of RC officers; AR 135-178 and AR 635-200 for separations of enlisted members; and AR 635-40 for disability separations).

(3) Soldier's eligibility for, and election to accept, a nonmedical retirement.

c. Soldiers with unresolved 3 or 4 profile designators, and not fitting one of the categories listed in paragraphs 6-8a and 6-8b are not eligible for involuntary REFRAD.

d. Soldiers who voluntarily request to leave the WTU prior to receiving a fit for duty rating must be counseled by the PEBLO and have the consensus of the Triad of Care, approval of the Triad of Leadership, and concurrence of the respective ARNG deputy State surgeon or regional support command surgeon. Additionally, the Soldier must—

(1) Submit a DA Form 4187 (Personnel Action) for medical retention processing, medical retention processing 2 or ADME declination, or withdrawal statement through his or her chain of command.

(2) If military medical authority advises that the Soldier should be retained on active duty for further evaluation and treatment and the Soldier is competent to decide that he or she wants to leave the program, the Soldier may sign the withdrawal statement only after counseling by an individual knowledgeable about the medical retention processing, medical retention processing 2, and ADME programs, the incapacitation pay, and transitional medical benefits concerning the consequences of voluntarily leaving the WTU prior to receiving a fit for duty rating.

#### **6-9. Unit notification**

a. The MTF commander will ensure that the parent unit is notified any time a Soldier enters a WTU. Notification will be made within 24 hours. If the unit is deployed, the forward unit commander or designated representative will be notified. The notification will include the date of entry and a copy of the orders assigning or attaching the Soldier to the WTU. Another notification is made when the patient is returned to duty or another disposition is made.

b. In cases where the Soldier is admitted to the MTF during periods of mobilization or named operations, if the deployed unit cannot be determined or contacted, the patient administrator will notify the emergency operations center (or alternate designated location) of the installation from which the Soldier's unit is deployed.

c. When a patient is admitted while en route overseas, the patient administrator will notify the Army traveler's

assistance center. The patient administrator will indicate the probable length of hospitalization and whether the patient is expected to be assigned to the WTU.

#### **6–10. Coordinating instructions and screening for entry into a Warrior Transition Unit**

*a. Purpose.* A medical screening assists health care providers and unit commanders in identifying Soldiers who may benefit most from assignment or attachment to a WTU.

*b. Process.*

(1) The health care provider will complete a medical screening with input from the health care team to include the BH staff.

(2) The completed medical screening will be reviewed and signed by the unit commander and included in the documentation forwarded to the Triad of Leadership.

*c. Coordinating instructions.*

(1) SCs will ensure Soldiers who may qualify for assignment or attachment to the WTU are referred to the Triad of Leadership for evaluation.

(2) Unit commanders will provide a completed nomination to the Triad of Leadership.

#### **6–11. Determination of eligibility and ineligibility for transfer to Community Care Units**

*a.* Eligibility and selection of the WTU Soldier for further attachment to a Community Care Unit is a joint decision between the WTU and Community Care Unit mission command, M2 team based on administrative and medical data. WTU will screen all eligible RC WTU Soldiers within 30 days to determine eligibility for referral to a Community Care Unit.

(1) The Soldier must be unencumbered by legal or administrative actions or holds, including flags for adverse action, UCMJ or administrative separation actions.

(2) The Soldier must be able to attend required unit activities, scheduled medical appointments, and demonstrate the reliability required for remote mission command and administrative management.

(3) Medical care must be no more than within a 50-mile radius (or one hour travel time) from the Soldier's residence. However, occasional specialty appointments that require travel greater than 50 miles are permitted.

(4) The Soldier must have completed Phase I goal setting with the WTU lead OT prior to Community Care Unit transfer.

(5) The Soldier must have a housing plan for a permanent (not transient) residence that accommodates functional limitations, have a street address and provides for telephonic contact. The RC Soldiers' residence and home of record will be the same, however, exceptions may be granted on a case-by-case basis (for example, Soldiers might choose to live with Family members who can assist in their convalescent or rehab care).

(6) The Soldier must have reliable transportation for travel to and from medical appointments and designated place of duty. Transportation must accommodate any physical limitations (reliable transportation includes the mass transit system, rides from Family or friend).

(7) Soldiers are not required to have a CER work site identified before transfer. All transferring Soldiers must be placed in a CER work site that aligns with their CTP career track and career goal(s) within 60 days of CER eligibility. The CCU TC will assist the Soldier in identifying an appropriate work site. The work site must be within the limits of the Soldier's physical profile and must be within 50 miles of their residence. Additionally, if a National Guard Armory or Reserve Center is within 50 miles of their residence the Soldier must be connected with the unit to ensure they receive administrative support. The Soldier must meet with their assigned armory or reserve center POC a minimum of once a week. RC Soldiers placed in an armory or reserve center are on Title 10 orders, and therefore will not participate in Title 32 duties, such as annual training (AT) or inactive duty for training (IDT). The duties performed must be commensurate with their rank and MOS, to the extent possible.

(8) The Soldier must require a minimum of 60 days of clinical care to achieve MRDP.

(9) The Soldier's medical treatment and care plan can be managed by the Community Care Unit. There must be confirmation that appropriate medical care is available within commuting distance from residence. However, specialty and sub-specialty care that may require occasional medical TDY is permitted.

(10) COMPO 2 and 3 Soldiers with medical conditions that do not require complex medical care management for RTD (REFRAD) or disability processing.

(11) Soldiers not meeting the criteria in paragraph 6–11a(1) through 6–11a(10) may qualify for an EPT (see para 6–12c).

*b.* Soldiers are ineligible for transfer in the following circumstances:

(1) Behavioral disorders that render them administratively unfit or non-retainable.

(2) Planned residence is within 50 miles of an MTF.

(3) Reach MRDP within 60 days.

(4) Entered in the PDES and the IDES/MEB integrated narrative summary is not yet completed.

(5) Medical conditions are not commonly treated by civilian practitioners.

(6) Require mental health observation or treatment beyond the capacity or scope of the Community Care Unit, or whose home environment is not conducive to supporting healing and healthy outcomes.

(7) The level and type of medical care required is not available in the Soldier's community.

(8) Soldier that is designated high risk by the command.

## **6-12. Exception to eligibility for transfer**

### *a. Policy.*

(1) All active component Soldiers will be assigned or attached to the WTU at the installation of their parent unit. If a WTU does not exist on that installation or medical capability or capacity is not available, an alternate WTU with medical capability and capacity commensurate with Soldiers needs closest to their support network may be requested. If medical capabilities are not available at current WTU, a transfer request may be submitted with supporting documentation, including recommendation from the attending physician stating that the necessary medical care cannot be accomplished through the use of routine medical TDY.

(2) RC Soldiers will be attached or transferred to a WTU and/or Community Care Unit with medical capability and capacity commensurate with their needs closest to their support network. Any transfer action that does not meet criteria outlined in paragraph 6-11 will be considered an ETP.

*b. The originating MTF or WTU Triad of Care will ensure Soldiers meet both clinical and administrative eligibility as described in chapters 3 and 4.*

*c. Soldiers are eligible to request a transfer as an ETP provided that the request is based on—*

(1) Personal issues that cannot be resolved through the use of leave, correspondence, power of attorney, or the help of Family members or other parties.

(2) Medical problems of a Family member. A signed statement from the attending physician giving medical diagnosis and prognosis of illness must be provided. This statement should also address how transferring the Soldier will affect the Family member's medical condition.

(3) Legal issues. A signed statement from a licensed attorney must state the legal problems and reasons why transfer of the Soldier will be beneficial.

(4) Other than medical or legal problems. Supporting documents from appropriate persons (such as clergy, social workers, and others who have a working knowledge of the problem) must be included.

(5) Health and welfare of the Family members. The affected Family member must be—

(a) The spouse, child, parent, minor brother or sister, guardian (in loco parentis), or the Soldier's only living blood relative.

(b) Or other authorized dependent, as described in AR 600-8-14.

(6) Condition of a parent-in-law and no other member of the spouse's Family is available to assist with or resolve the problem.

(7) Terminal illness with less than 12 months' life expectancy of an immediate Family member. Documentation by attending physician must be provided.

(8) Threat that the Soldier's minor children are being made wards of the court or placed in an orphanage or foster home as a result of Family separation. Separation must be the result of military Service and not of neglect or misconduct on the part of the Soldier.

(9) The Soldier's Family member having disabling allergies aggravated by climatic conditions.

(10) Threat to life to the Soldier or Family member.

(11) Provides adequate documentation supporting movement of Soldier more than one time within the same fiscal year, if applicable.

*d. Active component (COMPO 1) Soldiers may be transferred to a Community Care Unit under the following conditions:*

(1) Soldiers incurred a severe and/or catastrophic illness, injury, or terminal illness and require significant care needs; or,

(2) Require the assistance of a Family member and/or caregiver support network who live remotely from the installation to manage the Soldier's daily living activities, and the Soldier is not expected to RTD or remain in the military; or,

(3) Other exceptions which require case-by-case review, such as single Soldier who may be able to RTD after extensive recovery and requires assistance by the Family whose parents reside remotely.

*e. Soldiers will submit a DA Form 4187 to request an ETP to transfer. All requests must be endorsed by the first lieutenant colonel (O-5) or higher in the Soldier's chain of command and set forth the extenuating circumstances. Requests and supporting documentation, if applicable, should be submitted through the RMC to the STARTC.*

*f. The WTC commander is the single approval authority for all ETP transfers of Soldiers. The WTC commander may delegate this approval authority, in writing, to a division chief within WTC.*

*g. Responsibilities.*

(1) *Leadership involvement.* Leaders will actively support the entire spectrum of Soldier's movement among WTUs; identifying the goal of healing "closest to home" is a priority.

(2) *The Warrior Transition Command, G-1.* HR Action Branch will process ETP transfers to the WTC commander for action. Additionally, the WTC G-1 is—

(a) The single arbitrator for resolution of discrepancies and disputes.

(b) Responsible for overall process improvement and subsequent changes to policy and documentation regarding WTU transfers. Monitors MODS transfer module to identify Soldier transfer eligibility.

(3) *Regional medical commands.* Monitor submitted PMR in TRANSCOM Regulating and Command and Control Evacuation System and provide feedback to STARTC personnel regarding eligibility no later than 48 hours of request of information.

(4) *The Warrior Transition Unit commanders.* Ensure mission command and M2 coordination and communication between gaining and losing unit. The gaining unit must acknowledge report date of the Soldier and be proactively involved in the warm handoff of the inbound Soldier and his or her Family.

(5) *The Warrior Transition Unit Triad of Care and leadership.* Ensure compliance with eligibility criteria and associated checklists by utilizing a proactive approach to ensure a seamless handoff.

(6) *Medical Command Soldier Transfer and Regulating Tracking Center.* Coordinate, regulate and track all WTU Soldier transfers. Additionally, the STARTC will—

(a) Request assistance from RMCs as necessary and ensure submitted PMRs are resolved within 3 business days.

(b) Update Soldier movements within the TRANSCOM Regulating and Command and Control Evacuation System database within 3 business days upon receipt of disapproval response from WTC.

(7) *Medical Command Human Resources.* In coordination with STARTC, publish attachment orders for all COMPO 2 and 3 WTU Soldiers within 3 business days of notification from STARTC with the goal of moving Soldiers closest to their home of record.

### 6-13. Care in a non-Army medical facility

The WTU Soldiers outside a 50-mile radius to an MTF may be admitted to a non-Army medical treatment facility (Air Force, Navy, VA, and civilian). The Army MTF having geographical area of responsibility will place the Soldier in the status of absent sick in accordance with AR 40-400 guidance. The responsible WTU will prepare the order and forward it to the Soldier's assigned unit and the facility at which the Soldier is hospitalized.

a. Table 6-1 shows current location fields in the MODS-WT module that will be used to account for assigned or attached Soldiers receiving care in remote medical facilities.

b. The MODS clinical comment fields will be annotated as follows:

(1) The specific location of the remote medical facility where the Soldier is receiving treatment.

(2) The WTU case managers will document each contact with the Soldier receiving remote care.

(3) The WTU command and staff will document, and enter into MODS-WT module, administrative comments regarding visits with Soldiers receiving care in a VA polytrauma rehabilitation center.

(4) The Soldier's NCM will contact the Soldier in remote medical facilities weekly.

(5) The WTU will provide assigned or attached Soldiers and their Family members with standardized WTU information containing WTU Triad of Care and ombudsman POC information.

(6) A Soldier's absent sick status is documented in the appropriate systems including, as a minimum, the Composite Health Care System and MODS-WT module.

**Table 6-1**

**Current location fields**

Civilian inpatient	For all Soldiers receiving inpatient treatment in a civilian facility.
Civilian rehab	For all Soldiers receiving outpatient treatment in a civilian facility.
VA inpatient	For all Soldiers receiving inpatient treatment in a VA facility (non-Polytrauma Rehabilitation Centers).
VA Polytrauma Center	For all Solderis receiving inpatient treatment at a VA Polytrauma Rehabilitation Center.
VA rehab	For all Soldiers receiving outpatient treatment at any VA medical facility.

## **6-14. Administrative procedures for disposition of component 1 Soldiers assigned in continental United States Warrior Transition Units**

COMPO 1 Soldiers who are returned to duty and assigned to a WTU will be reported to HRC by the WTU commander or the first O-5 in the chain of command for assignment instructions. Unless—

*a.* Soldier has 20 or more years of Federal service and desires to retire within 180 days of the RTD date; then the Soldier may request permission from HRC to retire in lieu of a PCS move. However, the MTF commander may make exceptions if it is determined that other action will better serve the interest of the Government, then reassignment instructions will be requested as stated, or Soldier is reassigned within the installation.

*b.* Soldier is pending security clearance and assignment instructions cannot be obtained. These Soldiers will not remain assigned to a WTU solely to await the results of these actions. MTF commanders have the option to reassign the individual within the installation.

*c.* Soldier is pending release or discharge in accordance with governing separation regulations.

*d.* Officer has applied for or is scheduled for retirement within 60 days, or has submitted a tender of resignation; then, the officer will remain assigned to the WTU until instructions are received from HRC. The MTF commander will promptly report such officers to CG, HRC (AHRC-PDT-R). A copy of the board proceedings will accompany this report.

## **6-15. Disposition of non-mobilized Reserve component personnel**

Inpatient non-mobilized RC personnel on active duty orders for more than 31 days and those with orders 30 days or fewer and not approved for ADME status will not be assigned to the WTU. Such Soldiers may remain in a MTF in a patient status and draw pay and allowances or, with the Soldier's consent, be continued on active duty while being treated for an injury, illness, or disease incurred or aggravated in the LOD (see AR 135-381). Non-mobilized RC Soldiers on active duty orders for 31 days or more may be extended on active duty upon recommendation of their physician.

## **6-16. Non-Army personnel**

The WTU will provide administrative and logistical support to non-Army active duty personnel while in an inpatient or outpatient status at an Army MTF. Active duty personnel from other Services admitted directly or by transfer to the MTF may be attached to the WTU at the request of the Service. The WTU will account for attached personnel from other Services in MODS-WT.

## **6-17. Geographically dispersed personnel**

*a.* Geographically dispersed Soldiers assigned or attached to units that are not based on an installation with a SC and MTF commander may be eligible for entry to a WTU, provided they meet eligibility criteria in paragraph 6-2 or 6-3.

*b.* Requests for WTU entry should be submitted through the requesting command's G-1, and command surgeon or psychologist, and then for review and validation to the WTC command surgeon and commander for approval. The validated request will be forwarded to WTC, G-1 for processing.

*c.* The WTC commander is the sole approval authority for WTU entry of all geographically dispersed military personnel.

## **Section II**

### **Cadre Assignments**

## **6-18. Cadre selection**

*a.* In accordance with AR 614-200 for enlisted assignments, or AR 614-100 for officers, SCs are responsible for resourcing and approving personnel to fill component-specific WTU cadre positions. SCs will identify, screen, and select best-qualified candidates to fill WTU cadre positions. Thus, commanders will establish and conduct Cadre Selection Panels to select the best qualified candidates.

*b.* Soldiers identified for WTU cadre positions must meet the following military education and experience requirements:

(1) *Squad leaders.*

(a) Warrior Leader Course required, Advanced Leader Course preferred.

(b) At least one successful leadership experience as a SL required.

(c) At minimum, E-5.

(2) *Platoon sergeants.*

(a) Advanced Leader Course required, Senior Leader Course preferred.

(b) At least one successful leadership experience as a SL or PSG required.

(c) At minimum, E-6.

(3) *First sergeants.*

(a) Senior Leader Course required, 1SG Course required.

- (b) At least one successful leadership experience as a PSG.
- (4) *Company commander.*
  - (a) Captains Career Course required.
  - (b) Successfully commanded for at least 1 year.
- (5) *Nurse case manager.*
  - (a) Captains Career Course preferred.
  - (b) At minimum, O-3.
  - (6) *Senior nurse case manager.*
    - (a) Intermediate Level Education required.
    - (b) Advanced Nurse Leadership Course preferred. Successfully served as a clinical nurse OIC or in a supervisory position.
- c. Additionally, Soldiers identified for WTU cadre positions must display strong manner of performance, strong potential for promotion, and have completed all required NCO Education System (NCOES) level training for their grade.
- d. Soldiers identified for WTU cadre positions will complete DA Form 7424 (Sensitive Duty Assignment Eligibility Questionnaire) indicating whether they have any reports of unfavorable information within the previous 12 months. If a Soldier indicates any unfavorable information, only the SC will make the final determination for assignment as a cadre.
- e. All personnel identified for assignment as WTU cadre will be assigned against an authorized tables of distribution and allowances position corresponding to their service component.
- f. WTU commanders or cadre selection panels will interview and review the records of candidates to validate if a candidate possesses the required skills and attributes to work as WTU cadre. Candidate recommendations will then be forwarded to the SC for final approval. WTUs will maintain all interview packets for 180-days from day of interview.
- g. Upon acceptance, MEDCOM Reserve Augmentation and Mobilization Plans and Operations Division will process RC cadre through DA G-3, Department of the Army Mobilization Processing System-Army, for a request for orders under contingency-active duty for operational support in a voluntary status in accordance with DA G-1 personnel policy guidance instructions.
- h. Cadre assignment length is 2 years to avoid cadre strain. Active component cadre personnel will be stabilized for 24 months upon assignment into the WTU. One 12-month extension may be requested for exceptional cadre personnel under extenuating circumstances. Submit extension requests through the chain of command to WTC commander. WTC will endorse and return requests to the SC for submission to HRC, AHRC-EPMD or AHRC-OPMD, for final approval.
- i. Assignment and tour lengths for CSMs will be strictly managed by HRC, AHRC-SGM.
- j. RC cadre orders are for a period not to exceed 730 days. Cadre members wishing to continue in the position after their initial tour of duty must submit an extension request through the chain of command to the WTC commander. WTC will coordinate with component force providers and provide final approval. Approved extension requests must be entered into Department of the Army Mobilization Processing System-Army tour of duty no later than 180 days before their initial orders end.
- k. WTUs will initiate replacement and ID of personnel with the responsible force provides (RFPs) no later than 180 days prior to the projected or programmed loss date.
- l. To have HRC backfill COMPO 1 positions vice filling those positions with local assets, WTUs may request through their chain of command MTF and RMC with endorsement from the SC. WTUs will forward requests to MEDCOM HR Soldier Transition Support Branch for coordination with HRC.

#### **6-19. Approval authorities for assignments of cadre**

The SC is the approval authority for all cadre assignments except those involving component mismatches. SCs may delegate this authority one level except for Soldiers with unfavorable information.

#### **6-20. Component mismatch assignments.**

- a. All personnel identified for assignment as cadre to a WTU will be assigned against an authorized position corresponding to their service component (as reflected in the MODS-WT module of the contingency battle roster (CBR)).
- b. The Commander, WTC, is the sole approval authority for component mismatch assignments. Requests for component mismatch approval will be sent by the requesting WTU "THRU" the SC, to "Commander, Warrior Transition Command (MCWT-PER)." Requesting officials will forward requests electronically to the WTC to [usarmy.pentagon.medcom-wtc.list.g1-orders-approval@mail.mil](mailto:usarmy.pentagon.medcom-wtc.list.g1-orders-approval@mail.mil).
- c. Upon receipt of requests, WTC, G-1 will notify the RFPs of the identified Soldier and the position. Requests for concurrence and non-concurrence will be sent in writing to each RFP.
- d. Once the WTC, G-1 receives the concurrence or non-concurrence, the WTC commander will approve or disapprove the request. The originating office will be notified in writing of the decision. If the request is approved, the

written notification will include the duration of the mismatch. Notification of approval or disapproval will be completed within 10 calendar days of receipt of the request. By name request assignments are not authorized without the written approval of the WTC commander.

### **6-21. Responsibilities**

*a.* The WTU commanders will—

(1) Follow policy and procedures outlined in paragraphs 6-18 through 6-20 when identifying and selecting military personnel to fill component-specific WTU cadre positions.

(2) Coordinate with MTF, RMC, MEDCOM Warrior Transition HR, USARC, ARNG, and SCs to ensure unit is fully staffed.

(3) Ensure military personnel assigned as WTU cadre successfully complete the WTU cadre orientation course (distance learning) and appropriate WTU Triad of Care training, staff training or NCM course preferably before but no later than 90 days after assuming duties.

(4) Counsel new personnel upon arrival of the demands of the role; expectations in terms of time demands and duty stressors; location and how to access BH support; and expectations of the position related to customer service focus. Commanders will also use the SLRRT to identify potential personal stressors that may impact performance. If a personal stressor is identified, measures must be put in place to assist the Soldier. If the commander assesses the Soldier to have personal stressors that will negatively impact duties and performance, the commander should discuss with the SC or HRC a potential re-assignment for the Soldier.

(5) Counsel all RC Soldiers and officers on submitting extension requests and the 1095 rule (see para 6-18) and sanctuary.

*b.* RMCs will—

(1) Monitor and coordinate with SC to ensure that cadre staffing of subordinate WTUs is in accordance with approved and prescribed staffing ratios.

(2) Provide by name request eligible personnel for WTU key leader positions (battalion commander, (non-centralized selection list), CSM (non-centralized selection list), separate company commander, and 1SG) through the SC to HRC no later than 270 days prior to report date.

(3) Once a month, report the number of open positions within the region (broken down by unit) to WTC, G-1. Validate all RC positions are in the Tour of Duty System and that tour of duty positions are eligible to accept applicants.

(4) Train WTUs on the use of tour of duty.

*c.* SCs will ensure that subordinate WTUs are fully manned in accordance with approved and prescribed staffing ratios.

### **6-22. Cadre stability**

Stability of cadre, both medical and administrative, is critical to the success of the WCTP. Commands must minimize turnover and closely control the movement and transfer of members of the Triad of Care (SL, PSG, and NCM) within WTUs—

*a.* The first O-6 commander in the chain of command is the approving authority for the movement of personnel within the WTUs that results in changes of personnel within the Triad of Care.

*b.* WTU commanders will obtain approval of the first O-6 commander in their chain of command prior to movement of cadre (SL or PSG, NCM) within the Triad of Care.

*c.* Personnel assigned to a Triad of Care position (SL or PSG, NCM) will remain in their assigned position for the complete tenure of their tour unless one of the following obligations occurs:

(1) PCS, professional development, leave or other official administrative re-assignment as directed in AR 614-200 or AR 614-100.

(2) Relief for Cause, Article 15 or other UCMJ and/or disciplinary actions.

*d.* WTU commanders will establish a policy for the movement of personnel that result in breaking the Triad of Care. The policy must include timely notification of the Soldier and his or her Family.

*e.* Commanders at all levels are responsible for implementing this guidance. Changes to a Soldier's Triad of Care should be kept to a strict minimum to promote healing, enhance positive cadre-Soldier and Family rapport and alleviate separation anxieties.

### **6-23. Exemption from Professional Filler System**

*a.* The WTU cadre personnel and WTC staff documented in assigned positions in CBR will be reflected as exempt in the MODS Decision Support Tool and will not be assigned to PROFIS, Professional Filler Deployment System (PDS), medical augmentee and individual assignments.

*b.* The MEDCOM major subordinate commands will ensure WTU cadre personnel are assigned to the proper WTU operational UIC and are posted in assigned positions in the CBR.

- c. The MEDCOM major subordinate commands will not assign WTU cadre personnel to PROFIS, PDS, medical augmentee and individual assignments.
- d. As an exception, COMPO 1 medical corps officers assigned to WTUs who have not deployed may be assigned as PROFIS, but not PDS, medical augmentee, or individual assignments.
- e. The WTU cadre and WTC staff that volunteer for PROFIS assignments must have their chain of command recommendations before approval.
- f. Commanders at all levels should ensure implementation procedures are established to ensure compliance.

#### **6–24. Collateral duty exemption**

- a. The WTU mission is to provide mission command, primary care, and case management for recovering Soldiers as the Army's premier capability to set the conditions for healing and promote the timely return to the force or transition to civilian life.
- b. Non-WTU commanders at any level will not task WTU cadre for collateral duties such as staff duty officer, staff duty NCO, charge of quarters, FLIPL. Cadres are a critical link for Soldiers and their Families as they heal to RTD or transition into the civilian life. Interference with the cadre and Soldier's primary mission could seriously erode the trust and confidence in accomplishing the goals of the CTP.
- c. WTU commander may utilize Soldiers in the WCTP for unit level tasking (for example, charge of quarters) only when this duty does not interfere with the Soldier's medical recovery plan (as validated by the PCM). The PCM must provide written concurrence if the Soldier is taking narcotics, psychotropic medications, or sleep aids prior to assuming duties that include driving, providing supervision over other WTU Soldiers, and utilizing heavy machinery.

### **Section III**

#### **Career and Education Readiness Work Site Selection**

#### **6–25. Definition**

A CER work site is where a WTU Soldier participates in a work activity that aligns with the Soldier's CTP track and supports the Soldier's long-term career goals.

#### **6–26. Policy**

- a. Soldiers must be determined CER eligible by the commander and the M2 in collaboration with the interdisciplinary team prior to participation at a CER work site.
- b. The CER work sites must be within 50 miles of the Soldier's current residence. An ETP must be requested for CER work sites more than 50 miles from where Soldier resides.
- c. The ETP with justification must be initiated and signed by the WTU staff and the WTU commander; and—
  - (1) Routed through the RMC WTO to WTC, G–1 for approval.
  - (2) The sole approval authority for an ETP is the WTC commander.
- d. All CER work sites require a job safety analysis. Composite risk management (CRM) will be used if specific hazards are identified (see Army Techniques Publication (ATP) 5–19). CRM is the process to mitigate hazards. A job safety analysis must be completed at least once per work site unless there are physical changes to the work site that were not previously identified as potential job hazards. An additional job safety analysis will be required when potential job hazards are newly identified at a previously cleared work site.
- e. The WTU commanders will ensure provisions stated are strictly enforced.
- f. Overseas travel and travel across an international border are not permitted to accommodate a selected CER work site.

#### **6–27. Continental United States and outside the continental United States work site placement**

Work sites outside the continental United States are not permitted except for Soldiers at WTU Fort Richardson, WTU Fort Wainwright, Community Care Unit-Puerto Rico, Pacific RMC and Europe RMC. Work sites at these locations will comply with paragraph 6–26.

### **Section IV**

#### **Leave and Passes**

#### **6–28. Leave and Pass Management Program**

- a. Leave and passes for WTU Soldiers and cadre will be managed in accordance with AR 600–8–10. WTU commanders will consult with the WTU Soldier's NCM prior to approving any leave, passes, to include convalescent leave, to ensure that the request does not interfere with the Soldier's medical care plan.
- b. The WTU commanders must establish an annual unit leave and management program and internal controls to account for all leave requests in accordance with AR 600–8–10.

c. Soldiers in IDES are authorized leave and passes; however it should not interfere with completion of IDES.

### **6–29. Respite Pass Program**

a. *Purpose.* The purpose of the Respite Pass Program is to increase resiliency among the staff at the WTUs. WTUs cadre work diligently to ensure the health, welfare, and successful transition of Soldiers, often performing continuous duty of excessive duration. This program will assist with cadre well-being through a regular and unhindered recharging period.

b. *Eligibility.* Military and DA Civilian members of the interdisciplinary team assigned and working in a WTU.

c. *Military personnel.* Commanders and 1SGs will create an official respite program that will allow the company-level cadre members of the interdisciplinary team, a quarterly 4-day special pass period of unhindered time away from the demands of caring for Soldiers in accordance with the parameters set forth in AR 600–8–10. This program does not limit a commander's discretion to reward any other special pass to a deserving member of the cadre, consistent with applicable personnel policies and regulations.

d. *Department of Army Civilian.* When possible, commanders should allow the use of compensatory time, annual leave, or time-off awards for DA Civilian members of the interdisciplinary team, in accordance with Department of Defense Instruction (DODI) 1400.25 on DA Civilian Attendance and Leave, and Awards regulatory guidance, to accomplish the purpose of this policy.

e. *Warrior Transition Unit commanders, command sergeants major, and first sergeants.* All WTU commanders, CSMs, and 1SGs should identify and adopt best practices for the implementation and execution of this program. Commanders will ensure interdisciplinary team cadre members—

- (1) Temporarily hand over their Soldiers' files and responsibilities to another command-designated NCO or officer.
- (2) Temporarily turn over their Government-issued communication devices.
- (3) Have minimal, if any, contact with their Soldiers during the respite pass period.

### **6–30. Medical care while on leave or pass**

Soldiers will be briefed by their NCMs on procedures for obtaining medical care prior to taking leave or pass. Whenever possible, Soldiers requiring medical care should go to the nearest MTF (U.S. Army, U.S. Navy, or U.S. Air Force). Soldiers are required to contact their NCMs immediately if they seek medical attention at an MTF or local community hospital while on leave or pass. The NCM is required to develop a plan for the Soldier's medical treatment while on leave or pass. If there are no MTFs in the Soldier's leave or pass area, they may do the following:

a. For emergency care: go to the nearest emergency room or call the appropriate number for an emergency in the location. Tri-Service Medical Care preauthorization is not necessary for emergency medical treatment.

b. For urgent care: call the nearest emergency room or TRICARE help line to determine if this is an emergency.

c. For non-urgent care: preauthorization by TRICARE is required. You must contact NCM or call TRICARE toll-free number for assistance.

### **6–31. Removal from the Warrior Care and Transition Program – Non-compliance to the Warrior Care and Transition Program**

Soldiers assigned to the WCTP have a mission to heal and transition. WTUs, including Community Care Units, will continue to provide a compassionate healing environment, while holding Soldiers to the highest standards expected of every Soldier in the United States Army. Soldiers are expected to be accountable and actively participate in meeting the goals outlined in their individual CTP (see para 2–21). REFRAD COMPO 2 and 3 or RTD (COMPO 1) authority for a non-compliant Soldier from a WTU is the first O–6 commander in the chain of command, normally the MTF commander. Paragraphs 6–31a through 6–31f are areas of special emphasis:

a. *Comprehensive transition plan.* Soldiers are accountable for establishing and meeting their goals. They will complete all the requirements related to their CTP such as goal setting, scrimmages, FTRs, and self-assessments as directed by their command teams (commanders and senior enlisted advisors). The chain of command and health care providers will provide the support and counseling to assist Soldiers. The AWCTS, Armed AHLTA, and Army counseling forms (DA Form 4856) will be used to document all Soldiers progress through their CTP.

b. *Conduct.* Despite individual illnesses or injuries, Soldiers remain subject to ARs, customs and courtesies, administrative policies, and the UCMJ. Soldiers must comply with policies and regulations to the fullest extent possible within the limits of their medical profiles. AR 600–20 states that commanders are responsible for establishing leadership climate of the unit and developing disciplined and cohesive units. Commanders should consult with their servicing Judge Advocates as part of the disciplinary process.

(1) Soldiers are responsible for attending formations, town halls, and unit activities, as directed by their command teams. As Soldiers progress through their recovery, they will actively engage with transition activities to include education programs, internships, and adaptive reconditioning activities. Participation in recreational trips will not conflict with a Soldier's medical plan. Therapeutic events and/or trips are considered part of the medical plan.

(2) Developmental counseling, whether event or performance oriented, will be used to review a Soldier's demonstrated performance and potential. Reception and integration counseling familiarizes the Soldiers with the unit's standards and clarifies requirements and expectations.

*c. Incidents of misconduct.* Commanders will do everything possible to assist and enable Soldiers to heal and transition successfully. Commanders will use their experience and discretion to assess incidents of non-compliance and misconduct on a case-by-case basis. Available commander options include: counseling, RTD from the WTU program, UCMJ action or administrative separation under the provisions of AR 635-200, AR 600-20, AR 600-8-24, and or AR 635-40 (consistent with the guidance in para 6-31d(1)). Commanders must ensure these decisions are well-reasoned and made in the best interests of the Soldier and the Army. Commanders should seek legal advice when recommendation or decision is to pursue administrative or UCMJ action on a Soldier. Nothing in this paragraph is intended to mandate that certain action be taken when dealing with misconduct except as is required by regulation (for example, mandatory processing for administrative separation for wrongful use of drugs). Commanders are reminded that the decision to take punitive action in a particular case rests with that commander. Normally, commanders may not separate or REFRAD Soldiers who are currently in the MEB processing. However, this does not preclude commanders from administering UCMJ action, initiating separation action, or conducting counseling with corrective training.

(1) Administrative separation during the MEB process will be as followed—

(a) For enlisted Soldiers, except in separation actions under AR 635-200 and circumstances provided for under AR 635-200, disposition through medical channels takes precedence over administrative separation processing.

(b) Refer to AR 600-8-24 for separation processing of commissioned and warrant officers.

(2) Ineligibility for disability processing. Refer to AR 635-40 for circumstances in which Soldiers may be ineligible for disability processing. These include:

(a) Soldiers charged with an offense (see AR 635-40).

(b) Soldiers with suspended sentences (see AR 635-40).

(c) Enlisted Soldiers subject to administrative separation (see AR 635-40).

(d) Soldiers AWOL (see AR 635-40).

(e) Commissioned or warrant officers who may be separated under other than honorable conditions (see AR 635-40).

*d. Medical instructions.* A medical appointment is a Soldier's appointed place of duty. Soldiers are expected to keep scheduled clinical and non-clinical appointments, follow medical instructions, use prescription medications as directed, and adhere to physical profiles. A Soldier's adherence to medical instructions from providers, social workers, and NCMs is essential to healing and transition. A Soldier's failure to keep scheduled appointments or follow medical instructions may constitute a failure to obey lawful orders and may result in UCMJ action, adverse administrative action, or removal from the WCTP. Disposition will be determined based on respective ARs. Soldiers will not make initial or specialty medical or surgical appointments without a referral or approval from their PCM. Additionally, Soldiers will not cancel appointments without approval of their NCM.

*e. Medication use.* Soldiers will use prescription and over the counter medication only as directed and will report any side effects to the PCM or NCM and chain of command immediately. The following guidance is strictly enforced to ensure the Soldier's well being and safety:

(1) Prescriptions are valid only for the duration and purpose prescribed. Prescription drugs are inappropriately used when taken outside the intended purpose, beyond the prescribed dates, in excess of the prescribed dosing regimen or when a Soldier uses another individual's prescribed medication.

(2) Soldiers must report the use of non-prescription medications and substances, including herbals, supplements, and energy drinks to their NCM and PCM.

(3) PCMs must approve the use of over the counter medications, as these medications may have adverse effects and/or reactions when taken in conjunction with prescribed medications.

(4) Distributing or sharing one's own prescription drugs and use of another's prescription drugs are illegal. Soldiers who do so may be subject to UCMJ or adverse administrative action.

*f. Illegal drugs.* Use, possession, and distribution of illegal drugs are violations of the UCMJ. Illegal drugs are prejudicial to good order and discipline and use is inconsistent with healing. Commanders will conduct random urinalysis testing in accordance with AR 600-85. Use of illegal drugs may result in mandatory separation processing in accordance with AR 635-200 or UCMJ action if deemed appropriate by the Soldier's commander. In accordance with AR 635-200, "processed for separation" means that separation action will be initiated and processed through the chain of command to the separation authority for appropriate action.

## **Section V**

### **Army Body Composition Program**

#### **6-32. General**

Army Weight Standards. In accordance with AR 600-9, paragraph 3-3, Soldiers assigned or attached to a WTU must meet the body fat standard. Weight gain that results in body fat content that exceeds the Army standards is inconsistent

with successful recovery. Soldiers in non-compliance with AR 600–9 will be flagged in accordance with AR 600–8–2, enrolled in the ABCP and expected to make satisfactory progress in the ABCP. Units must ensure Soldiers not meeting height and weight standards are enrolled in nutrition counseling and that weight standards and goals are annotated in the CTP.

### **6–33. Exemption**

*a.* The following Soldiers are exempt from the requirements of AR 600–9; however, they must maintain a Soldierly appearance:

(1) Soldiers with major limb loss. Major limb loss is defined as an amputation above the ankle or above the wrist which includes full hand and/or full foot loss. It does not include partial hand, foot, or toes.

(2) Soldiers in COAD and/or COAR status.

(3) Pregnant and postpartum Soldiers.

*b.* Soldiers diagnosed with a temporary medical condition, by a medical provider, that directly causes weight gain or body fat loss may have up to six months to undergo treatment to resolve the medical issues under the guidance of the PCM. This may be extended up to 12 months if the PCM determines the medical condition dictates. If the Soldier does not exhibit satisfactory progress, the Soldier will be subject to separation.

*c.* Soldiers that do not meet the criteria have the option to request a temporary ETP. However, Soldiers may be granted temporary exemptions because of chronic medical conditions or orthopedic conditions that preclude them from participating in the ABCP. They will still be required to meet height and weight standards. If a Soldier believes his or her medical condition(s) prevents them from meeting the requirements of AR 600–9, he or she can request an ETP to be temporarily exempt from meeting the requirements of AR 600–9 (see AR 600–9, para 3–17). The exemption paperwork must be endorsed by the PCM and processed through the Soldier's chain of command, reviewed by the servicing staff judge advocate, and submitted directly to the DCS, G–1, who is the sole approval authority.

*d.* Soldiers who have been diagnosed with a medical condition that precludes participation in the ABCP will not be administratively separated in accordance with AR 635–200. To remain fit, all Soldiers will participate in adaptive physical training within the limitations of their profile. The use of certain medication to treat an underlying medical disorder or the inability to perform all aerobic events may contribute to weight gain but are not considered sufficient justification for noncompliance with AR 600–9 and the Soldier will be flagged.

## **Section VI**

### **Inspection Programs**

#### **6–34. Organizational Inspection Program**

The OIP in accordance with AR 1–201 helps to validate WTUs compliance with program standards; facilitate continuous operational improvements; identify innovations and share best practices between WTUs; and compile and communicate WTU trends to senior leadership. Commanders are required to correct critical deficiencies.

#### **6–35. Staff Assistance Visits**

*a.* SAVs provide MTF, WTU, SFAC, and select garrison staff guidance and knowledge on the operations of a WTU. The SAVs are multidisciplinary and led by designated SMEs. These visits ensure that every organization understands and adheres to Army standards and maximizes operational capability of the WTU.

*b.* Each SAV team includes SMEs from MEDCOM RMCs and external participation from DA G–1, IMCOM, USAFMCOM, and the DVA, if available. Each team contains Active, Reserve, and National Guard members and will have both Army level and regional representation.

## **Chapter 7**

### **Automation Systems Supporting the Warrior Care and Transition Program**

#### **Section I**

#### **The Army Warrior Care and Transition System**

##### **7–1. Purpose**

The AWCTS is the Army's system of record for documentation of the CTP. The AWCTS uses an integrated data architecture, which provides accurate and timely data from multiple authoritative sources and provides the user the ability to track Soldiers in the WCTP through their recovery, rehabilitation and transition back to military duty or civilian life as a Veteran. In addition, AWCTS supports the Army's most severely wounded Soldiers and Veterans through the AW2 program. The AWCTS is a HIPAA compliant, role based access system.

## **7-2. General**

The AWCTS will be utilized to document all CTP processes. Paper-based documenting should be used when AWCTS is not available and as a general content guideline. Such paper documenting should be entered into AWCTS when the system becomes available.

*a.* Content. Entries will be made into AWCTS by the appropriate cadre member who observes, or cares for the Soldier during their assignment or attachment to the WTU. No one is permitted to complete the documentation within AWCTS on a Soldier unfamiliar to him or her.

*b.* Signatures. All entries into AWCTS are authenticated.

*c.* Date and time. All entries made within AWCTS are electronically dated and timed.

*d.* Corrections to entries. To correct an entry, the user must submit a help desk ticket through their appropriate CTP management analyst. While an incorrect entry may be deleted, the date, time, and name of the person making the change will be visible on the audit log to show a complete audit trail.

*e.* The AWCTS also supports the AW2 program.

## **7-3. Responsibilities**

*a.* The WTU commander will—

(1) Determine by category of personnel their role-based access to AWCTS.

(2) Ensure all individuals receive HIPAA training within 30 days of assignment to WTUs or prior to receiving access to AWCTS and annually during their birth month thereafter, and maintain a file record of certificates of training.

(3) Counsel individuals with access to AWCTS on their obligation to maintain the confidentiality and privacy of PHI and to report violations in accordance with AR 40-66.

*b.* The CTP management analyst will—

(1) Initiate Soldier in-processing record into AWCTS.

(2) Ensure WTU requests access to AWCTS are submitted using DD Form 2875 (System Authorization Access Request) which is an inspectable item during OIPs.

(3) Provide users access to AWCTS based on their roles in the CTP.

*c.* Interdisciplinary team will—

(1) Document as appropriate all required entries into AWCTS based on the Soldier's CTP.

(2) Ensure and assist Soldiers with completing their information into AWCTS.

(3) The AW2 advocate must document in the Soldier's CTP as well in the AW2 AWCTS module.

## **Section II**

### **Medical Operational Data System-Warrior Transition**

## **7-4. Purpose**

The MODS-WT application was developed by the Army Medical Department as the system of record for documenting Soldiers' progress through the AWCTP. MODS-WT facilitates WTU chain of command's comprehensive monitoring and management of the condition of WTU Soldiers by providing real-time visibility of demographic, administrative, clinical and transition information compatible with the needs of leadership and affected medical personnel. The MODS-WT module is an online, HIPAA-compliant, tiered access system that incorporates Army Knowledge Online authentication. The MODS-WT module also facilitates the tracking of personnel from all branches of Service treated at an Army WTU. MODS-WT module allows designated users to create, edit, and delete records on Active and RC Soldiers assigned or attached to WTUs.

## **7-5. Responsibilities**

*a.* Commander, WTU will—

(1) Designate a MODS-WT functional lead to provide oversight of the application.

(2) Provide analytical support to internal and external customers and stakeholders as required.

(3) Designate sufficient MODS-WT management analysts to provide timely day-to-day management of the application (such as, access, system modifications, and updating of the homepage), provide analytical support to the WTC, and participate as members of the WTC organizational inspection team.

*b.* Commanders, RMC will—

(1) Designate a MODS-WT analyst to manage access and to provide analytical support to the Director, Regional WTO.

(2) Ensure that the Regional MODS-WT analyst recommends access for users based on their roles in the CTP and in AWCTS and that all applicants or users maintain a current HIPAA training status.

(3) Ensure that the Regional MODS-WT analyst promptly submits requests for users' access to the WTC management analysts.

(4) Ensure that the Regional MODS–WT analyst performs weekly reconciliation with affiliated WTU to ensure users’ access is revoked immediately upon departure from units.

c. The WTU commander will—

(1) Determine MODS–WT role-based access levels for categories of personnel.

(2) Ensure that all applicants are HIPAA compliant prior to registering for access, and that all users maintain a current HIPAA training status.

(3) Counsel MODS–WT users regarding their duty to preserve the confidentiality of PHI and to report violations of the same.

(4) Designate a MODS–WT lead and ensure that the lead requests access for users in an expeditious manner to support the unit’s mission.

(5) Ensure that the unit’s MODS–WT lead utilizes the RMC MODS–WT analyst to address MODS–WT issues as required.

(6) Ensure that all users’ access to the MODS–WT module is immediately revoked upon their departure from the WTU.

d. The WTU Human Resource Staff will—

(1) Create a MODS–WT module record for each Soldier immediately upon arrival at the initial WTU in-processing.

(2) Review and update MODS–WT data upon Soldier’s arrival at gaining WTU to ensure completeness and accuracy.

(3) Manage all demographic and administrative data fields in each assigned or attached WTU Soldier’s record to ensure completeness and accuracy of the data.

(4) Synchronize efforts with the affected NCM to facilitate comprehensive management of each WTU Soldier.

e. The WTU NCM will—

(1) Perform a thorough review of each (assigned or attached) WTU Soldier’s record to ensure accuracy of data regarding medical condition(s), TRICARE data, and clinical comments and data fields.

(2) Manage all clinical data fields in each assigned or attached Soldier’s record to ensure completeness and accuracy of the data.

(3) Synchronize efforts with the interdisciplinary team to ensure appropriate data capture in MODS–WT.

(4) Ensure that weekly clinical data entries are entered in MODS–WT. Soldiers on transitional leave require a monthly entry except where a Soldier’s condition changes, or he or she is hospitalized.

## **Chapter 8 Community Partnership and Interaction**

### **Section I Donations**

#### **8–1. General**

AR 1–100, AR 1–101, and the JER establish policies for accepting, receiving, processing, and reporting gifts offered to MEDCOM from non-Federal entities (NFEs).

#### **8–2. Acceptance of donations**

a. *Warrior Transition Command.* The WTU commanders and WTC personnel are not delegated the authority to accept gifts on behalf of the U.S. Army and will not accept gifts or donations even in the absence of a recognized acceptance authority.

b. *The Surgeon General.* TSG is the acceptance authority for all WTC gifts, and all WTU gifts over \$50,000. TSG will forward all proffers of gifts valued greater than \$250,000 to the SECARMY for acceptance.

c. *Regional medical commanders.* Pursuant to AR 1–101, TSG has delegated acceptance authority to RMCs for gifts valued up to \$50,000 for Army MTFs within their region and gifts for distribution to individuals, including WTU personnel. Therefore, RMC commander have acceptance authority for all WTC gifts, and all WTU gifts under \$50,000.

d. *Gifts according to the Joint Ethics Regulation.* Soldiers may accept gifts in their personal capacities according to the limitations of the JER. Legal review is strongly advised in all cases and is required in cases exceeding the requirements of JER.

e. *Separated and medically retired Soldiers.* Army gifts regulations only apply to Active and RCs (COMPO 2 and 3) of the United States Army. The Army gift regulations are inapplicable to separated or medically retired Soldiers. Commanders, to include TSG and RMC commanders, do not have the authority to accept gifts on behalf of separated or medically retired Soldiers.

*f. Army Wounded Warrior advocates.* AW2 advocates may not receive gifts on behalf of wounded, ill, or injured Soldiers.

### **8–3. Solicitation of gift and donation**

The WTU and WTC personnel will not solicit, fundraise, or otherwise request or encourage a gift from NFEs. However, in response to an inquiry, WTU and WTC personnel may inform a prospective donor of the needs of the WTU, WTC, and AW2 Programs only after coordinating with WTC Command Judge Advocate (CJA).

## **Section II**

### **Community Organizations Support**

#### **8–4. Use of Community Organizations Support**

*a.* Organizations that wish to provide goods or services to the U.S. Army’s wounded, ill, or injured Soldiers, Veterans, their Families, and caregivers must first complete the WTC Community Support Network registration application. The application can be found at <http://www.wtc.army.mil/modules/support%20network/index.html> or can be requested by emailing [usarmy.pentagon.medcom-wtc.mbx.communitysupportnetwork@mail.mil](mailto:usarmy.pentagon.medcom-wtc.mbx.communitysupportnetwork@mail.mil). Once the completed application is received by the Community Support Network coordinator, a review will be conducted on public sites to ensure the organization is in good standing. Upon successful review, the organization will have their information added to the Community Support Network site and will be entitled to the same opportunities afforded to all other organization members. Community Support Network will continue to conduct random organization audits and survey with members of the Community Support Network population to ensure organizations maintain satisfactory standards. Organizations that want to make specific donations to the WTC will need to contact the WTC Office of TJAG. Each donation will be considered on a case-by-case request.

*b.* Participation in the WTC Community Support Network is strictly voluntary. The WTC Community Support Network is not to be used as a business solicitation tool. To be in the WTC Community Support Network, all services to the Community must be freely given, covered by insurance, or significantly reduced in price with all costs being disclosed up front and prior to any agreement between the organization and all wounded, ill, or injured Soldiers, Veterans, their Families, and caregivers. Participation in the WTC Community Support Network does not constitute expressed or implied endorsement by the Community Support Network, WTC, AW2, the U.S. Army, or the DOD or permission to use any Army logos. The WTC Community Support Network reserves the right to discontinue hosting or using any organization’s information, products, and/or services at any time for any reason.

#### **8–5. The Community Support Network**

Community Support Network includes a wide variety of organizations, such as:

- a.* Army programs.
- b.* Civic organizations and clubs.
- c.* Corporations.
- d.* Federal, State, and local government programs.
- e.* Local businesses.
- f.* Nonprofit organizations.
- g.* Veterans Service Organizations.

#### **8–6. Types of Services**

The types of services community supports provide to the Army’s wounded, ill, or injured Soldiers, Veterans, and Family members include:

- a.* Adaptive materials.
- b.* Care packages.
- c.* Career training or education.
- d.* Caregiver support.
- e.* Employment opportunities.
- f.* Financial counseling.
- g.* Financial support.
- h.* Housing assistance or opportunities.
- i.* HR support.
- j.* Interactive communications forums.
- k.* Letters and messages.
- l.* Mental wellness and counseling.
- m.* Moral support.
- n.* Physical rehabilitative support.

- o.* Recreational services.
- p.* Retirement and transition assistance.
- q.* Retreats.
- r.* Services for Families.
- s.* Services for children.
- t.* Travel support.

### **8-7. Rules and limitations affecting the community support network**

The JERs (DOD 5500.07-R, chap 3) (supported by DOD Inspector General Report D-2009-032 (America Supports You Program)) requires that the Army interact differently with Federal entities than with NFEs, therefore, when listing these organizations on your Web site Federal and non-Federal must be separated.

### **8-8. Organizations not accepted into the community support network**

There are certain instances when organizations should not be accepted into the Community Support Network—

- a.* If they appear on the State Department list of Foreign Terror Organizations.
- b.* If they have had multiple problematic interactions with Soldiers, Veterans and Family members.
- c.* If they publicly display information that directly conflicts with the mission of the WTC, AW2, or WTU.
- d.* If membership is a vehicle to gain favor with the DOD, the Army, or other Federal agency.

## **Chapter 9 Family Programs**

### **Section I Family Support Groups**

#### **9-1. Warrior Transition Unit Family Readiness Support Assistance**

*a.* The primary function of a WTU FRSA is to know and understand the role of the FRG, and how community agencies can support the Soldiers and their Families (see para 2-26 and/or AR 608-1). By knowing how to access and navigate the programs offered by community service programs, the FRSA can provide appropriate referrals to military and community resource agencies. Becoming an active component of the Commanders Family Program, the FRSA can strengthen the program by promoting effective and efficient communication between the unit, the garrison, and the Families. As units undergo changes in volunteers and leadership, FRSAs are essential in being able to provide continuity and stability.

- b.* The FRSA will—
  - (1) Assist with—
    - (a)* Executing well-being calls to Families of WTU Soldiers, by referring Family members to services located at the SFAC and ACS.
    - (b)* Establishing and updating FRG rosters, telephone trees, and email distribution lists.
    - (c)* Providing referrals to community agencies (such as ACS, chaplain, social work services, and so forth) and identifying POCs.
    - (d)* Providing timely and accurate information on FRG leaders to commanders (for example, email all FRG leaders).
    - (e)* Making copies, typing agendas, writing and mailing FRG communications.
    - (f)* Establishing and maintaining unit's virtual FRG Web site.
    - (g)* Completing volunteer forms (DD Form 2793, (Volunteer Agreement for Appropriated Fund Activities & Non Appropriated Fund Instrumentalities)) to ensure they are properly signed.
    - (h)* Assisting commanders with volunteer awards.
    - (i)* Providing assistance with the understanding of the SOPs for FRG fund audits.
    - (j)* Obtaining employer ID number for banking purposes of Informal Funds for FRGs.
    - (k)* Contacting FRG leaders for Family members.
  - (2) Attend—
    - (a)* The FRG and steering committee meetings.
    - (b)* Installation information exchange meetings (for example, Senior Spouse Command and Staff).
    - (c)* Newcomer's briefings to obtain information on new Soldiers and Family members to pass onto FRG Leaders.
  - (3) Develop and distribute—
    - (a)* Correspondence, newsletters, announcements, flyers, activity calendars, reports, and requests from draft.
    - (b)* Timely and accurate information to Soldiers and their Family members that is appropriate to their needs.
    - (c)* FRG mailings.

- (d) Creates, updates, and maintains phone rosters.
- (e) Unit Facebook page to communicate with the Soldiers and their Families.
- (4) Schedule and coordinate—
  - (a) Family readiness training or unit sponsored training for Soldiers and families, and key volunteers.
  - (b) Video teleconferences between deployed Soldiers and families.
  - (c) FRG events across brigade, battalion, and company.
  - (d) Guest speakers for FRG meetings or events.
  - (e) Locations for FRG meetings.
  - (f) Childcare for deployment briefings and FRG meetings.
- (5) Maintain—
  - (a) Regular telephonic and/or electronic contact with FRG leaders, commanders, RDC, and ACS Family Program staff, for up to date information on Family readiness activities and issues.
  - (b) Volunteer records, ensure volunteer records are properly maintained and utilize the Volunteer Management Information System.
  - (c) A roster of FRG leaders and email distribution list of FRG leaders to the brigade, battalion, and company.
  - (d) ID of POCs and information on community resources.
  - (e) FRG binders that contain appointment letters, banking information, SOPs, chain of concern roster, volunteer job descriptions, volunteer agreement forms, training certificates. Further assist units in maintaining these binders.
- (6) Monitor and report—
  - (a) Suspense's and process correspondence through appropriate channels.
  - (b) State of unit families and report to commander.
  - (c) Safekeeping, storage, destruction of office and FRG records, ARs and policies, and computer output.
  - (d) Gathers and updates contact information for in-processing Soldiers regarding incoming Family members.
- c. A FRSA will not—
  - (1) Serve as the commander's administrative assistant for activities not related to Family readiness activities.
  - (2) Lead any FRG Meetings, make decisions, or act as an official spokesperson for the unit.
  - (3) Be directly involved with unit fund raising activities or be accountable for the monies in the FRG account. (Event coordination is permissible.)
  - (4) Be involved in the casualty assistance notification procedures or direct support of affected Families.
  - (5) Duplicate services or overlap existing resources in the military community.
  - (6) Duplicate the roles and responsibilities of the volunteer FRG leader – FRSA positions will not serve as, or replace FRG leaders.
  - (7) Be involved in suicide prevention activities.
  - (8) Teach Family readiness training, or any other training currently provided by the existing community agencies.
  - (9) Serve as the SME for installation and Army Family Readiness.

## **9–2. Family Readiness Groups**

- a. FRGs are command-sponsored organizations of all assigned Soldiers, DA Civilians, volunteers and their Families (immediate and extended) that together provide mutual support and assistance among the Family members, the chain of command, and community resources. FRGs provide a means for people within a military unit to help each other, primarily through the efficient dissemination of accurate information. While FRGs are usually associated with deployments, they provide many more essential services in support of the Total Army Family Program.
- b. FRGs should—
  - (1) Provide a communications network that—
    - (a) Develop open and honest channels of communication between the command and Family members.
    - (b) Ensure exchange of accurate information.
    - (c) Can be used as a conduit to identify problems or needs to the command.
  - (2) Assist military and personal preparedness by—
    - (a) Educating Family members about the Army and helping them adjust to military life.
    - (b) Gaining and sharing information about the military community.
    - (c) Providing support during periods of separation whether from a deployment or other situations.
    - (d) Providing referrals to resources available outside of the military community.
- c. FRGs should communicate an environment that promotes confidence, cohesion, commitment, and a sense of well being among the Soldiers and their Families.

## Section II Nonmedical Attendants

### 9–3. Background

The NMA Program enables physician-designated, seriously ill or injured, or very seriously ill or injured Soldiers to identify an individual that will be placed on invitational travel orders (ITOs) to provide support and assistance to the Soldier as they heal and recover. The attending physician and the MTF commander must approve the individual to serve as the NMA. Normally, one person is authorized to serve as a NMA. In extenuating circumstances, more than one NMA may be authorized. Once the Soldier reaches a level of independence, the NMA is no longer authorized. Authority for this section is governed by 37 USC 481k; Joint Travel Regulations (JTRs), paragraph U7205; DOD Financial Management Regulation, Volume 9, chapter 8; and DODI 1341.12, Special Compensation for Assistance with Activities of Daily Living.

### 9–4. Entitlements

*a. The nonmedical attendants orientation.* All Soldiers and their Families attached or assigned to a WTU will receive the attached orientation briefing related to NMAs within the first 30 days of assignment or attachment to the WTU in an outpatient status.

*b. Entitlements.*

(1) If the NMA is a uniformed Servicemember or a Government employee, the NMA is authorized TDY travel and transportation allowances.

(2) If the NMA is a Family member or friend not affiliated with the military, the individual will be placed on ITOs; (commonly referred to NMA orders) with entitlements as described in the JTR. The JTR is updated and changed often. Commanders must periodically review these paragraphs to ensure entitlements have not changed. The JTR is available at <http://www.defensetravel.dod.mil>.

(3) The NMA is entitled to one round trip ticket between the NMA's home and the location at which the Soldier is receiving treatment. There are times when a NMA purchases their own ticket; however, they will only be reimbursed the amount the Government would pay for a ticket. For example, the Government will not reimburse for a first class ticket unless it is the same amount the Government would pay for a ticket.

(4) A NMA required to drive to the MTF where the Soldier is receiving care can be reimbursed for mileage incurred during their trip to the Soldier's MTF. However, NMAs that reside within the MTF's local commuting area (as designated by the area's senior mission commander) are not entitled to reimbursement.

(5) Other trips. If the NMA accompanies the Soldier to another authorized treatment facility, the NMA may be entitled to transportation or reimbursement for travel. Normally this reimbursement is for travel outside of the local commuting area.

(6) Per diem.

*(a)* While the NMA is on ITOs, the NMA is entitled to per diem allowance. Per diem allowance covers the cost of lodging, meals, and incidentals. Lodging and meal per diem rates are based upon location and have a pre-determined limit established by the Federal Government. If the NMA's primary residence is within the local commuting area for the location where the Soldier is receiving treatment, the NMA will not receive per diem. The local commuting area is determined by the SC within that area.

*(b)* Per diem allowances are not granted to a NMA when the NMA accompanies a Soldier to non-therapeutic activity such as a recreational event. A therapeutic activity is an activity that is determined by a physician to be of medical benefit to the Soldier; a recreational event does not meet this requirement. For example, when the NMA attends an overnight event that is purely for fun (for example, accompanies the Soldier on his or her leave), the NMA is not entitled to per diem for the time the Soldier is attending that activity.

*(c)* Per diem is paid on a monthly basis to the NMA via the Defense Travel System (DTS). It is normally deposited into the NMA's specified bank account. Monthly reimbursement continues until the PCM determines that the Soldier no longer needs a NMA. At that time, the NMA orders will be terminated.

*(d)* Per diem pay and SCAADL. NMA entitlements and SCAADL are two unrelated programs. A Soldier may receive SCAADL while having a NMA however, the NMA entitlements will be granted upon the criteria. See chapter 10, section I, for more information on SCAADL.

(7) Health care. If the NMA is a non-Defense Enrollment Eligibility Reporting System eligible person, the NMA is entitled to military evaluation and care on a space available basis at the local MTF (hospital). Local commands will provide additional information on the care available within their MTF and the local area. The NMA will be required to provide information of their private health insurance to the MTF and the NCM. If the NMA has insurance and needs care not offered by the MTF, the NCM will assist with finding health care within the local area.

(8) Soldiers at VHA Polytrauma Rehabilitation Centers. If the Soldier is transferred to a VHA Polytrauma Rehabilitation Center, lodging will be available to the NMA at no cost. The VA lead coordinator at the Polytrauma Rehabilitation Center will serve as the coordinator for lodging; however, the WTU SL or NCM will ensure the NMA is briefed on the accommodations and check in procedures. The NMA will continue to receive per diem for meals and

incidentals while at the VHA Polytrauma Rehabilitation Center. The NMA will not receive the lodging portion of per diem payments.

### **9–5. Nonmedical attendant responsibilities**

The NMA's primary responsibility is to contribute to the Soldier's health and welfare. The NMA and the Soldier will be counseled (by the SL) on NMA duties and responsibilities upon arrival to the unit. NMA responsibilities focus not only on the Soldier's health and welfare, but also on the NMA's self care.

a. The NMA will support the cadre and abide by all ARs and local command policies while on NMA orders and at Army facilities.

b. The NMA contributes to the Soldier's health and welfare by—

- (1) Providing support and comfort to the Soldier.
- (2) Escorting the Soldier to and from medical and military appointments.
- (3) Assisting the Soldier with shopping.
- (4) Assisting the Soldier to maintain an environment that facilitates healing, recovery, and transition.
- (5) Assisting the Soldier to maintain an environment that minimizes hazards or dangers in their daily living environment.
- (6) Understanding the Soldier's medical care plan including medications, prescribed therapies, dietary needs, and exercise requirements.
- (7) Serving as an advocate for the Soldier regarding medical care and administrative activities.
- (8) Motivating the Soldier to complete medical care and transition plans.
- (9) Helping the Soldier establish daily routine and participating with setting and meeting goals and expectations.
- (10) Assisting the Soldier in the physical security of medications and pertinent medical equipment, medical records, and personal information as appropriate.
- (11) Abide by all HIPAA rules and policies. HIPAA rules provide guidelines for maintaining privacy of personal health information.

c. Self care responsibilities.

(1) NMAs must provide necessary demographic information to their DTS personnel in order to complete the required paperwork to receive their pay and entitlements. The information includes providing their full name, birthdate, Social Security number, checking account number, and bank routing number.

(2) NMAs should designate an emergency POC at their home to provide assistance in their absence. This person can help take care of things at the NMA's home, such as picking up the mail, or taking care of the house. NMAs may need legal assistance to generate a power of attorney if the NMA is going to be away from their home of record for an extended time period. The cadre should help facilitate a legal assistance appointment for the NMA.

(3) Contact friends and family to gain emotional support and assistance as needed. In addition, NMA are encouraged to use the SFAC for assistance and support.

(4) Receive care for the caregiver training from the NCM. This training will provide the NMA with valuable tools to help manage stress and increase resiliency.

(5) Access WTU BH care (social workers) as needed and as available for support and help with gaining skills to manage stress and adjust to the new environment, Soldier expectations, and NMA resiliency.

d. NMA administrative duties include but are not limited to—

- (1) Complete all required training designated by the local command.
- (2) Complete required DTS documents as directed.
- (3) Notify the DTS Specialist any time the Soldier is on leave or attends a recreational trip of greater than 24 hours as the NMA is not entitled to per diem during these periods. If the NMA does not notify the DTS Specialist, the NMA is at risk of overpayment and recoupment of funds.
- (4) Accompany the Soldier, at least weekly to SL meetings and at least twice per month to NCM meetings.
- (5) Attend formations and town halls with the Soldier at least once per quarter.
- (6) Attend FRG meetings at least once per quarter.
- (7) Meet with the MTF ombudsman who works with the WTU within 30 days of arrival. If the Soldier is attached to a Community Care Unit, this meeting can occur via telephone communication. The Soldier's SL or PSG will document that this action is complete in the Soldier's personnel file.
- (8) Meet with the SFAC staff as soon as possible after arrival to the WTU to receive an orientation brief. The Soldier's SL or PSG will document that this action is complete in the Soldier's personnel file. While at the SFAC, the NMA may schedule classes that will be helpful to the Soldier and/or the NMA. The SFAC offers many classes such as financial planning, education and tuition assistance, and Family assistance.
- (9) Attend Transition Assistance Program(s) and Comprehensive Soldier and Family Fitness Programs with the Soldier.

## 9-6. Command responsibilities

### a. RMCs.

- (1) RMCs will maintain a list of all NMAs within their region.
- (2) Ensure WTU cadre are trained in the management of NMAs.
- (3) RMC commanders will ensure a method for direct billing is in place for NMA lodging near VHA Polytrauma Rehabilitation Centers for individuals on NMA orders.

(a) RMC commanders will coordinate with their supporting contracting activity to determine the best direct billing method for their region.

(b) Lodging facilities should offer the following amenities or a combination thereof: handicap accessibility, Americans with Disabilities Act compliance, wheelchair accessible shuttle service, continental breakfast, kitchenettes, handicap parking, and be in close proximity to the VHA Polytrauma Rehabilitation Center.

(c) Contracting actions will be in accordance with the JTR, which limits the daily amount paid for lodging to applicable per diem rates. NMA travel orders will be annotated to reflect that lodging will be provided by Government contract at no cost to the traveler.

b. WTU or Community Care Unit commanders will manage the NMA program effectively to ensure NMAs needs are met in a proactive manner.

(1) Ensure the WTU cadre have a thorough understanding of the NMA Program and understand which Soldiers may be assigned a NMA.

(2) Train cadre on the NMA recommendation process and the process for assigning a NMA.

(3) Appoint a WTU NMA coordinator as an additional duty for a unit personnel. Ensure the designated NMA coordinator—

(a) Manage the NMA program.

(b) Proactively anticipate and manage NMA needs, ensuring customer service focus is maintained.

(c) Remain current on all NMA policies and regulations.

(d) Plan and execute NMA support groups based upon the commander's intent.

(e) Serve as the NMA support group facilitator.

(f) Keep the chain of command informed of NMA issues and concerns.

(4) Ensure NCMs receive training on Care of the Caregiver (training occurs at the Army Medical Department Center and School via the NCM Course).

(5) Maintain an accurate list of all NMAs with contact information.

(6) Conduct NMA training. Required training includes—

(a) WTU and SFAC orientation within 30 days of arrival.

(b) IDES familiarization briefing within 30 days of arrival.

(c) Orientation to the expectations, duties, and responsibilities of a NMA within 5 days of assignment as a NMA.

(d) Care for the caregiver training conducted by the NCM.

(e) Encourage NMAs to participate in unit fire and rescue drills.

(7) Provide support to the NMA.

(a) Assign and train one WTU cadre member on the DTS system. Ensure the designated cadre in-processes all NMAs in the DTS system within one business day of NMA approval. This individual provides administrative support for all subsequent required DTS submissions.

(b) Provide resources for NMA who wish to take First Aid and CPR training.

(c) Ensure any Soldier transferring to a VA Polytrauma Rehabilitation Center is connected to a VA polytrauma liaison, who will provide the NMA with specific lodging accommodations at the VA Polytrauma Rehabilitation Center for which the Soldier is transferred. The commander will ensure the NMA receives information on accommodations, understands that they are not required to pay for accommodations at the VA Polytrauma Rehabilitation Centers, and they will not receive the lodging portion of per diem.

c. Designated WTU NMA coordinator will—

(1) Manage the NMA program.

(2) Proactively anticipate and manage NMA needs, ensuring customer service focus is maintained.

(3) Remain current on all NMA policies and regulations.

(4) Plan and execute NMA support groups based upon the commander's intent.

(5) Serve as the NMA support group facilitator.

(6) Keep the chain of command informed of NMA issues and concerns.

d. SLs will—

(1) Identify, to the interdisciplinary team, Soldiers who would benefit from the support of a NMA.

(2) Counsel Soldiers and their NMAs on the NMA's entitlements, and NMA's duties and responsibilities.

(3) Ensure the Soldier and NMA attend required training and training is documented in the Soldier's personnel file.

(4) Maintained accurate NMA contact information.

- (5) Escort the NMA to the WTU DTS-trained personnel so the NMA can initiate and complete required paperwork.
- (6) At least weekly, meet with both the Soldier and the NMA. Communicate any needs to the interdisciplinary team and help resolve issues as soon as possible.
- (7) Ensure the Soldier initiates a CTP goal for developing skills that facilitate independent living and enhanced resiliency.
  - e. NCMs will—
    - (1) Meet with both the Soldier and the NMA on a monthly basis. Assess the NMA for signs of stress, decreased resiliency, and burnout. If needed, meet with the Soldier's interdisciplinary team to discuss the diminished resiliency. Coordinate for appropriate care. Reinforce Care for the Caregiver tools and techniques to improve coping.
    - (2) Train NMAs on stress, burnout, and resiliency and care for the caregiver. Document training in AHLTA and ensure SL document in the Soldier's personnel file.
    - (3) Train NMAs on HIPAA related to the protection of the Soldier's health information and ensure SL document in the Soldier's personnel file.
    - (4) Assist the NMA with locating health care if needed based upon MTF policy, the NMA's insurance coverage, and NMA health care needs.
    - (5) Assist the Soldier to gain independent living skills.
  - f. PCMs will—
    - (1) Understand the PCM training related to assignment process for NMAs within 10 days for assignment as a PCM.
    - (2) Validate the Soldier will benefit from a NMA.
    - (3) Counsel the Soldier and the NMA on the reason the Soldier will benefit from a NMA and the anticipated length of time the NMA will be needed.
    - (4) Complete the PCM worksheet that recommends the commander approve the Soldier for a NMA. The PCM will document the reason for the NMA and the anticipated length of time the NMA will be needed.
    - (5) Assess the Soldier at least 30 days prior to the NMA orders ending to determine if the NMA is still needed. If needed, the PCM will complete the required documentation on the PCM worksheet to exceed orders.
  - g. The Soldier will—
    - (1) Inform the PCM and command team of the person they would like to serve as their NMA.
    - (2) Inform the chain of command and interdisciplinary team of NMA issues impacting NMA's ability to provide support as soon as possible.
    - (3) Inform the NMA of areas where he or she may need assistance.
    - (4) Strive to gain independence by developing and implementing a proactive, engaged, and realistic CTP.

## **9-7. Nonmedical attendant designation process**

The process to have an individual designated as a NMA is outlined.

- a. The Soldier's PCM will recommend, to the commander or the first O-5 in the chain of command, the need for the Soldier to have a NMA assigned and identify the anticipated length of time for the NMA (the initial length of time cannot exceed 180-days). In addition, the PCM will ensure the Soldier has a completed DA Form 2984 (Very seriously ill, seriously ill, and/or special category patient report) on record that designates the Soldier as seriously or very seriously ill or injured. The PCM must counsel the Soldier and the NMA on the reason(s) why the Soldier would benefit from a NMA, the anticipated length of time needed for the NMA, and when a re-evaluation will be performed to determine the continued need for the NMA. This counseling must be documented in AHLTA and discussed with the WTU's interdisciplinary team to ensure all members understand the reason for the NMA and the anticipated length of time for the NMA. This will ensure the interdisciplinary team delivers consistent messages to the Soldier and the NMA.
- b. The PCM must complete and forward the PCM worksheet to the WTU commander within one business day of confirming the Soldier's need for a NMA.
- c. The WTU commander will document the Soldier's need for a NMA on a DA Form 4187, annotate their recommendation for approval or disapproval of the NMA, and submit the DA Form 4187 to the MTF commander within one business day after receiving the PCM worksheet.
- d. The MTF commander will return the DA Form 4187 to the WTU with their approval or disapproval within five days of initial submission.
- e. The WTU commander will submit approved DA Form 4187 to the unit finance personnel within 2 duty days of receipt from the MTF commander. If the MTF commander disapproves the request, the WTU commander will meet with the Soldier to discuss the rationale.
- f. For approved requests, the unit finance clerk complete the necessary documents to generate the NMA's ITOs. Once the orders are complete, the finance clerk will forward to the unit DTS specialist. The DTS specialist will meet with the NMA to establish the NMA's DTS account and counsel the NMA on their DTS requirements including submitting travel vouchers and close out procedures.

*g.* The interdisciplinary team will ensure the Soldier develops goals in their CTP to gain independence that enable the Soldier to function without a NMA.

*h.* At a minimum of 30 days prior to the end of the NMA orders, the Soldier must be re-assessed for the continued need for a NMA. The Soldier and the NMA must be counseled on the outcome of the re-evaluation by the PCM and this must be documented in AHLTA. In addition, the first commander in the Soldier's chain of command must counsel the Soldier and the NMA in writing if the PCM determines the Soldier no longer requires a NMA.

*i.* The Soldier may appeal the denial of a NMA request or the decision to terminate the NMA orders. The RMC, or his or her representative, is the appellate authority.

(1) In order to appeal the NMA denial, the Soldier or someone with the legal authority to act on the Soldier's behalf, must complete and submit a DA Form 4187 (Request for Personnel Action) within 5 days of denial to the WTU commander.

(2) The WTU commander will forward the appeal to their RMC commander within 7 days.

(3) The RMC commander will provide a decision to the Soldier and the WTU within 5 days of receipt.

### **9–8. Removal from nonmedical attendant status**

An individual may lose their NMA status if their presence does not contribute to the recovering Soldier's health and welfare. If NMA status is removed, the NMA will lose the NMA benefits and entitlements. The approval authority for removal of NMA status is the WTU commander in conjunction with the MTF commander.

*a.* If the removed NMA is a spouse or parent, that individual will no longer receive NMA benefits and entitlements but may remain with the Soldier at their own expense. However, the Soldier may select another candidate as a NMA. If lodging accommodations do not support having the removed NMA and the new NMA, the Soldier, along with the Triad of Care, may elect to send the removed NMA back to their originating location.

*b.* If the Triad of Care witnesses or receives a credible, substantiated report of a NMA providing unsafe care or impeding the Soldier's ability to heal, recover, and transition, the WTU will report the findings to the MTF's FAP. The WTU will work with FAP to outline a plan to ensure the Soldier has a safe environment. The WTU and FAP may also refer the case to Adult Protective Services in the State in which the MTF is located. If the NMA is deemed unsafe for the Soldier, the WTU commander must consult their servicing Judge Advocate for guidance. Removal of a NMA from the Soldier's immediate location must be approved by the first O–5 in the chain of command (under the advisement of FAP and the Staff Judge Advocate). The WTU commander should also consult the installation for installation level policy and guidance.

### **9–9. Nonmedical attendant training requirements**

The WTU will offer NMA training that will aid in providing personal care (as defined) to the Soldier. Recommended training includes:

*a.* WTU orientation within 30 days of arrival.

*b.* IDES familiarization briefing within 30 days of arrival.

*c.* Orientation to the expectations, duties, and responsibilities of a NMA within 30 days of assignment as a NMA to include NMA eligibility criteria, NMA assignment and termination processes (to include removal for unsafe acts), and NMA benefits (including local benefits as outlined by the local WTU, MTF, and installation).

*d.* First Aid training and CPR training may be offered to an NMA within 90 days of assignment as a NMA.

*e.* Fire and rescue drills.

## **Section III**

### **Memorial Ceremonies and Services**

#### **9–10. Background**

In accordance with AR 600–20, commanders will conduct a memorial event (memorial ceremony or memorial service) for every Soldier who dies while assigned to their unit. For Soldiers who are attached to the WTU, the assigned Reserve unit for COMPO 2 and 3 Soldiers and the assigned unit for COMPO 1 Soldiers are responsible to conduct a memorial event for every Soldier who dies while assigned to their unit. In the event the assigned unit is unable to provide a memorial event due to logistical reasons, the assigned unit will coordinate with the attached WTU to provide that service.

#### **9–11. Policy**

WTU will ensure their supporting Casualty Assistance Center is notified of the time and place of unit memorial events.

## **Chapter 10 Benefits and Special Compensation**

### **Section I Special Compensation for Assistance with Activities of Daily Living**

#### **10-1. Background**

SCAADL with ADL, under the provisions of DODI 1341.12, is a program authorizing compensation for catastrophically ill or injured Soldiers who are in an outpatient status. SCAADL compensation is intended to help offset the economic burden borne by primary caregivers providing these Soldiers with nonmedical care, support, and assistance. Soldier participation in the SCAADL program is voluntary. SCAADL eligibility extends to only those Soldiers with qualifying injuries or illnesses meeting the eligibility criteria in DODI 1341.12 and is not retroactive.

#### **10-2. Appeal process**

The ASG for Warrior Care and Transition is the sole Appellate Authority for the U.S. Army SCAADL program. Instructions (with sample of forms) on the appeal process and additional information on SCAADL are located at <http://www.wtc.army.mil/modules/soldier/s7-scaadl.html>.

### **Section II Family Caregiver Benefit and Compensation**

#### **10-3. Direct billing for nonmedical attendant lodging expenses at Veterans Health Administration Polytrauma Rehabilitation Centers**

a. The cost of lodging for Family members designated as for NMAs who accompany Soldiers who are transferred to a VHA Polytrauma Rehabilitation Center can cause a significant financial hardship. RCM commanders should—

(1) Ensure a method for direct billing is in place for NMA lodging near VHA Polytrauma Rehabilitation Centers for individuals on NMA orders.

(2) Coordinate with their supporting contracting activity to determine the best direct billing method for their region.

b. Lodging facilities must be to standard and should offer the following amenities or a combination thereof: handicap accessibility, shuttle service, continental breakfast, kitchenette, and close proximity to the VHA medical center.

c. Contracting actions will be in accordance with JTR U 4135, which limits the daily amount paid for lodging to applicable per diem rates. NMA travel orders should be annotated to reflect that lodging will be provided by Government contract at no cost to the traveler.

#### **10-4. Military escorts for Family members or nonmedical attendants traveling on official orders at Warrior Transition Units only**

a. The MEDCOM MTFs will provide formal military escorts for NMAs or Family members traveling on official orders to visit or care for Soldiers. Family members will utilize travel on official orders while NMAs will use NMA orders. MTF or WTU commanders will ensure a local policy is in place consistent with this regulation.

b. Responsibilities.

(1) The MTF and WTU will establish a duty roster (DA Form 6 (Duty Roster)) for military escorts assigned to meet and escort Family members or NMAs traveling on official orders. A senior NCO at the rank of sergeant first class or above will serve as principal escort to Family members or NMAs of Soldiers serving in the rank of captain and below. Field grade officers in the rank of major and above will serve as principal escort to Family members or NMAs of Soldiers serving in the rank of major and above. When a senior NCO or field grade officer is unavailable for escort duty, the WTU commander will coordinate with the MTF for assistance.

(2) Commanders will ensure escorts report all problems or concerns to the escort OIC or noncommissioned officer in charge (NCOIC) during duty hours. During non-duty hours, escorts will report them to the duty officer of the day who will record issues in the daily staff journal (DA Form 1594 (Daily Staff Journal or Duty Officer's Log)). The escort will ensure that hand-off to the appropriate person is accomplished and all the Family members' or NMA's immediate needs are addressed prior to relinquishing his or her escort detail.

(3) The MTFs and WTUs are responsible for developing their own internal escort policy consistent with the guidance in this policy.

#### **10-5. Medical care benefit for caregivers of members of the Armed Forces recovering from serious injuries or illnesses**

a. A Family member or non-family member designated as a caregiver by the Servicemember who is recovering from serious injuries or illnesses may receive outpatient and inpatient care at a MTF on a space-available basis.

b. For a caregiver to qualify, the Soldier's injury or illness must be incurred in the LOD while on active duty and be

of such severity to render the member medically unfit to perform the duties of his or her office, grade, rank, or rating. The designated qualified caregiver must be—

- (1) On ITOs while caring for the Soldier;
- (2) Acting as a NMA caring for the Soldier; or,
- (3) Receiving per diem while caring for the Servicemember.

## **Chapter 11**

### **Training Requirements**

#### **Section I**

#### **Warrior Transition Unit Orientation and Sustainment Training**

##### **11–1. Warrior Transition Unit training requirements**

This regulation provides training focus by establishing guidance, goals, requirements, and objectives and by outlining the overall training strategy for the WTC and all of its elements. Commanders should limit the AR 350–1 requirements to training that specifically supports the WTU cadre in the performance of their mission and the transitioning Soldier’s expected outcome; however, commanders must complete requirements as directed by Army, and by their RMC, SMC, and MTF commanders. This regulation provides base-line standardization for all units associated with the WTC. Additionally, this regulation documents major training events to help commanders prioritize resources and efforts. Units should refer to the current MEDCOM Command Training Guidance for specific requirements.

##### **11–2. Training priorities**

*a.* WTU cadre should be trained to be a subject-matter expert on the CTP to enhance the execution and Soldier understanding of the program. Commanders should have intimate knowledge of individual Soldier’s issues and program shortfalls and be able to act on that information. This is a number one priority. For Soldiers transitioning back into the Army, individual training should focus on skill level tasks consistent with their CTP and MOS. For Soldiers transitioning out of the Army, training will be focused on the skills identified in their CTP as critical for success as a veteran.

*b.* Commanders will develop and execute an adaptive reconditioning program that challenges Soldiers within the limits of their physical profile to inspire them to meet or exceed rehabilitation goals and focuses on abilities versus disabilities. Physical fitness is an important component to recovery and an integral part of being a Soldier (see chap 11, sec II).

(1) All Soldiers, within the limits of their profile, will participate in a minimum of 150 minutes per week of moderate intensity physical adaptive reconditioning, and a minimum of two adaptive reconditioning activities per week specified by Soldiers’ diagnoses and related to the Soldiers’ transition goals in the CTP domains (see chap 11, sec II).

(2) Commanders and trainers should understand that Soldiers may experience memory problems, headaches, irritability, confusion, and dizziness, which may affect their physical training programs. These Soldiers may need to begin at a lower level of cardiovascular training for a shorter amount of time. Working with the local physical and OTs as well as the primary care and NCMs is essential to ensure a safe and effective program that meets the individual Soldier’s goals.

(3) Commanders will ensure physical fitness testing and weigh-ins are routinely conducted within the limits of Soldier’s profile.

*c.* Commanders will execute recurring training on BH issues with both cadre and Soldiers to ensure vigilance is maintained in preventing crises. Commanders will ensure Soldiers are in continued oversight, over watch, and communications to assist any Soldier with a BH issue.

*d.* Commanders will ensure Soldiers referred into IDES attend an IDES overview brief, and IDES multi-disciplinary meeting and continuous counseling sessions with their PEBLOs and Soldiers’ MEB Counsel. Additionally, Soldiers and Family members may also obtain an introduction to the DES at [http://www.realwarriors.net/ides/M/wrap\\_page.htm](http://www.realwarriors.net/ides/M/wrap_page.htm).

##### **11–3. Required unit training**

*a. Suicide intervention.* Commanders will—

(1) Ensure all leaders read the "Army 2020 Generating Health and Discipline in the Force, Report 2012 (Gold Book)" report published in July 2010 at <http://www.armygl.army.mil/hr/suicide>. This will assist commanders in planning suicide intervention training that can help expose gaps in identifying, engaging, and mitigating high-risk behavior among Soldiers.

(2) Conduct core training quarterly readdressing suicide and accidental death intervention through collective and individual training using Army resources such as the “Beyond the Front” interactive video, “Shoulder-to-Shoulder: No

Soldier Stand Alone” video and the “Ask your buddy”, “Care for your buddy”, “Escort your buddy” (“ACE”) quick reference card. These tools enhance awareness and intervention skills; identify potential stressors, warning signs, and risky behaviors, and promote healing; and prepare Soldiers and their Families for the stressors of post-deployment and healing, and also assist with the detection of possible BH issues. These resources are located at [www.preventsuicide.army.mil](http://www.preventsuicide.army.mil). Commanders are also encouraged to utilize unit chaplain and social workers to enhance their suicide prevention program.

*b. Safety.* Commanders must be vigilant and innovative in the conduct of safety training. It is most effective at the company level and below. Commanders should focus on those hazards unique to the WTU population, in areas such as medication management control, alcohol abuse, operation of privately owned weapons following medical profiles and provider instruction, reducing high risk behaviors.

*c. Physical fitness training.* Physical fitness is essential to the Soldier’s recovery and rehabilitation. WTU cadre should set the example with a fitness program that pushes Soldiers to exceed the Army minimum standards. This should be managed at the company or below level. An individual program of continued progress could also meet the requirement.

*d. Unit resilience training program.* Resilience training is a quarterly training requirement and must be incorporated into the NCO professional development and the OPD, Civilian, and Family training (see sec III of this chapter). Resilience training resources are located at <https://www.resilience.army.mil/>. It consists of 14 required skills, supported by informal training throughout the year. The resilience training program goal is to enhance the overall strength of the Army “Strong Minds and Strong Bodies” by incorporating mental and emotional strength skills training. Each WTU will request training allocations through their regions for at least one NCO in comprehensive Soldier and Family fitness MRT courses in order to develop and execute resilience training programs. The MRT will manage the unit program and conduct training for Soldiers, Family members, caregivers, and all cadre members. This training is designed to provide Soldiers a preventive set of tools to accomplish the rigorous emotional, mental, physical, social, and spiritual challenges of Soldiering in the 21st century. Additionally, all new SLs and PSGs are required to attend the Cadre Resilience Course, which is held the week before the WTU Triad of Care training for SLs and PSGs.

#### **11–4. Required leader training**

*a. Cadre Resident Course.* The WTU resident training is mandatory for all newly assigned company commanders, 1SGs, NCMs, PSG, and SLs. If available, commanders are encouraged to send other members of the cadre to the course to orient them on the WCTP. This includes OT, PT, social workers, and staff. Cadre members should attend the class TDY in route; however, all eligible cadre must attend the training as soon as possible but no later than 90 days of assuming their positions.

*b. Company level leaders track at Resident Course.* The company level leaders track at the WTU Resident Course was designed to provide orientation to new company commanders, 1SGs, executive officers and other cadre. All new company level leaders will attend the course at their first opportunity before or within the first 120 days of assuming their position.

*c. The Warrior Transition Command Senior Leader and Clinician Course.* This course is developed and executed by WTC and gives new commanders, SGMs, WTU clinical leaders, and TCs an overview of the WTC, select policies and doctrine, and current command level issues, initiatives and guidance. This course will be conducted on a quarterly basis unless there are insufficient eligible personnel.

(1) This course is mandatory for all new WTU brigade, battalion, and separate company commanders, CSMs, 1SGs, battalion surgeons, lead social workers, PCMs, and NCM supervisors within 90 days of assuming their positions. New TCs, OTs, and PTs are required to attend within the first 6 months of assuming their duties.

(2) As space becomes available, this course is also open to RMC and WTO chiefs, MTF commanders and CSMs that will have WTU brigades, battalions, or separate companies assigned to their MTF.

(3) This course will complement, but not replace, the annual MEDCOM Pre-Command Course.

(4) RMC commanders will ensure their incoming senior leaders are scheduled to attend the Senior Leader and Clinician Course within 90 days of assuming their positions.

*d. The Medical Command Pre-Command Course.* This course is offered twice a year (annually) and is conducted at Fort Sam Houston. All command selection list brigade and battalion commanders, as well as the respective CSMs, are required to attend.

*e. Cadre Resilience Course.* The Cadre Resilience Course focuses on providing WTU first-line supervisors (SLs and PSGs) with resilience skills that they can incorporate into their own lives and mentorship interactions with the Soldiers they support. Cadre Resilience Course provides standardized resilience training to increase resilience within cadre and staff personnel. The course is approved by the Comprehensive Soldier and Family Fitness and is designed to help cadre develop critical thinking, knowledge, and skills to overcome challenges and to bounce back from adversity. Additionally, the course helps cadre understand how to use course material to mentor WTU Soldiers and to create a more resilient environment for healing and transition. SLs and PSGs are required to attend Cadre Resilience Course the week prior to attending the WTU Resident Course.

## **11-5. Major training events**

*a. Army Wounded Warrior Training.* The AW2 conducts a new hire orientation training that ensures new advocates are adequately prepared to perform their duties and responsibilities. This course is conducted several times during the year and advocates are required to complete the training within a few days of being assigned to the position or attend the first available class.

*b. Warrior Transition Command Annual Training Summit.* The WTC Training Summit meets annually and focuses on training centered on all aspects of the CTP and remote care. The training is divided into several tracks: commander, CSM, and 1SG track, and PCM, NCM, OT, social worker, pharmacists, and SFAC. Commanders are encouraged to support these tracks by allowing select personnel to attend the training that focuses on improving WTU capabilities.

## **11-6. Training safety**

The WTU commanders will utilize the safety training requirements outlined in AR 350-1 DA Pamphlet 385-10 to ensure cadre, Soldiers, and Civilian employees are knowledgeable in the practical application of safety within their workplace.

## **Section II**

### **Adaptive Reconditioning Program**

#### **11-7. Purpose**

To provide guidance for incorporating activities from all six domains (physical, emotional, spiritual, social, Family, and career) of the CTP into the Soldier's adaptive reconditioning plan and encouraging Soldiers to reach their maximum potential.

#### **11-8. Background**

Adaptive reconditioning supports the 2013 Army Ready and Resilient Campaign and aligns with the Army Surgeon General's Performance Triad of activity, nutrition, and sleep. Adaptive reconditioning utilizes activity to help increase mental, emotional, and physical well being in order to build resiliency and achieve individual CTP goals.

#### **11-9. Adaptive reconditioning team**

The adaptive reconditioning team consists of the WTU surgeon, PCM, PT, PTA, OT, COTA, site coordinator, NCM, NCOIC, SL, and other members of the interdisciplinary team as directed by the commander.

#### **11-10. Policy**

*a.* WTU commanders will manage the adaptive reconditioning program and team whereas the WTU surgeon (or the WTU PCM in separate companies) will provide oversight and guidance to the adaptive reconditioning team. The adaptive reconditioning team consisting of the WTU PT is the team lead, and an adaptive reconditioning site coordinator who, under the guidance of the team lead, will plan, coordinate, and assist with executing the adaptive reconditioning activities. Other members of the adaptive reconditioning team are described in paragraph 11-9.

*b.* The Adaptive reconditioning program will include mandatory and individualized Soldier needs activities. The mandatory activities are designed to meet the needs of the WTU population, based upon the top diagnoses within the WTU population. Individual Soldier needs include but are not limited to CTP short term and long term goals. The program will have mandatory events on a weekly basis that are integrated into the unit's battle rhythm and target the top diagnoses of the unit. All Soldiers, once cleared by their PCM, will attend the mandatory scheduled events. These adaptive reconditioning events are therapeutic and part of the Soldier's recovery, however, medical appointments take priority. WTU commanders are responsible for ensuring events are scheduled to maximize Soldier participation.

*c.* The adaptive reconditioning program consists of those activities conducted for Soldiers for the purposes of optimizing well-being, returning to an active productive life-style, and achieving their short-term and long-term goals in any of the six CTP domains. The program consists of a variety of adaptive sports and physical conditioning activities, as well as other reconditioning activities including, but not limited to, visual and performing arts, music performance and composition, writing, ministry, and agriculture.

*d.* A comprehensive adaptive reconditioning program provides Soldiers with opportunities to improve their physical, emotional, and mental well-being and return to an active lifestyle that will continue after their transition. Regular activity throughout the day can improve health by reducing stress, strengthening the heart and lungs, increasing energy levels, and improving mood. The overall intent is that Soldiers will adopt an activity that they will continue once they leave the WTU. A balance between executing a challenging program and protecting the Soldier's healing process is required to achieve CTP goals.

*e.* All Soldiers, within the limits of their profile, will participate in a minimum of 150 minutes per week of moderate intensity physical adaptive reconditioning, and a minimum of two adaptive reconditioning activities per week specified by Soldiers' diagnoses and related to the Soldiers' transition goals in the CTP domains.

*f.* The adaptive reconditioning team may count the time a Soldier participates in an intervention program through the

MTF, BH, or traumatic brain injury clinics as a part of the Soldier's individualized adaptive reconditioning plan for the specified CTP domain.

*g.* Therapeutic events are one of the many adaptive reconditioning activities used to help Soldiers achieve their short or long-term CTP goals. A therapeutic event must have a reasonable expectation of a beneficial effect on the Soldier's health and outcome. The Soldier's PCM is the authority for designating whether a given activity is therapeutic. These events are considered mandatory and must be attended once prescribed and can only be superseded by medical appointments or command approval for excusals.

*h.* These are therapeutic events that involve travel away from the Soldier's unit or quarters. Therapeutic trips require approval from the Soldier's commander or his/her designee and will be accomplished by placing both the Soldier and any required attendant in a TDY status. Trips must not interfere with the performance of official duties, will not detract from readiness, and will not interfere with the Soldier's treatment progression, healing, or transition. These events are considered mandatory and must be attended once prescribed and only superseded by medical appointments or command approval for excusals.

*i.* Leisure activities are those determined by the PCM not to have a therapeutic purpose as described in paragraph 11–10g. Soldiers must obtain a leisure event trip clearance authorization from the adaptive reconditioning team to mitigate any potential issues arising from attending the leisure activity. Those participating in leisure activity will use leave or pass in accordance with AR 600–8–10.

### **11–11. Adaptive reconditioning equipment**

*a.* The local MEDCOM medical maintenance facility will establish a scheduled service program to manage adaptive reconditioning medical equipment maintenance throughout its life cycle in accordance with procedures outlined in manufacturer specifications and Army policies (see AR 40–61 and AR 750–1). Medical equipment is any instrument, apparatus, implement, machine, appliance, implant, in vitro reagent or calibrator, software, material or other similar or related article, intended by the manufacturer to be used, alone or in combination, for human beings for one or more of the specific purposes of—

(1) Diagnosis, prevention, monitoring, treatment, or alleviation of disease.

(2) Diagnosis, monitoring, treatment, and alleviation of, or compensation for, an injury.

*b.* Adaptive reconditioning equipment used to support the adaptive reconditioning program must be placed on the owning unit's property books for accurate accountability. All purchased and donated equipment which supports the program must be placed on the property book. Each item of medical equipment will be tested for serviceability and electrical safety prior to initial use, and at least annually thereafter, unless otherwise recommended by the original manufacturers' guidelines. AR 40–61 specifies that equipment user or operator personnel will—

(1) Routinely clean medical equipment.

(2) Perform before, during, and after-operation preventive maintenance checks and services (PMCS) in accordance with manufacturer literature.

(3) Replace components and accessories as needed, according to equipment user manuals and maintain accurate records of replacement components and accessories.

(4) Use technical manuals, manufacturer literature, and local SOPs as guides for proper operator maintenance.

(5) Request support from the local MEDCOM medical maintenance facility for repairs and services beyond the scope of operator maintenance.

### **11–12. Responsibilities**

*a.* The RMCs will ensure the WTU establish an adaptive reconditioning program in accordance with this policy; review adaptive reconditioning metrics and submit them to the WTC adaptive reconditioning branch monthly no later than the 15th of the month.

*b.* The WTU commander will—

(1) Develop and implement an adaptive reconditioning program that includes activities across the CTP domains.

(2) Ensure the planned adaptive reconditioning activities are aligned with Soldiers' diagnoses and relate to Soldiers' transition goals.

(3) Conduct a final review of the program to ensure use of the Soldiers' time is optimized and that the program assists the Soldiers to achieve their transitional goals.

(4) Designate an adaptive reconditioning program NCOIC for each company to assist site coordinators with ensuring participation in the adaptive reconditioning program.

(5) Provide oversight to the Community Care Unit for the implementation of their adaptive reconditioning program. Ensure the adaptive reconditioning metrics are reported to the Office of the Secretary of Defense (OSD) Warrior Care Policy Office, WTC, and RMC POCs by the site coordinator as required.

(6) Ensure all Soldiers participating in an adaptive reconditioning, therapeutic, or leisure (sponsored) and competition events receive medical clearance and authorization to attend.

(7) Ensure all Soldiers receive counseling on adherence to the tenants of their profile, to include the prohibition against consuming alcohol while on therapeutic trips.

- (8) Ensure all donated trips and events are properly staffed in accordance with ARs and local policies and are evaluated by the servicing command or staff judge advocate.
- (9) Ensure use of resources from the community supporters (located at [http://www.WTC.army.mil/modules/support%20network/c1\\_adaptivereconditioning.html](http://www.WTC.army.mil/modules/support%20network/c1_adaptivereconditioning.html)) to maintain a robust and diverse adaptive reconditioning program.
- (10) Conduct monthly after action reviews with the adaptive reconditioning team to evaluate Soldier participation with respect to specified diagnosis and CTP goals.
  - c. The WTU surgeon (or the WTU PCM in separate companies) will provide oversight and guidance for the adaptive reconditioning team, to include advising the commander on programs most appropriate for the WTU population and overseeing their implementation.
  - d. The PCM will—
    - (1) Consider and incorporate adaptive reconditioning options into each Soldier's medical care plan and document same in the AHLTA.
    - (2) Include adaptive reconditioning considerations when writing Soldier profiles.
    - (3) Provide medical clearances for adaptive reconditioning activities and trips when needed.
  - e. The PT is the adaptive reconditioning program lead and SME for the physical domain. In the absence of a WTU PT, the WTU OT will assume the lead as designated by the commander. The PT or representative, will—
    - (1) Provide guidance to the site coordinator for all events and activities that fall primarily in the physical domain.
    - (2) Assess each Soldier within 21 days of in-processing to determine base-line physical fitness.
    - (3) Assign each Soldier to an ability group in accordance with FM 7–22, and establish goals for physical fitness and health maintenance for those Soldiers with profile(s).
    - (4) Educate SL on reconditioning physical training in accordance with the National Fire Protection Association, Health Care Code 99, 2012 Edition.
    - (5) Ensure Soldiers have an appropriate profile based on the eProfile written by the PCM and provide the Soldiers a copy of their individual profile to carry at all times.
    - (6) Design and provide an individualized exercise program that benefits each Soldier's fitness ability. As part of the adaptive reconditioning program, take into consideration the physical, social, and emotional requirements for the Soldier's Career track and goals.
    - (7) Reassess the Soldier's progress every 60 days to determine the effectiveness of the individualized adaptive reconditioning program and adjust the program to meet the needs of the Soldier. These recurring 60-day reassessments will be documented in ALHTA.
    - (8) Provide oversight and assistance to the Community Care Unit aligned to the WTU (if applicable) in the implementation of their adaptive reconditioning program. The PT will meet with the Community Care Unit commander and interdisciplinary team quarterly to review the Community Care Unit Soldier population profiles to ensure the adaptive reconditioning program is meeting the needs of the Soldiers completing the program near their homes.
    - (9) Review CRM assessment (see ATP 5–19) prior to commander approval. Ensure all Soldiers complete a media release authorization statement prior to attending any event for which the public affairs office is involved. The Soldier's SL will maintain the media release authorization statement.
    - (10) Ensure all Soldiers have a completed leisure event and/or trip documentation prior to participation. Leisure event and/or trip documentation includes: medical clearance, trip authorization (DA Form 4187), therapeutic trip counseling (DA Form 4856), list of therapeutic trips taken in the past 6 months, print out of the Soldier's medical appointments, and a print out of the Soldier's no show history for medical appointments. For leisure or non therapeutic trips, Soldiers must complete DA Form 31.
      - (11) Perform the duties of a PTA in their absence (for example, unavailability and/or assignment).
  - f. The PTA works under the supervision of a PT, and will—
    - (1) Assist in executing the individualized adaptive reconditioning program designed by the PT for the Soldier. Educate the Soldier on maintaining an active and healthy lifestyle.
    - (2) Reassess the Soldier's physical fitness progress under the direction of the PT, every 60 days.
    - (3) Attend the unit's physical fitness training program (differs from the adaptive reconditioning program) to assist the unit with providing safe, effective physical training for their Soldiers.
    - (4) Assist in executing the adaptive reconditioning program.
    - (5) Assist the site coordinator with completing the metrics for participation in adaptive reconditioning events.
    - (6) Assist the site coordinator and adaptive reconditioning program NCOIC with equipment storage and maintenance planning.
    - (7) Ensure all Soldiers have a completed medical clearance prior to participating in any activities.
  - g. The OT will assist with modifying the Soldier's adaptive reconditioning plan to ensure the plan appropriately challenges the Soldier and accommodates their career and health needs. In addition, the OT will—
    - (1) Complete an initial assessment within 14 days of the Soldier's arrival at the WTU which includes—
      - (a) Determining the Soldier's ADL skills.

- (b) Screening the Soldier for any assistive technology needs.
- (2) Inform the PT of the career track and goals of the Soldier that will facilitate their transition either back to the force or to a productive civilian life.
- (3) Communicate and assist members of the adaptive reconditioning team to identify activities that benefit Soldiers by addressing short and long term CTP goals.
- (4) Assist the adaptive reconditioning team to modify any aspect of the activity to allow Soldiers to achieve their goals.
- (5) Perform the duties of a COTA in their absence (for example, unavailability and/or assignment).
- (6) Assist and supervise the COTA in performing his or her duties listed.
- (7) Lead the adaptive reconditioning program in the absence of the PT.
- h. The COTA (under the supervision of the OT) will complete the Soldier's Phase I goal setting training within 21 days of the Soldier's arrival as a part of the Soldier's in-processing. In Phase I goal setting, the Soldier will identify adaptive reconditioning activities in which they would like to participate. The COTA will—
  - (1) Educate the Soldier on the six domains of the CTP and explore each domain with the Soldier based on his or her CTP goals.
  - (2) Educate the Soldier in initial goal setting as directed by the OT.
  - (3) Within 30 days of the Soldier's arrival to the WTU, coordinate with other interdisciplinary team members as appropriate to assist the Soldier with creating transition goals across the domains.
  - (4) Assist in the planning and execution of adaptive reconditioning events.
  - (5) Assist the site coordinator in maintaining metrics for adaptive reconditioning program participation.
- i. The site coordinator is an asset of the OSD, Office of Warrior Care Policy. Site coordinators serve as the planner and coordinator for all adaptive reconditioning activities for the WTU commander's adaptive reconditioning program. The site coordinator will—
  - (1) Plan and coordinate activities that support the CTP domains. These activities will be planned based upon input from the adaptive reconditioning team and must be related to the needs of the Soldier population and each Soldier's CTP goals. The WTU commander is the final approval authority of all new adaptive reconditioning activities and special events.
  - (2) Gain commander's approval prior to coordinating public affairs office or media coverage for an event.
  - (3) Ensure the therapeutic or leisure clearance is completed for the Soldier 24 hours prior to the commencement of the adaptive reconditioning event.
  - (4) Collaborate with the WTU adaptive reconditioning team, installation morale, welfare, and recreation, and United Service Organization to coordinate events and activities for Soldiers.
  - (5) Reach out to the local community, but do not solicit, to find adaptive reconditioning activities that meet the unit's overall needs. Site coordinators in conjunction with the adaptive reconditioning program NCOIC are responsible for completion of the risk assessment and validating that the sponsoring agency will provide a safe setting for participating Soldiers. The sponsoring agency must provide proper equipment and venue to maximize safety. The event must be approved by the commander and vetted through legal as well as the commands gifts and donations prior to Soldier attendance.
  - (6) Identify or coordinate at least one new adaptive reconditioning opportunity on post and or in the community each month with the intent to introduce the Soldier to new experiences based upon their goals and recommendations from the adaptive reconditioning team. 50 percent of the new adaptive reconditioning opportunities must have the potential to become reoccurring events based upon effectiveness and feedback from the Soldiers.
  - (7) Provide the S3 a list of command approved events so that events are reflected on the S3 calendar and ensure all required paperwork is complete for a Soldier to attend events conducted off post.
  - (8) Provide a completed CRM assessment (see ATP 5-19) on all proposed activities to the adaptive reconditioning team lead at least one week prior to the event for approval by the commander.
  - (9) Ensure all donated adaptive reconditioning opportunities to include equipment is reviewed by the command and servicing Judge Advocate for approval prior to acceptance.
  - (10) Prior to scheduling any adaptive reconditioning activity, provide the commander with an outline of associated costs. Events will not be scheduled without the approval of the commander (including free activities).
  - (11) Attend local adaptive reconditioning events as a member of the adaptive reconditioning team and assist in coordinating the activity and completing an after action report that is provided to the commander. The after action reviews will be reviewed at least monthly with the adaptive reconditioning team as a tool for future planning.
  - (12) Provide a primary POC and a secondary POC for communication for each adaptive reconditioning event.
  - (13) Provide assistance with conducting adaptive reconditioning activities.
  - (14) Coordinate for coaches, instructors, and SMEs for adaptive reconditioning activities based on the needs and experience level of the Soldiers.
  - (15) Provide weekly metrics report to OSD as required by OSD (total number of Soldiers actually participating in an event).

(16) Provide WTC adaptive reconditioning branch and RMC with the following:

(a) *Monthly report.* Adaptive reconditioning rollup which includes the total number of Soldiers actually participating in an activity along with the CTP domain associated with the Soldier's goal.

(b) *Quarterly report.* The report should include adaptive reconditioning training schedules and/or calendars. Competitive activities and special events should be highlighted to ensure the appropriate visibility.

(17) Assist the Community Care Unit in developing relationships in their Soldiers local communities to ensure Soldiers have access to adaptive reconditioning opportunities.

(18) Use of resources from the community supporters (located at [http://www.WTC.army.mil/modules/support%20network/c1\\_adaptivereconditioning.html](http://www.WTC.army.mil/modules/support%20network/c1_adaptivereconditioning.html)) to maintain a robust and diverse adaptive reconditioning program.

j. The NCM will—

(1) Meet with the Soldier weekly to review their clinical progress.

(2) Coordinate all the medical appointments to determine the Soldier's availability to participate in an adaptive reconditioning event and communicate with the adaptive reconditioning team if the Soldier is involved in an activity that would prevent participation in the event.

k. The adaptive reconditioning program NCOIC will—

(1) Assist site coordinators with ensuring participation in the adaptive reconditioning program. (NCOIC will work with adaptive reconditioning team along with the SL.)

(2) Assist SL to ensure Soldiers comply with adaptive reconditioning requirements.

(3) Coordinate with adaptive reconditioning team to conduct risk assessments for adaptive reconditioning events and activities.

(4) Coordinate with site coordinator to ensure adaptive reconditioning equipment is properly accounted for and secured as required.

(5) Ensure adaptive reconditioning equipment is properly stored and maintained. This includes coordination with the local MEDCOM medial maintenance facility for all equipment maintenance.

(6) Assist adaptive reconditioning team in setup and teardown of events and activities.

(7) Assist in proper accounting of Soldiers participating in adaptive reconditioning events and activities.

l. The SL will—

(1) Assist the Soldier in developing and maintaining a daily activities calendar or schedule that includes both the Soldier's clinical and non-clinical plan of care including adaptive reconditioning activities.

(2) Track all of the Soldier's appointments.

(3) Communicate with the adaptive reconditioning team the Soldier's availability to attend adaptive reconditioning activities and events.

(4) Ensure each Soldier carries a copy of their profile on them at all times.

(5) Ensure each Soldier participates in a minimum 150 minutes per week of moderate intensity physical adaptive reconditioning, and a minimum of two adaptive reconditioning activities per week within the specified domains of the CTP.

(6) Inform the POC for the adaptive reconditioning event if the Soldier is unable to attend.

(7) Maintain any media releases the Soldier signs related to adaptive reconditioning activities.

m. The Soldier will—

(1) Participate in a minimum of 150 minutes per week of moderate intensity physical adaptive reconditioning, and a minimum of two adaptive reconditioning activities per week specified by his or her diagnoses and related to his or her transition goals in the CTP domains.

(2) Be on time, in the correct uniform, and at the right location for the adaptive reconditioning activity and event.

(3) Carry a copy of their individual profile at all times.

(4) Advise the SL no later than 24 hours prior to the scheduled event if transportation is required.

(5) Notify the SL at least 2 hours prior to the event if unable to attend a scheduled adaptive reconditioning activity or event.

(6) Provide feedback to the adaptive reconditioning team related to the effectiveness of the program.

(7) Conduct end user maintenance (see para 11–11) within the limits of his or her profile. Notify site coordinator and adaptive reconditioning program NCOIC of equipment maintenance needs.

(8) Seek medical clearance for each adaptive reconditioning event in timely manner to allow the appropriate level of clearance and ensure a trip approval documentation for those events requiring an overnight stay is completed with the assistance of the interdisciplinary team at least 24 hour prior to the start of the event.

(9) Adhere to the tenants of their profile to include no alcohol consumption during therapeutic activities, events, or trips.

## **Section III**

### **Comprehensive Soldier and Family Fitness**

#### **11–13. General**

The Comprehensive Soldier Family Fitness increases the physical and psychological health and resilience and enhances the performance of Soldiers, Families, and Army Civilians. Comprehensive Soldier and Family Fitness Training Center, formerly known as the Comprehensive Soldier and Family Fitness-Performance and Resilience Enhancement Program sites support each WTU locally or through mobile training teams (MTTs) and provide training that is focused on performance enhancement and resilience.

#### **11–14. Responsibilities**

Comprehensive Soldier and Family Fitness Training Centers and MTT will—

*a.* Provide Phase II goal setting training to all Soldiers in the WTU, between day 31 and 90 of assignment or attachment (first-post scrimmage).

(1) Phase II goal setting training consists 16 hours block of instruction that include the development of mental skills, building confidence, attention control, energy management, goal setting, integrating imagery, and a capstone exercise.

(2) Soldiers are required to complete Phase I goal setting, conducted by the OT or COTA, within the first 21 days of being assigned to a WTU prior to receiving Phase II goal setting training.

*b.* Provide quarterly mental skills (Performance Enhancement and Resilience)-oriented support to WTU-organized adaptive reconditioning activities for WTU Soldiers, including all Warrior Games Training Camps and Clinics.

*c.* Conduct the WTC Cadre Resilience Course in conjunction with the WTU Cadre Course. The Cadre Resilience Course is a 5-day course focused on providing WTU first-line supervisors (SLs and PSGs) with resilience skills that they can incorporate into their own lives and mentorship interactions with the Soldiers they support.

*d.* Offer a minimum of one performance enhancement and/or resilience workshop per quarter for Family members of Soldiers in the WTU.

*e.* Conduct performance and resilience training at the WTU cadre courses, specifically for any attendees that did not receive the Cadre Resilience Course (SL, NCMs, and so forth).

*f.* Conduct, through coordination with WTU commanders, cadre-specific refresher training workshops as a component of the Comprehensive Soldier and Family Fitness dedicated quarterly trainings.

*g.* Assist in the unit's resilience training plan through collaboration with WTU unit MRT. If one is not available, Comprehensive Soldier and Family Fitness Training Center staff provide resilience training upon request. Resilience training should be incorporated into NCO professional development and OPD, Soldier, Civilian, and Family training (see sec III of this chapter).

*h.* Support WTC's mission CER for Soldiers in the transition process by offering learning enhancement training. Learning enhancement is a blend of evidence-based learning strategies with performance enhancement skills and is open to all Soldiers and Family members through workshops scheduled on a quarterly basis through collaboration with the WTU CER coordinator.

#### **11–15. Unit requirement**

WTU will develop and execute a resilience training program by requesting through their region, training allocation in comprehensive Soldier and Family fitness MRT courses. As a minimum, each WTU must have one NCO MRT to manage the unit program and conduct training for Soldiers, Family members, caregivers, and all cadre members listed in paragraph 11–4. The unit's MRT will advise the commander on the completion of the resiliency training requirements for the USR.

## **Appendix A References**

### **Section I Required Publications**

#### **AR 1–201**

Army Inspection Policy (Cited in paras 2–13c, 6–34.)

#### **AR 40–400**

Patient Administration (Cited in paras 5–3g, 5–4e, 5–19, 6–13.)

#### **AR 40–501**

Standards of Medical Fitness (Cited in paras 5–2a, 5–4b, 6–7b(1), 6–7a(1), 6–8b(1).)

#### **AR 600–9**

The Army Body Composition Program (Cited in paras 2–19k, 2–21a(12), 2–23a(6), 6–32, 6–33d, 6–33c, 6–33a.)

#### **AR 600–85**

The Army Substance Abuse Program (Cited in paras 2–19m, 2–19ag, 6–31f.)

#### **AR 635–40**

Physical Evaluation for Retention, Retirement, or Separation (Cited in paras 2–25a(4), 5–3g, 6–7a(3), 6–8b(2), 6–31c, 6–31c(2), 6–31c(2)(c), 6–31c(2)(d), 6–31c(2)(e), 6–31c(2)(b), 6–31c(2)(a).)

#### **AR 635–200**

Active Duty Enlisted Administrative Separations (Cited in paras 2–19ag, 2–21a(12), 2–23a(6), 2–23a(8), 6–7b(2), 6–31f, 6–31c, 6–31c(1)(a), 6–33d.)

### **Section II Related Publications**

A related publication is a source of additional information. The user does not have to read it to understand this publication. Unless otherwise stated, all Army publications are available at <http://www.apd.army.mil/>. DOD publications are available at <http://www.dtic.mil/whs/directives/>. USCs and PLs are available at <http://www.gpoaccess.gov/fdsys/>.

#### **AR 1–100**

Gifts and Donations

#### **AR 1–101**

Gifts for Distribution to Individuals

#### **AR 11–2**

Managers' Internal Control Program

#### **AR 15–1**

Committee Management

#### **AR 15–6**

Procedure for Investigating Officers and Boards of Officers

#### **AR 25–30**

The Army Publishing Program

#### **AR 25–55**

The Department of the Army Freedom of Information Act Program

#### **AR 25–400–2**

The Army Records Information Management System (ARIMS)

**AR 40-3**

Medical, Dental, and Veterinary Care

**AR 40-61**

Medical Logistics Policies

**AR 40-66**

Medical Record Administration and Healthcare Documentation

**AR 40-68**

Clinical Quality Management

**AR 40-905**

Veterinary Health Services

**AR 135-18**

The Active Guard Reserve (AGR) Program

**AR 135-155**

Promotion of Commissioned Officers and Warrant Officers Other than General Officers

**AR 135-175**

Separation of Officers

**AR 135-178**

Enlisted Administrative Separations

**AR 135-205**

Enlisted Personnel Management

**AR 135-381**

Incapacitation of Reserve Component Soldiers

**AR 190-11**

Physical Security of Arms, Ammunition, and Explosives

**AR 190-45**

Law Enforcement Reporting

**AR 195-2**

Criminal Investigation Activities

**AR 340-21**

The Army Privacy Program

**AR 350-1**

Army Training and Leader Development

**AR 385-10**

The Army Safety Program

**AR 420-1**

Army Facilities Management

**AR 600-8-1**

Army Casualty Program

**AR 600-8-2**

Suspension of Favorable Personnel Actions (Flags)

**AR 600–8–4**

Line of Duty Policy, Procedures, and Investigations

**AR 600–8–7**

Retirement Services Program

**AR 600–8–10**

Leaves and Passes

**AR 600–8–14**

Identification Cards for Members of the Uniformed Services, Their Family Members, and Other Eligible Personnel

**AR 600–8–19**

Enlisted Promotions and Reductions

**AR 600–8–22**

Military Awards

**AR 600–8–24**

Officer Transfers and Discharges

**AR 600–8–101**

Personnel Processing (In-, Out-, Soldier Readiness, and Deployment Cycle)

**AR 600–8–105**

Military Orders

**AR 600–20**

Army Command Policy

**AR 600–60**

Physical Performance Evaluation System

**AR 601–280**

Army Retention Program

**AR 608–1**

Army Community Service

**AR 614–100**

Officer Assignment Policies, Details, and Transfers

**AR 614–200**

Enlisted Assignments and Utilization Management

**AR 623–3**

Evaluation Reporting System

**AR 630–10**

Absence Without Leave, Desertion, and Administration of Personnel Involved in Civilian Court Proceedings

**AR 635–8**

Separation Processing and Documents

**AR 670–1**

Wear and Appearance of Army Uniforms and Insignia

**AR 750–1**

Army Materiel Maintenance Policy

**Army Directive 2011–22**

Special Compensation for Assistance with Activities of Daily Living

**Army Directive 2012–18**

Military Occupational Specialty Administrative Retention Review

**Army Directive 2013–01**

Guidance on the Acquisition and Use of Service Dogs by Soldiers

**ATP 5–19**

Risk Management

**Building the Soldier Athlete: A Profile Physical Training Supplement**

This publication is from OTSG, Proponency Office for Rehabilitation and Reintegration, Falls Church, VA 22041 (Available at <http://www.armymedicine.army.mil/r2d/Building%20the%20Soldier%20Athlete.pdf/>.)

**DA Pam 385–10**

Army Safety Program

**DA Pam 623–3**

Evaluation Reporting System

**Defense Health Agency**

Medical Management Guide, October 2009

**Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised**

This publication is available from the American Psychiatric Press, Inc., 1400 K Street, N.W., Suite 1101, Washington, DC 20005 (Available at <http://www.appi.org/>.)

**DOD 5500.07–R**

Joint Ethics Regulation (JER)

**DOD 6025.18–R**

DOD Health Information Privacy Regulation

**DOD 7000.14–R (Volume 7A & 7B)**

Department of Defense Financial Management Regulations (Military Pay Policy and Procedures – Active Duty and Reserve Pay) (Available at <http://comptroller.defense.gov/fmr/>.)

**DOD 7000.14–R (Volume 12, Chapter 30)**

Operation and Use of General Gift Funds

**DODD 1241.01**

Reserve Component Medical Care and Incapacitation Pay for Line of Duty Conditions

**DODD 6010.04**

Healthcare for Uniformed Service Members and Beneficiaries

**DODI 1241.2**

Reserve Component Incapacitation System Management

**DODI 1300.18**

Department of Defense Personnel Casualty Matters, Policies, and Procedures

**DODI 1300.24**

Recovery Coordination Program

**DODI 1300.25**

Guidance for the Education and Employment Initiative (E21) and Operation Warfighter (OWF)

**DODI 1332.18**

Disability Evaluation System (DES)

**DODI 1341.12**

Special Compensation for Assistance with Activities of Daily Living

**DODI 1400.25**

DOD Civilian Personnel Management System

**DODI 6490.04**

Mental Health Evaluations of Members of the Military Services

**DOD Inspector Report D-2009-032**

The America Supports You Program (Available at <http://www.dodig.mil/pubs/index.cfm?start=681&office=Audit.>)

**FM 6-22**

Army Leadership: Competent, Confident, and Agile

**FM 7-22**

Army Physical Readiness Training

**FM 7-22.7**

The Army Noncommissioned Officer Guide

**Joint Travel Regulations**

Joint Travel Regulations (Available at [http://www.defensetravel.dod.mil/.](http://www.defensetravel.dod.mil/))

**Joint Travel Regulations U4135**

Lodging and/or Meals Obtained Under Contract

**Joint Travel Regulations U7205**

Non-Medical Attendant for Very Seriously and Seriously Wounded, Ill, or Injured Member

**MCM 2008**

Manual for Courts-Martial, 2012 Edition (Available at [http://www.apd.army.mil/.](http://www.apd.army.mil/))

**Memorandum, Deputy Secretary of Defense**

Medical Care for Members of the Armed Forces Recovering from Serious Injuries or Illness, 1 April 2010

**National Defense Authorization Act for Fiscal Year 2008, Pub. L. 110-181, Jan. 28, 2008, 122 Stat. 3. 110-181, Section 1672.**

Medical Care for Families of Members of the Armed Forces Recovering from Serious Injuries or Illness

**NGR 600-100**

Commissioned Officers Promotions – Federal Recognition and Related Personnel Actions (Available at [http://www.ngbpdc.ngb.army.mil/.](http://www.ngbpdc.ngb.army.mil/))

**NGR 600-200**

Enlisted Personnel Management (Available at [http://www.ngbpdc.ngb.army.mil/.](http://www.ngbpdc.ngb.army.mil/))

**PL 104-191**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**PL 110-181 Title XVI and XVII**

Wounded Warrior Matters Act of 2008

**PL 110-325**

ADA Amendments Act of 2008

## **The Joint Commission Manuals**

Comprehensive Accreditation Manual for Hospitals: Ambulatory Care Manual, Home Care Manual, Long Term Care Manual, Healthcare Networks Manual, Behavioral Health Manual, Pathology and Clinical Laboratory Manual (Available at TJC, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.)

### **10 USC Chapter 58**

Benefits and Services for Members Being Separated or Recently Separated

### **10 USC 502**

Enlistment oath: who may administer

### **10 USC 507**

Extension of enlistment for members needing medical care or hospitalization

### **10 USC 972**

Members: effect of time lost

### **10 USC 1072**

Definitions

### **10 USC 1074**

Medical and dental care for members and certain former members

### **10 USC 1074a**

Medical and dental care: members on duty other than active duty for a period of more than 30 days

### **10 USC 1076**

Medical and dental care for dependents: general rule

### **10 USC 1076d**

TRICARE program: TRICARE Standard coverage for members of the Selected Reserve

### **10 USC 1077**

Medical care for dependents: authorized care in facilities of uniformed services

### **10 USC 1142**

Preseparation counseling; transmittal of medical records to Department of Veterans Affairs

### **10 USC 1143**

Employment assistance

### **10 USC 1144**

Employment assistance, job training assistance, and other transitional services: Department of Labor

### **10 USC 1145**

Health benefits

### **10 USC 1176**

Enlisted members: retention after completion of 18 or more, but less than 20, years of service

### **10 USC 1201**

Regular and members on active duty for more than 30 days: retirement

### **10 USC 1202**

Regular and members on active duty for more than 30 days: temporary disability retired list

### **10 USC 1203**

Regular and members on active duty for more than 30 days: separation

**10 USC 1204**

Members on active duty for 30 days or less or on inactive-duty training: retirement

**10 USC 1205**

Members on active duty for 30 days or less: temporary disability retired list

**10 USC 1206**

Members on active duty for 30 days or less or on inactive-duty training: separation

**10 USC 1206a**

Reserve component members unable to perform duties when ordered to active duty: disability system processing

**10 USC 1207**

Disability from intentional misconduct or willful neglect: separation

**10 USC 2601**

General gift funds

**10 USC 2608**

Acceptance of contributions for defense programs, projects, and activities; Defense Cooperation Account

**10 USC 12301**

Reserve components generally

**10 USC 12302**

Ready Reserve

**10 USC 12304**

Selected Reserve and certain individual Ready Reserve members; order to active duty other than during war or national emergency

**10 USC 12322**

Active duty for health care

**37 USC 204**

Entitlement

**37 USC 481k**

Travel and transportation allowances: Nonmedical attendants for members who are determined to be very seriously or seriously wounded, ill, or injured.

**38 USC**

Veterans' Benefits

**38 USC 101**

Definitions

**38 USC 105**

Line of duty and misconduct

**38 USC 328**

Combat-related Injury and Rehabilitation Pay

**38 USC 1980A**

Traumatic injury protection

**38 USC 3675**

Approval of accredited courses

### **38 USC 4113**

Outstationing of Transition Assistance Program personnel

### **Section III**

#### **Prescribed Forms**

This section contains no entries.

### **Section IV**

#### **Referenced Forms**

Unless otherwise indicated, DA Forms are available on the Army Publishing Directorate (APD) Web site ([www.apd.army.mil](http://www.apd.army.mil)); DD Forms are available on the Office of the Secretary of Defense (OSD) Web site ([www.dtic.mil/whs/directives/infomgt/form/formprogram.htm](http://www.dtic.mil/whs/directives/infomgt/form/formprogram.htm)).

#### **DA Form 6**

Duty Roster

#### **DA Form 11-2**

Internal Control Evaluation Certification

#### **DA Form 31**

Request and Authority for Leave

#### **DA Form 1594**

Daily Staff Journal or Duty Officer's Log

#### **DA Form 2028**

Recommended Changes to publication and Blank Forms

#### **DA Form 2984**

Very seriously ill/seriously ill/special category patient report

#### **DA Form 3349**

Physical profile

#### **DA Form 4187**

Personnel Action

#### **DA Form 4700**

Medical Record Supplemental Medical Data

#### **DA Form 4856**

Developmental Counseling Form

#### **DA Form 7424**

Sensitive Duty Assignment Eligibility Questionnaire

#### **DD Form 2005**

Privacy Act Statement-Health Care Records

#### **DD Form 2793**

Volunteer Agreement for Appropriated Fund Activities and Non Appropriated Fund Instrumentalities

#### **DD Form 2796**

Post- Deployment Health Assessment

#### **DD Form 2870**

Authorization for Disclosure of Medical and Dental information

#### **DD Form 2875**

System Authorization Access Request

**DD Form 2793**

Volunteer Agreement for Appropriated Fund Activities & Non Appropriated Fund Instrumentalities

**DD Form 2900**

Post Deployment Health Reassessment

**DD Form 2958**

Service members Career Readiness Standards/Individual Transition Plan Checklist

**Appendix B  
Internal Control Evaluation****B-1. Function**

The function covered by this evaluation is to monitor the major components of the CTP for WTU Soldiers.

**B-2. Purpose**

The purpose of this evaluation is to assist commanders and managers in evaluating the key internal controls listed. It is intended as a guide and does not cover all controls.

**B-3. Instructions**

Answers must be based on the actual testing of key internal controls (for example, document analysis, direct observation, interviewing, sampling, simulation, or other). Answers that indicate deficiencies must be explained and the corrective action indicated in supporting documentation. These internal controls must be evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2 (Internal Control Evaluation Certification).

**B-4. Test questions**

- a. Has a self assessment completed and validated in AWCTS by SL and NCM within the first 7 days and at least current within 30 days (see paras 3-5 and 3-9)?
- b. Are self assessments with red and amber items with action plan documented in AWCTS (see paras 3-4 and 3-9)?
- c. Has goal setting Phase I training completed within 21 days (see paras 3-4 and 3-9)?
- d. Have in-processing requirements completed within 30 days (see paras 3-3 and 3-9)?
- e. Are transfers to Community Care Unit for eligible Soldiers completed within 30 days (see paras 3-3 and 3-9)?
- f. Has goal setting Phase II training with a MRT-Performance Enhancement Specialist completed within 90 days (see paras 3-4 and 3-9)?
- g. Are all completed Soldier for Life – Transition Assistance Program requirements documented on a DD Form 2958, signed by the Soldier for Life – Transition Assistance Program counselor Soldier, and commander, no later than 90 days prior to transition (see paras 3-7 and 3-9)?
- h. Are all eligible Soldiers participating in CER (see paras 2-11, 3-6, and 3-9)?
- i. Are MRDP reached or established no later than 365 days (see para 3-9)?
- j. Are scrimmages completed by the WTU commander on each Soldier's Transition Plan (90-day scrimmage) (see paras 3-5 and 3-9)?
- k. Are Soldiers scrimmages and FTR current or within 90 days (see paras 3-5 and 3-9)?
- l. Are transition readiness requirements completed and validated by the WTU commander prior to transition from the WTU (see paras 3-6 and 3-9)?
- m. Are all Soldiers participating in an Adaptive Reconditioning Program (see paras 3-6 and 3-9)?
- n. Does the unit Resilience Training Program meet requirement standards (see para 11-3, chap 11, sec III)?
- o. Are eligible Soldiers referred to VA (see paras 3-7 and 3-9)?

**B-5. Supersession**

None.

**B-6. Comments**

Help make this a better tool for evaluating management controls. Submit comments to Commander, Warrior Transition Command, G3/5/7, Plans, Policies, and Procedures (P3), (MCWT-OPT-P), 200 Stovall Street, Alexandria, VA 22332-0400.

## **Glossary**

### **Section I Abbreviations**

#### **1SG**

first sergeant

#### **ABCP**

Army Body Composition Program

#### **ACES**

Army Continuing Education System

#### **ACOM**

Army command

#### **ACS**

Army Community Service

#### **ADL**

activities of daily living

#### **ADME**

active duty medical extension

#### **AGR**

Active Guard Reserve

#### **AHLTA**

Armed Forces Health Longitudinal Technology Application

#### **AR**

Army regulation

#### **ARNG**

Army National Guard

#### **ASA (M&RA)**

Assistant Secretary of the Army (Manpower and Reserve Affairs)

#### **ASAP**

Army Substance Abuse Program

#### **ASCC**

Army service component commands

#### **ASG**

Assistant Surgeon General

#### **AW2**

Army Wounded Warrior

#### **AWCTS**

Army Warrior Care and Transition System

#### **AWOL**

absent without leave

#### **BH**

Behavioral Health

**BHI-PHA**

Behavioral Health Intake-Psychosocial History Assessment

**BLSW**

Baccalaureate Level Social Worker

**CER**

Career and Education Readiness

**CFR**

Code of Federal Regulations

**CG**

commanding general

**CJA**

Command Judge Advocate

**CMCW**

Case Management Complexity Worksheet

**COAD**

continuation on active duty

**COAR**

continuation on active Reserve

**COMPO**

component

**COTA**

Certified Occupational Therapist Assistant

**CRM**

composite risk management

**CSM**

command sergeant major

**CTP**

Comprehensive Transition Plan

**DA**

Department of the Army

**DCCS**

deputy commander for clinical services

**DCS**

Deputy Chief of Staff

**DD**

Department of Defense (forms)

**DES**

Disability Evaluation System

**DFAS**

Defense Finance and Accounting Services

**DOD**

Department of Defense

**DODD**

Department of Defense directive

**DODI**

Department of Defense instruction

**DPW**

director of public works

**DRU**

direct reporting unit

**DTS**

Defense Travel System

**DVA**

Department of Veterans Affairs

**ED**

emergency department

**EFMP**

Exceptional Family Member Program

**ETP**

exception to policy

**FAP**

Family Advocacy Program

**FLIPL**

financial liability investigation of property loss

**FM**

field manual

**FRG**

Family Readiness Group

**FRSA**

Family Readiness Support Assistants

**FTR**

focused transition review

**HHC**

headquarters and headquarters company

**HIPAA**

Health Insurance Portability and Accountability Act

**HQDA**

Headquarters, Department of the Army

**HR**

human resources

**HRC**

Human Resources Command

**ID**

identification

**IDES**

Integrated Disability Evaluation System

**IMCOM**

Installation Management Command

**ISSA**

interservice support agreement

**ITO**

invitational travel orders

**JER**

Joint Ethics Regulation

**JTR**

Joint Travel Regulation

**LCSW**

Licensed Clinical Social Worker

**LOD**

line of duty

**M2**

medical management

**MAR2**

MOS Administrative Retention Review

**MEB**

medical evaluation board

**MEDCOM**

Medical Command

**MODS**

Medical Operational Data System

**MODS-WT**

Medical Operational Data System-Warrior in Transition

**MOS**

military occupational specialty

**MRDP**

Medical Retention Determination Point

**MRT**

Master Resiliency Training

**MTF**

military treatment facility

**MTT**

mobile training team

**NCM**

Nurse case manager

**NCO**

noncommissioned officer

**NCOES**

Noncommissioned Officer Education System

**NCOIC**

noncommissioned officer in charge

**NCR**

National Capital Region

**NFE**

non-Federal entity

**NGB**

National Guard Bureau

**NMA**

nonmedical attendant

**OACSIM**

Office of the Assistant Chief of Staff for Installation Management

**OCAR**

Office of the Chief, Army Reserve

**OEF**

Operation Enduring Freedom

**OIC**

officer in charge

**OIF**

Operation Iraqi Freedom

**OIP**

Organizational Inspection Program

**OPD**

officer professional development

**OT**

occupational therapist

**OTSG**

Office of the Surgeon General

**OWF**

Operation Warfighter

**P-MART**

Pharmacy Medication Analysis and Reporting Tool

**PBH–TERM**

Psychological and Behavioral Health – Tools for Evaluation, Risk, and Management

**PCM**

primary care manager

**PCS**

permanent change of station

**PDA**

Physical Disability Agency

**PDES**

Physical Disability Evaluation System

**PDHA**

Post Deployment Health Assessment

**PDHRA**

Post Deployment Health Reassessment

**PDS**

Professional Filler Deployment System

**PEB**

physical evaluation board

**PEBLO**

physical evaluation board liaison officer

**PHI**

protected health information

**PL**

public law

**PMR**

Patient Movement Request

**POC**

point of contact

**PROFIS**

Professional Officer Filler System

**PSG**

platoon sergeant

**PT**

physical therapist

**PTA**

physical therapist assistant

**RC**

reserve component

**REFRAD**

release from active duty

**RMC**

regional medical command

**RTD**

return to duty

**S3**

Operations officer

**SAV**

staff assistant visit

**SC**

senior commander

**SCAADL**

Special Compensation for Assistance with Activities of Daily Living

**SECARMY**

Secretary of the Army

**SFAC**

Soldier and Family Assistance Center

**SL**

squad leader

**SME**

subject matter expert

**SOP**

standard operating procedure

**SSA**

Social Services assistant

**STARTC**

Soldier Transfer and Regulating Tracking Center

**STR**

Service Treatment Record

**SWRA**

Social Work Risk Assessment

**SWRA-Q**

Social Work Risk Assessment-Questionnaire

**TAG**

The Adjutant General

**TC**

transition coordinator

**TCS**

temporary change of station

**TSG**

The Surgeon General

**UCMJ**

Uniform Code of Military Justice

**UMT**

unit ministry team

**USAFMCOM**

U.S. Financial Management Command

**USAR**

United States Army Reserve

**USARC**

United States Army Reserve Command

**USC**

United States Code

**USR**

unit status report

**VA**

Veterans Affairs

**VAMC**

Veterans Administration Medical Center

**VCSA**

Vice Chief of Staff of the Army

**VHA**

Veterans Health Administration

**WCTP**

Warrior Care and Transition Program

**WTB**

Warrior Transition Battalion

**WTC**

Warrior Transition Command

**WTU**

Warrior transition unit

**Section II****Terms****absent sick**

An active duty Servicemember (Army, Navy, Air Force, Marine Corps) hospitalized in other than a U.S. MTF and for whom administrative responsibility has been assigned to a U.S. MTF. Absent sick moved to MTF. Patients who have been moved from a non-U.S. military facility to an MTF. Total absent sick. Patients who are absent sick the total time (never moved to an MTF).

**ACE**

“Ask your buddy, care for your buddy, escort your buddy.”

**Active Army**

Consists of: (1) Regular Army Soldiers on active duty; (2) ARNG of the United States and the USAR Soldiers on active duty except as excluded in paragraph b; (3) ARNG Soldiers in the service of the United States pursuant to a call; and, (4) All persons appointed, enlisted, or inducted into the Army without component. Excluded are ARNGUS and

USAR on: (1) Active duty for training; (2) AGR status; (3) Active duty for special work; (4) Temporary tours of active duty for 180 days or less; and, (5) Active duty pursuant to the call of the President (10 USC 12304).

### **active duty**

Full-time duty in the active military service of the United States. It includes RC personnel who are serving on full-time Federal duty, full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or the Secretary of the military department concerned. This also includes AGR duty under 10 USC 12301(d) and full-time National Guard duty under 32 USC 502(f).

### **activities of daily living**

ADL is a term used in health care to refer to daily self-care activities within an individual's place of residence, in outdoor environments, or both. Basic ADLs consist of self-care tasks, including personal hygiene and grooming, dressing and undressing, self feeding, functional transfers (getting from bed to wheelchair, getting onto or off of toilet, bowel and bladder management, ambulation, walking without the use of an assistive device (walker, cane, or crutches)), or using a wheelchair.

### **activity animals (animals utilized in animal assisted activities (AAA))**

These may include equines, camelids, and other species used in interactions designed to enhance quality of life. AAA interventions are not tailored to individual patient needs or medical conditions. Example: use of a puppy by a child life specialist or Red Cross volunteer to brighten the lives of children on a pediatric oncology ward.

### **Adaptive Reconditioning Program**

The Adaptive Reconditioning Program consists of those activities and sports conducted for wounded, ill, or injured Soldiers on a regular basis for purposes of optimizing their well-being, returning them to an active productive life-style, and helping Soldiers achieve their short-term and long-term goals.

### **adaptive reconditioning team**

The adaptive reconditioning team consists of the WTU surgeon, PCM, PT, PTA, OT, COTA, site coordinator NCM, NCOIC, SL, and other members of the interdisciplinary team as directed by the commander.

### **American with Disabilities Act**

The American with Disabilities Act is a civil rights law that prohibits, under certain circumstances, discrimination based on disability. The Americans with Disability Act was passed in 1990 Americans with Disability Act, and includes changes made by the Americans with Disability Act Amendments Act of 2008 (PL 110–325), which became effective on January 1, 2009.

### **Armed Forces Health Longitudinal Technology Application**

AHLTA is a centralized enterprise-wide medical and dental information management system that provides secure online access to Military Health System beneficiaries' records. It is used by medical clinicians in all fixed and deployed MTFs worldwide and provides health care personnel worldwide with access to complete, accurate health data to make informed patient care decisions – at the point of care – anytime, anywhere.

### **Army Career Alumni Program**

Army Career Alumni Program delivers transition and job assistance services to Soldiers to support them in making informed career decisions. These services include pre-separation counseling, VA benefits briefings, and Department of Labor Transition Assistance Program workshops, which cover career planning, job searches, resume writing and interviewing. Army Career Alumni Program services are available to separating and retiring Active Component Soldiers, demobilizing Reserve and National Guard Soldiers, Family members, retirees, and Civilians affected by BRAC, reduction in force or Global Realignment.

### **Army Continuing Education System**

ACES provides programs and services to promote lifelong learning opportunities for Soldiers and to sharpen the competitive edge of the Army. ACES improves the combat readiness by planning, resourcing, and implementing educational programs and services to support Soldier's professional and personal development.

### **Army Knowledge Online**

Army Knowledge Online is a Web-based portal that provides enterprise information services to Army, joint, and DOD customers on classified and unclassified networks. Army Knowledge Online includes e-mail, directory, discovery, and single sign-on functionalities.

### **Army Wounded Warrior**

AW2 is an Army program that assists and advocates for severely wounded, ill, or injured Soldiers, Veterans, and their Families, wherever they are located, regardless of military status. Soldiers in WTUs who qualify for AW2 are assigned to the program as soon as possible after their arrival. AW2 supports these Soldiers and their Families throughout their recovery and transition, even into Veterans status. This program, through the local support of AW2 advocates, strives to foster the Soldier's independence. The system of support and advocacy uses a nonmedical case management model to help guide severely wounded, ill, or injured soldiers from evacuation through treatment, rehabilitation, RTD or military retirement and transition into the civilian community. AW2 works inside the network of Army, Government, and local and national resources to help Soldiers and Families resolve many issues and foster independence into the next stage of their lives.

### **Army Wounded Warrior advocate**

AW2 advocates are DA Civilians or contractors located throughout the United States, to include Hawaii, Puerto Rico, and Germany. Advocates are located at WTUs, major MTFs, several Veterans Administration Medical Centers (VAMCs), and other VA facilities that perform case management and provide individualized, local support and assistance for assigned and/or eligible Soldiers or Veterans and their Families or Caregivers throughout the Soldier's or Veteran's lifecycle from injury, to returning to duty, or to transition into the civilian community.

### **attachment**

The placement personnel in an organization where such placement is relatively temporary.

### **baccalaureate level social worker**

A BLSW is a social worker with bachelor's degree in social work and appropriate State licensure. This type of social worker may provide care and case management, task management, planning and coordination of efforts and meetings, complex administrative tasks, education, advocacy, resource referral, conduct scrimmages, goal setting. They may not conduct BH risk assessment, or clinical and therapeutic interventions and treatment as they are not licensed, credentialed, or privileged in those areas.

### **“Building the Soldier as an Athlete Supplement”**

A guide for leaders to use to develop challenging fitness programs that not only maintain fitness, but also speed recovery. This supplemental guide breaks profiled Soldiers into groups to facilitate organized physical training. See <http://www.armymedicine.army.mil/r2d/Building%20the%20Soldier%20Athlete.pdf>.

### **Career and Education Readiness Program**

The CER Program provides a disciplined, purposeful approach intended to prepare each WTU Soldier for success in a long-term career that is personally meaningful, rewarding, and enables the Soldier to achieve financial independence. The focus of a Soldier's CER program is participation in CER activities which are simultaneously therapeutic and beneficial to the Soldier's rehabilitation. All WTU Soldiers will participate in a CER activity or activities as soon as they are determined to be eligible for CER activity. To be effective, Soldiers' CER activities must be consistent with their long-term career goals. It is inappropriate to place a Soldier in a CER activity merely to provide accountability or to “keep a Soldier busy.”

### **certified occupational therapist assistant**

COTA is the career domain SME in the CTP scrimmage in providing goal setting training to Soldiers and their Family. The COTA provides safe and effective occupational therapy services under the supervision, direction and guidance of, and in partnership with, the OT. All COTAs will maintain State and Federal licensing requirements in accordance with laws or regulations set forth by the American Occupational Therapy Association and the National Board for Certification in Occupational Therapy. The COTA, under supervision of the OT, provides goal setting training to Soldiers and their Family; serves as the career domain SME in the CTP scrimmage and assists Soldiers with work reintegration.

### **clinical social worker**

A clinical social worker is a social worker holding a master's degree in social work and licensed to practice independently in a State (for example LCSW or equivalent).

### **Combat Related Special Compensation**

Combat Related Specialty Compensation (CRSC) provides military retirees a tax free entitlement created for disability and non-disability military retirees with combat-related disabilities that will be paid each month along with any other retired pay. To qualify, Veterans must be entitled to and/or receiving military retired pay; be rated at least 10 percent by the DVA; waive VA pay from retired pay; and file a CRSC application. Web site at <https://www.hrc.army.mil/tagd/crsc>.

### **Community Care Units**

The community care realigns the management of Soldiers healing in their home communities to a Community Care Unit assigned to an installation WTU. Cadre will provide M2 and mission command of Soldiers within their designated area of responsibility. These Soldiers will continue to receive the benefits of a dedicated unit of cadre, Triad of Leadership, MTF staff, WTB staff and installation resources to ensure that all Soldiers have the same experience across the program.

### **companion animals, pets**

Any animal owned by individual Soldiers or beneficiaries not meeting the definition of a service animal. These terms are synonymous for the purposes of MEDCOM policy stated in paragraph 5–6.

### **COMPO 1, 2, 3**

Active component (COMPO 1), ARNG (COMPO 2), Component, USAR (COMPO 3).

### **competitive activities**

Competitive activities (events and trips) can also be used to help Soldiers achieve their short or long-term CTP goals and personal goals. These events may be considered therapeutic or leisure depending on the goals of the Soldier. These activities include but are not limited to unit level competition (commander's cup, stakes, tournaments, camps, clinics, and university and local competitions), regional competitions (Ohio Wheelchair Games, Dixie Games, camps, clinics), national competition (Warrior Games, Valor Games, National Veterans Wheelchair Games, Endeavor Games, and others).

### **Comprehensive Soldier and Family Fitness**

Comprehensive Soldier and Family Fitness Program is a systematic program that addresses the psychological attributes of human dimension, critical to success on the battlefield and throughout life. Comprehensive Soldier and Family Fitness – education seeks to provide Soldiers, Family members, and DA Civilians with the skills to be self-regulating, instinctive, adaptive, and mentally agile under intense pressure, while contributing to personal hardiness and resilience. Comprehensive Soldier and Family Fitness education also attempts to bridge the gap between the rehabilitation process and the Soldiers' transition to the Army or civilian life by providing knowledge and skills to take ownership and control of their recovery, to focus on abilities versus disabilities, and provide tools to enhance their mindset so that they have a sense of purpose and motivation about their future.

### **Comprehensive Transition Plan**

The CTP supports Soldiers in returning to the force or transitioning to a Veterans' status. The CTP employs seven interdisciplinary processes in developing an individual plan that the Soldier builds with the support of the WTU cadre. Although standardized, the CTP allows each Soldier to customize their recovery process, enabling them to set and reach their personal goals. The CTP provides a personal, customized plan created for the Soldier by the Soldier.

### **Computer/Electronic Accommodations Program**

The Computer/Electronic Accommodations Program provides assistive technology and services to Soldiers with disabilities, increases access to information and works to remove barriers to employment opportunities by eliminating the costs of assistive technology and accommodation solutions.

### **Concurrent Retirement and Disability Pay**

Concurrent Retirement and Disability Pay (CRDP) allows military retirees to receive both military retired pay and VA compensation. CRDP is a "phase in" of benefits that gradually restores a retiree's VA disability offset. An eligible retiree's retired pay is gradually increased (phase in) in restoration of the retired pay that is offset by VA disability pay. Retirees who are entitled to CRDP will receive both full military retired pay and full VA disability pay with no reduction. If qualified, enrollment is automatic. See Web site <http://myarmybenefits.us.army.mil/>.

### **continental United States**

Continental United States are the 48 contiguous States and the District of Columbia. For medical and TRICARE program rules, continental United States also includes Alaska and Hawaii.

### **continued on active duty and continued on Reserve duty**

Soldiers found not fit for duty by MEB and PEB may be eligible to apply for COAD and COAR regardless of the extent of their injuries. To be eligible for COAD and COAR, a Soldier must meet at least one of the following requirements: (1) served 15 to 20 years of service for COAD or 15 to 20 qualifying years of service for non-regular retirement for COAR; (2) qualified in a critical skill or shortage MOS; or, (3) incurred a disability which is a result of combat or terrorism.

**convalescent leave**

In this regulation, an authorized leave status considered a sick day when the convalescent leave occurs before the disposition of the patient. It is granted to active duty Servicemembers while under medical or dental care and prescribed for their recuperation or convalescence. Convalescent leave under this regulation is not the same as convalescent leave occurring after disposition of the patient or while the patient is en route to a new command. It is also not the same as convalescent leave granted by a line commander after patient discharge from the hospital.

**dependent**

Dependent is defined in Title 10 USC 1072 with respect to a member or former member of a uniformed service.

**Disabled Veterans Outreach Program**

Developed by the U.S. Department of Labor's Veterans' Employment and Training Service, Veterans' Employment and Career Transition Advisor provides Veterans, transitioning Servicemembers and their Family members, with resources to successfully transition to a rewarding public or private sector career. Disabled Veterans' Outreach Program Specialists provide one-on-one direct employment assistance at MTFs, WTUs and in American Jobs Centers and coach transitioning Servicemembers and Veterans in the use of online resources to further assist them with their reintegration into the civilian workforce.

**disposition**

Disposition is the discharge of a patient from a medical center or hospital, that is, a discharge to duty or home, transfer to another MTF, death, or other termination of inpatient care.

**elective care**

Elective care is a nonemergency care that, in the opinion of the cognizant medical authority, is not medically required but is requested or preferred by the patient. Examples are: face lift, vasectomy, augmentation mammoplasty, abdominoplasty, and liposuction.

**Electronic-Profile**

Electronic-Profile (eProfile) is a Web-based process for generating, approving and routing physical profiles that automatically updates physical, upper, lower, hearing, eyes, psychiatric data in the Medical Protection System, eliminates "pocket profiles," improves commander-provider communication, and reduces unwarranted variance in physical, upper, lower, hearing, eyes, psychiatric profiles. The Army has established eProfile as the standard for generating, approving, and routing physical profiles in order to improve medical readiness across the Army.

**eligible Soldier for nonmedical attendant**

To be eligible for a NMA a Soldier must be found to be "seriously wounded, ill, or injured" or "very seriously wounded, ill, or injured" by their attending physician (as designated on DA Form 2984); and due to the illness, injury, or wounds, needs continuing outpatient treatment.

**emergency care**

Medical treatment of patients with severe life-threatening or potentially disabling conditions resulting from accident or illness of sudden onset. These conditions necessitate immediate care to prevent undue suffering or loss of life. Dental treatment for relief of painful or acute conditions.

**emotional support animals**

Animals which provide comfort to persons with emotional or psychological disabilities, but do not perform specific tasks tailored to the individual needs. Emotional support animals are treated as pets for purposes of MEDCOM policy stated in paragraph 5-6.

**endstate**

The set of conditions required for achieving established objectives.

**equine assisted psychotherapy**

A form of AAT wherein horses are used to facilitate the ID and treatment of behavioral disorders, as well as relationship and communication difficulties.

**Exceptional Family Member Program**

The EFMP provides certain reimbursable and non-reimbursable medically related services to Family members with disabilities per DODI 1342.12 with the same priority as medical care to the active duty Soldier. The EFMP, works in concert with other military and civilian agencies, and provides a comprehensive, coordinated, multiagency approach for

community support, housing, medical, educational, and personnel services to Families with special needs. Delivery of reimbursable and non-reimbursable services is based on legislative, DOD authority, and Army policy.

### **existed prior to service**

A term added to a medical diagnosis to signify there is clear and unmistakable evidence that the disease or injury or the underlying condition producing the disease or injury existed prior to the individual's entry into military service.

### **Family members**

Family members of members of the uniformed services. Family members include persons who are related (see paras (1) through (5) of this definition) to an active duty Servicemember who is serving under a call or order that does not specify a duty period of 30 days or less. Persons are also Family members if the Soldier died while serving on such active duty, is retired, or died while in a retired status. This includes Family members of retired members of RC if the member died while under 60 years of age and chose to take part in the Survivor Benefit Plan. In such a case, the Family member's entitlement becomes effective on the date the deceased retiree would have been 60 years of age. Categories of Family members and their specific entitlements are as follows: (1) Spouse, even if not actually dependent on the active duty Servicemember or retired member. (2) The un-remarried former spouse of an active or retired member whose marriage to the member was dissolved on or after 1 February 1983 who— (a) On the date of marriage dissolution had been married to the member for at least 20 years during which time the member performed at least 20 years of service that is creditable in determining eligibility for retired or retainer pay; or (b) Does not have medical coverage under an employer-sponsored health plan. (3) Un-remarried widow or widower even if not actually dependent on the active duty Servicemember or retired member at the time of the member's death. (4) A legitimate child, an illegitimate child who has been legitimized or whose paternity has been judicially determined, an adopted child who is adopted before age 21, or stepchild, who is unmarried and is— (a) Under 21 years of age even if not dependent on the active duty Servicemember or retired member; (b) Twenty-one (21) years of age or older but incapable of self-support due to a mental or physical disorder that existed prior to his or her 21st birthday (23rd birthday if in student status) and is, or was at the time of death of the active duty Servicemember or retired member, dependent on the member for over one-half of his or her support. (Sponsor must submit a request for dependency determination to DFAS. A medical sufficiency statement must accompany request. See AR 600-8-14 for sample medical sufficiency statement.); or (c) Twenty-one (21) or 22 years of age and pursuing a full-time course of education. The course must be approved by the Secretary of Defense or the Secretary of Education, as applicable, or by a State agency under 38 USC 3675. Further, the person must be, or must have been at the time of death of the active duty Servicemember, or retired member, dependent for over one-half of his or her support. A child in this category, who during the school year or between semesters suffers a disabling illness or injury that interrupts attendance at the institution, remains eligible for care until 6 months after the disability is removed or until his or her 23rd birthday, whichever occurs earlier. A child includes an unmarried child of a male member who was illegitimate at the time of birth and who is, or was at the time of death of the active duty Servicemember or retired member, dependent on the member for more than one-half of his or her support. The child must also reside with or in a home provided by the member or the parent who is the member's spouse. A child also includes the illegitimate child of an active duty Servicemember or retired female member. Children in this category are eligible for medical care on the date of birth since they need not be dependent on the female member for support or reside in a home provided by the member. (5) Parent or parent-in-law (natural or adoptive) who is, or was at the time of death of the active duty Servicemember or retired member, dependent on the member for over one-half of his or her support and residing in a dwelling place provided or maintained by the member. (This does not include a stepparent or person who has assumed the role of a parent.) Family members of foreign nationals. Eligible spouses and children only. (The same conditions apply as for U.S. Family members.)

### **focused transition review**

The FTR is a formal meeting that is similar to the scrimmage. However, FTRs have a different purpose that ensures a common understanding between the Soldier, his or her Family, the chain of command, and the interdisciplinary team. The group reviews the Soldier's transition plan progress and develops a new plan to track for the remaining transition actions and sub-goals. Additionally, the FTR acts as a feedback and an after action review of the process for each Soldier and the supporting interdisciplinary team.

### **Global Assessment Tool**

The Global Assessment Tool (GAT) is a Web-based instrument that combines objective health data with survey-based questions providing the individual self-awareness in the five dimensions of strength: physical, emotional, social, spiritual and family. GAT is a confidential survey that is mandatory at least annually for Soldiers; optional for Family members and DA Civilians that measures psychological health and resilience. The GAT is administered on the Army Fit Web site (<https://armyfit.army.mil/>).

### **high risk Soldiers**

A Soldier is considered high risk when he or she exhibits behavior that places the individual or others in danger or

harm's way and/or leads to criminal, self-destructive behavior, and/or consequences that negatively impact personal, work, health, and/or relationships.

### **hippotherapy (or equine assisted therapy)**

A form of AAT which utilizes horses to assist with physical, occupational, or speech therapy as part of an integrated treatment program supervised by a clinical specialist.

### **Individualized Adaptive Reconditioning Program**

An individualized plan, that consists of adaptive reconditioning activities, and is specific to the CTP needs of the wounded, ill, or injured Soldier, which is conducted by the Soldier on a regular basis for purposes of optimizing physical well-being, returning to an active productive life-style, and helping to achieve any of the Soldier's Sub and Priority (short-term) and Transition and Outcome (long-term) CTP goals. The Individualized Adaptive Reconditioning Program it is not a traditional clinic-based rehabilitation program, but may support the Soldier's medical plan and goals, when appropriately coordinated with the MTF-based health care providers. The Individualized Adaptive Reconditioning Program is developed by the PT, in consultation with the Soldier, and, as appropriate, with various members of the WTU cadre.

### **Integrated Disability Evaluation System**

The IDES combines the DOD and VA disability processes and uses a streamlined evaluation for delivery of a total benefits and compensation package.

### **interdisciplinary team members**

The interdisciplinary team members include, but are not limited to, the following WTU personnel: Triad of Care (PCM, NCM, SL, or PSG), LCSW, clinical pharmacist, OT/COTA, PT/PTA, chaplain, AW2, TC, SFAC personnel, and/or others as needed to support the needs of the WTU Soldier.

### **invitational travel orders**

ITOs outline the benefits and entitlements that a person receives while performing a specific duty. NMAs will receive ITOs, commonly referred to as NMA orders, for providing support as outlined in this policy to the Soldier. The entitlements and benefits a NMA receives are based upon the JTR, the Soldier's geographic location, the NMA's primary residence, and the relationship of the NMA to the Soldier.

### **leisure activities**

Leisure activities (events and trips) are those determined by the PCM not to have a therapeutic purpose as described in paragraph 11-10g. Soldiers must obtain a Leisure Event Trip Clearance authorization from the adaptive reconditioning team to mitigate any potential issues arising from attending the leisure activity. Those participating in leisure activity will use leave or pass in accordance with AR 600-8-10.

### **letter requesting contact**

A certified letter sent to the Community Care Unit Soldier by the Community Care Unit LCSW when email messages have gone unanswered and three telephonic attempts to contact the Soldier were unsuccessful. The letter will include recognition of previous attempts and instructions for the Soldier to contact his or her LCSW to enable the LCSW to maintain a BH case management on the Soldier. The letter can also include unit updates, program announcements, and/or resource materials.

### **Life Cycle Management Plan**

Life Cycle Management Plan is a process used by AW2 advocates to measure the progress of severely wounded, ill, or injured Soldiers, Veterans, and their Families throughout their recovery and transition, and into Veteran status.

### **mascoats**

Animals maintained by specific CONUS-or OCONUS-based non-deployed Army units for the purpose of advancing esprit de corps. In accordance with AR 40-905, mascoats must be on orders (signed by an officer in the rank of lieutenant colonel or higher) and will receive full medical care as Government-owned animals. Within the CENTCOM Area of Operations, General Order 1B prohibits "adopting as pets or mascoats, caring for, or feeding any type of domestic or wild animal."

### **meaningful work**

Meaningful work can be any specific element in a disciplined, purposeful program intended to prepare a Soldier for success in a long-term career that is personally meaningful, rewarding, and enables the Soldier to achieve financial independence.

**medical care**

Unless otherwise specified, includes, but is not limited to the following: inpatient treatment, outpatient treatment, nursing care, medical examinations, immunizations, drugs, subsistence, and/or transportation. Other adjuncts such as prosthetic devices, spectacles, hearing aids, and orthopedic footwear. This includes appliances such as braces, walking irons, and elastic stockings.

**medical evaluation board**

The MEB is an informal process comprised of at least two physicians who compile, assess, and evaluate the medical history of a Soldier and determine how the injury or disease will respond to treatment.

**medical management**

M2 is the exercising of primary decision authority regarding diagnosis and treatment of an individual patient.

**Medical Operational Data System**

MODS is a Military Health Services System that provides the Army Medical Department with an integrated automation system that supports all phases of Human Resource Life-Cycle Management in both peacetime and mobilization.

**medical retention determination point**

The MRDP is the point in time in which a determination can reasonably be made whether or not further medical care will cause the Soldier to meet medical retention standards or render them capable of performing the duties required by their office, grade, rank, or rating.

**medical retention processing-evaluation, medical retention processing, medical retention processing 2**

Medical retention processing orders voluntarily extend demobilizing RC Soldiers on active duty for a short term (normally less than 60 days) for a medical evaluation, to retain RC Soldiers on active duty who incur an injury, illness, or disease, or who aggravate a pre-existing medical condition while on active duty in support of a contingency operation, and to return RC Soldiers to active duty who were released from active duty with a LOD for unresolved injuries or illness incurred while on active duty in support of a contingency operation.

**medical subject matter expert**

The medical SME for the CTP is a physician or midlevel provider, or that person's representative, who is familiar with the goals and objectives of the Soldier's CTP.

**member of a uniformed service**

A person appointed, enlisted, inducted, or called, ordered, or conscripted into a uniformed service who is serving on active duty or ADT.

**military working dogs**

Any Government-owned dog that was procured, acquired, or bred to meet working dog requirements of the Military Departments and DOD agencies (see AR 700-81).

**mission command**

The exercise of authority and direction by commanders, using mission orders to enable disciplined initiative within the commander's intent to empower agile and adaptive leaders in the conduct of unified land operations.

**nurse case manager**

The NCM is a registered nurse who works with the Soldier throughout their time the WTU. NCMs are responsible for helping Soldiers regain health or improved functional capability by facilitating the development and implementation of goals. The NCM communicates and collaborates with all members of the interdisciplinary team to help ensure the Soldier has a comprehensive plan that addresses all domains of strength. The NCM ensures that the Soldier and the SL or PSG understands the medical plan of care and that the medical team is aware of the Soldier's nonmedical goals.

**nonmedical attendant**

A person selected by an eligible Soldier, and approved by the Soldier's attending physician and the MTF commander, who will contribute to the healing and recovery of the Soldier. This individual is placed on military orders which provide certain benefits to the individual.

**occupational therapy**

Occupational therapy is a health professional whose goal is to enable individuals with functional impairments to attain their maximum level of participation and independence. OTs identify strengths and deficits in functional performance and use meaningful activities (for example, ADL; roles such as parent, worker, student, or spouse) to help meet

recovery goals. In the WTU, OTs help Soldiers return to their military roles and responsibilities or to civilian life by helping to develop and regain skills or learn new strategies to allow success in all areas of their lives.

### **occupational therapist**

OT is the career domain SME in the CTP scrimmage in providing goal setting training to Soldiers and their Family. The OT performs all aspects of the screening, evaluation, and reevaluation process services for an individual patient and maintains current knowledge of legislative, political, social, cultural, societal, and reimbursement issues that affect clients and the practice of occupational therapy. The OT respects the clients' socio-cultural background and provides client-centered and family-centered occupational therapy services.

### **ombudsman**

Ombudsmen investigate complaints and resolve issues with local agencies in addition to serving as an advocate for Soldiers and Families faced with the complex, often overwhelming challenges related to health care and transition, such as physical disability processing, RC medical retention, transition, DVA, and pay issues. Ombudsmen are usually selected as a result of their extensive military medical experience and many have typically served as sergeants major within Army medical units.

### **Operation War Fighter**

OWF is a temporary assignment or internship program, developed by the DOD, for Servicemembers who are convalescing at MTFs at first in the National Capitol Region but increasingly throughout the United States. The program provides recuperating Servicemembers with meaningful activity outside of the hospital environment and offers it a formal means for integrating the internship as a possible future employment opportunity into the Soldiers CTP.

### **organic assets**

Organic assets are the staff personnel that belongs to a unit (that is, WTU cadre or PCM versus an MTF ER contract provider who belongs to the MTF).

### **per diem**

Per diem is the allowance for lodging (if required, excluding taxes), meals and incidental expenses. The calculation of travel per diem rates within the Federal Government is a shared responsibility of three organizations: Government Services Administration which prescribes rates for the continental United States; the Department of State which prescribes rates for foreign overseas locations; and Defense Travel Management which prescribes rates for overseas non-foreign areas (for example, Alaska, Hawaii, Puerto Rico, and Guam).

### **permanent catastrophic**

A permanent catastrophic injury or illness is a permanently severely disabling injury, disorder, or illness that compromises the ability of the Soldier to carry out ADL to such a degree that the person requires personal or mechanical assistance to leave home or bed, or constant supervision to avoid physical harm to self or others.

### **Physical Disability Evaluation System**

The PDES encompasses both the Army MEB and PEB processes. When a Soldier is determined not meeting medical retention standards by the MEB, the attending physician refers the Soldier to the PEB.

### **physical evaluation board**

The PEB is the sole forum within the Army to determine a Soldier's unfitness for duty as a result of a physical impairment. The factual determination as whether a Soldier is fit or unfit for duty exclusively focuses upon duty performance. If the board determines that a Soldier is physically unfit for duty in his or her present grade, rank, primary MOS or officer specialty, and current duty position by reason of a physical disability. The PEB then recommends a disability rating percentage based upon the Soldier's present degree of severity for each medical diagnosis found to be separately unfitting.

### **physical evaluation board liaison officer**

A PEBLO is an experienced, mature officer, NCO, or Civilian employee designated by the MTF commander to perform the primary duties of counseling Soldiers who are undergoing physical disability evaluation. The PEBLO provides Soldiers with authoritative and timely answers to their questions about the physical disability system and aids them in understanding their rights and entitlements. The PEBLO is not, and need not be, an attorney.

### **physical therapist**

A PT is a health care professional that provides services in physical therapy, which is a dynamic profession with an established theoretical and scientific base and widespread clinical applications in the restoration, maintenance, and promotion of optimal physical function. Physical therapy encompasses physical, psychological, emotional, and social

well being. PTs diagnose and manage movement dysfunction and enhance physical and functional abilities; restore, maintain, and promote not only optimal physical function but optimal wellness and fitness and optimal quality of life as it relates to movement and health; and prevent the onset, symptoms, and progression of impairments, functional limitations, and disabilities that may result from diseases, disorders, conditions, or injuries. PTs direct and supervise PTAs.

#### **physical therapy assistant**

A PTA works as part of a team to provide physical therapy services under the direction and supervision of the PT. PTAs implement selected components of patient or client interventions treatment, obtain data related to the interventions provided, and make modifications in selected interventions either to progress the patient or client as directed by the PT or to ensure patient or client safety and comfort. PTAs assist the PT in the treatment of individuals of all ages who have medical problems or other health-related conditions that limit their abilities to move and perform functional activities in their daily lives. The PT is responsible for the services provided by the PTA.

#### **platoon sergeant**

PSGs serve as the first line supervisor to the Soldier and the link to command. The PSG is responsible for facilitating the resolution of administrative issues that arise, and helps guide Soldiers through their CTP process and goals while enforcing military standards.

#### **primary care manager**

PCMs exercise primary decision authority regarding diagnosis and treatment of an individual patient. The PCM is either a physician trained in a primary care specialty or a midlevel provider with a primary care background.

#### **protected health information**

PHI is individually identifiable health information that is transmitted or maintained by electronic or any other form or medium (except as provided in DOD 6025.18–R). PHI excludes individually identifiable health information in employment records held by a covered entity in its role as employer.

#### **recreational animals**

Animals not owned by an individual and used solely for recreational purposes (for example, horses utilized at a riding stable).

#### **remain in the Army track**

Remain in the Army track is one of the two tracks which the Soldier can select to transition back. If the Soldier selects to remain in the Army, he or she will continue in military service. Included are: (a) Active Component (COMPO 1) Soldiers returning to their current or an alternate MOS; and, (b) National Guard (COMPO 2) and USAR (COMPO3) Soldiers who will be attached to the WTU until they meet Army retention standards and are released from active duty to continue service in the ARNG or Army Reserve in their current or an alternate MOS.

#### **scrimmage**

The scrimmage is an informal meeting with the Soldier's interdisciplinary team that uses the six domains of strength (career, physical, emotional, social, Family, and spiritual) to develop and refine a future oriented transition plan. The scrimmage is designed to engage the Soldier in finalizing identified goals, sub-goals, and supporting action statements for their time in the WTU and the future. Minimum attendees at all scrimmages will include: the Soldier and his or her Family (if available), SL or PSG, LCSW, OT or COTA, NCM, and AW2 advocate for assigned AW2 Soldiers.

#### **self assessment**

The self assessment is a tool that allows the Soldier to identify issues and concern that the cadre can validate and quickly resolve. Within AWCTS Self Assessment Module, the Soldier provides input on 17 different fields and provides a green, amber, or red rating for each field. The self assessment module provides Soldiers with the ability to write concerns and input for each field. Once a Soldier completes the self assessment, the NCM and SL are required to individually review and concur or non-concur with the Soldier's self assessment and create a plan to manage the Soldier's concern(s), if needed within 7 days.

#### **senior commander**

The SC is normally the senior general officer at the installation. The SC's mission is the care of Soldiers, Families, and Civilians, and to enable unit readiness. While the delegation of senior command authority is direct from HQDA, the SC will routinely resolve installation issues with IMCOM and, as needed, the associated ACOM, ASCC, or DRU. The SC

uses the garrison as the primary organization to provide services and resources to customers in support of accomplishing this mission. All applicable commands support the SC in the execution of SC responsibilities; therefore, the SC is the supported commander by the IMCOM region director, the garrison, and tenants.

### **service animals and/or service dogs**

A service animal is a dog that is individually trained to perform tasks upon a given command or cue, for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Example: use of seeing-eye dogs by the visually-handicapped. The Army does not currently recognize the use of service dogs for BH conditions, as outlined in Army Directive 2013-01. Therefore, psychological service dogs are not authorized for active duty Soldiers (including activated RC Soldiers) to whom the directive applies. The provision of emotional support, well-being, comfort, or companionship does not constitute work or tasks for the purpose of this definition. Moreover, it is specifically noted that other species of animals, whether wild or domestic, trained or untrained, are not service animals. Operationally, conferring upon a dog the label of 'service animal' or 'service dog' has significant implications: (1) Within the MEDCOM, it is expected that such service dogs, meeting the requirements outlined in paragraph 5-6 and will be given access to hospitals, treatment facilities, recreational facilities, barracks, and other structures as long as such access does not compromise public health and safety and does not interfere with principles of good order and discipline. (2) It implies that the individuals (Soldier or beneficiary) maintains possession of the dog, which has been "individually (specifically) trained" to assist with the needs of that particular individual. Therapy animals and activity animals remain within the possession of therapists, providers, and third-party owners; animals that do not meet the definition of a 'service dog' yet remain in the possession of an individual Soldier or beneficiary are defined as 'Companion Animals' or 'Pets' for the purpose of MEDCOM policy stated in paragraph 5-6. (3) Individuals requiring a service dog generally are expected to require such dog for an extended period of time, typically for life. Such a requirement renders a Soldier non-deployable.

### **service-dogs-in-training**

Dogs undergoing a period of training designated to lead to their ultimate employment as service dogs. At the discretion of the installation's SC, access to Army facilities by trainer with service-dogs-in-training may be granted, provided that the training is occurring under the auspices of a source accredited by an organization recognized by VA. In some cases, the training of service dogs occurs as part of a medically supervised program wherein the trainer benefits from the act of training dogs for service to other individuals. The use of such medically supervised training programs and the granting of access rights to MTFs to such dogs in training are at the discretion of the commander of the applicable MTF. A Soldier is not authorized to train his or her own service dog.

### **service treatment record**

The chronological documentation of medical and dental care received by an active duty Servicemember during the course of his or her military service. Inpatient clinical records are not part of the STR.

### **sister Services**

Sister Services are the other branches of service – Air Force, Navy, Marines, and Coast Guard.

### **skilled companion animals**

Synonymous with emotional support animal, skilled companion animals are treated as pets for purposes of stated MEDCOM policy in paragraph 5-6.

### **Soldier Adaptive Reconditioning Program**

The overall WTU program of adaptive reconditioning activities that is conducted by wounded, ill, or injured Soldiers on a regular basis for purposes of optimizing physical well-being, returning to an active productive life-style, and helping to achieve any of the Soldier's sub and priority (short-term) and transition and outcome (long-term) CTP goals. The WTU commander has overall authority, accountability, and responsibility for the conduct of the Soldier Adaptive Reconditioning Program, and the PT serves as the Soldier Adaptive Reconditioning Program manager and SME for the WTU command. The Soldier Adaptive Reconditioning Program is designed within the broad framework of Army physical readiness training doctrine, and allows for Soldier accountability, but is designed for and modified to the unique needs of wounded, ill, or injured Soldiers and WTU commands.

### **Soldier Family Assistance Center**

Soldier Family Assistance Center is a comprehensive centralized coordinating office that provides a variety of services to Soldiers and their Family members. The SFAC supports the hospitals and Warrior Transition Brigades, by developing, coordinating and providing designated services that address complex administrative and personal needs involving WTU Soldiers and their Family members.

### **Soldier Leader Risk Reduction Tool**

Soldier Leader Risk Reduction Tool provide a risk screening tool for commanders to use to develop a comprehensive picture of the health and welfare of their Soldiers; to assist and counsel their Soldiers in managing and mitigating their risk factors; and to transmit information on at-risk Soldiers as these Soldiers transition between commands. Personal information on this worksheet is to be used only by authorized personnel in the Soldier's chain of command.

### **Soldiers Medical Evaluation Board Counsel**

Soldiers MEB Counsel are licensed uniformed and civilian attorneys of the Army Judge Advocate General Corps who are specifically trained and certified to provide legal advice and representation to Soldiers in the MEB and PEB process, including representing Soldiers at formal PEB hearings. Soldiers MEB Counsels represent and advise Soldiers not commanders, and are also bound by attorney-client confidentiality. Soldiers MEB Counsels assist all Soldiers with active legacy DES or IDES cases regardless of unit assignment or current active duty status. These counsels inform, assist and advocate for Soldiers from the point of referral into the MEB process until their RTD or transition to civilian status. While managing expectations, Soldiers MEB Counsels strive to maximize a Soldier's goal of either returning to duty or maximizing appropriate military disability compensation. If necessary, Soldiers MEB Counsels assist with elections and rebuttals for any MEB and informal PEB decisions that a Soldier is called upon to make. Soldiers MEB Counsel assist all Soldiers with active MEB/PEB cases regardless of unit assignment or current active duty status.

### **Sole Provider Program**

Provide comprehensive prescription data of Soldiers in WTU from all points of service (MTFs, Mail Order, and Retail Network) and provide analysis of data to identify high-risk individuals based on command policy. The objective is to identify individuals who may require a more intensive medical review, to identify potential at-risk patients or to monitor adherence to a SPP. The data is delivered as a menu-driven database with individual look-up features and predefined reports designed to serve the needs of the health care provider(s) involved in the care of the WTU Soldier.

### **Special Compensation for assistance with Activities of Daily Living**

SCAADL provides compensation to a catastrophically injured or ill Soldier in order to offset the cost that may be incurred if a Soldier hired a home health care aid to provide assistance with ADL or help with the Soldier's safety. In order to receive SCAADL, a physician must certify that the Soldier requires daily assistance from another person to perform ADL or prevent the Soldier from harming self or others, and in the absence of this provision would require some form of residential institutional care. SCAADL is based on the Soldier's level of dependency, caregiver assistance required, and the local wage rate for a home health aide in the Soldier's geographic location. SCAADL and the NMA programs are different. SCAADL was developed to ensure catastrophically injured or ill Soldiers have the financial means to pay for someone to help them with ADL if they so choose. NMAs are placed on orders to provide support as outlined in this policy to the Soldier. NMA entitlements and benefits are in place to help the NMA with some of the costs of remaining geographically close to the Soldier. Based upon the Soldier's medical condition and physician determination, the Soldier may be eligible for both programs. Neither SCAADL nor NMA entitlements are to offset the loss of income by a NMA.

### **specific, measurable, attainable, realistic, and timebound**

Specific, measurable, attainable, realistic, and timebound is an acronym of terms used to describe the development of short and long term objectives that are: specific, time-based, measurable, and which provide realistic steps (goals) towards healing and determining priorities for each of the CTP six domains of strength. The goals can be both clinical and non-clinical. (Note that occupational therapy functions has determined "actionable" versus "attainable.") Specific, measurable, actionable, realistic, and timebound action statements are discussed in both goal setting Phase I and II classes.

### **squad leader**

The SL serves as the first line supervisor to the Soldier and the link to command. The SL is responsible for facilitating the resolution of administrative issues that arise, and helps guide the Soldier through the WTU process while enforcing military standards.

### **therapeutic events**

Therapeutic events can be one of the many adaptive reconditioning activities used to help Soldiers achieve their short or long-term CTP goals. To be therapeutic, an event must carry with it a reasonable expectation of a beneficial effect on the Soldier's health and outcome. The Soldier's PCM is the authority for designating whether a given activity is therapeutic. These events are considered mandatory and must be attended once prescribed and only superseded by medical appointments or command approval not to attend.

### **therapeutic trips**

These are therapeutic events that involve travel away from the Soldier's unit or quarters. Therapeutic trips require

approval from the Soldier's commander or his or her designee and will be accomplished by placing both the Soldier and any required attendant in a TDY status. Trips must not interfere with the performance of official duties, will not detract from readiness and will not interfere with the Soldier's treatment progression, healing, or transition. These events are considered mandatory and must be attended once prescribed and only superseded by medical appointments or command approval not to attend.

#### **therapy animals (animals utilized in animal assisted therapies (AAT))**

These may include equines and other species in addition to canines. They are used in goal-directed interventions wherein the animal is an integral part of a treatment process designed to improve physical, social, emotional, and cognitive function. The interventional goals are designed, documented, and tracked by a human health care professional and are tailored to each patient's individual needs. Upon completion of a therapy session, the animal is retained under the control and possession of MTF staff or volunteers rather than the patient. Example: use of equine therapy or horseback riding by a physical or OT as an aid to improving balance.

#### **Transfer**

A transfer occurs each time an inpatient is transported from one MTF (civilian or military) to another MTF, WTU, or Community Care Unit.

#### **Transition Assistance Program**

The Transition Assistance Program establishes a partnership among the DOD, VA, Homeland Security, and Labor's Veterans' Employment and Training Service, to provide employment and training information to Armed Forces members within 12 months of separation or 24 months of retirement.

#### **transition coordinator**

The TC is a member of the WTU cadre focused on the career domain of the CTP. The role of the TC is to manage the unit CER program and to ensure all WTU Soldiers are engaged in CER activities selected and customized for their individual circumstances, such as the Soldier's medical and physical abilities, long-term career goals as documented in their CTP, education, and previous work experience.

#### **transition from the Army track**

Transition from the Army track is one of the two tracks which the Soldier can select to transition back. The transition from the Army track will include all Soldiers who will not continue military service in either an active or reserve status. Soldiers who wish to apply for COAD or COAR will be referred to the PDES and will follow this track until approved for COAD or COAR. Soldiers who elect to apply for COAD or COAR will include activities within their individual CTP which maintain their military skills, and assist in their transition to civilian life.

#### **transition review**

Transition review starts during the in-processing and continues through the Soldier's stay in a WTU. All Soldiers will complete the first two processes and the initial scrimmage before transfer to a Community Care Unit. The transition review process provides the interdisciplinary team with an opportunity to review Soldier goals and progress with a focus on identifying and resolving issues that are impeding goal attainment. Each Soldier must take ownership of his plan to maximize the resources available in the WTU. The different elements of the transition review process (self-assessment, scrimmage, and FTR) must all work in concert to best facilitate the Soldier's successful transition.

#### **Traumatic Servicemembers Group Life Insurance**

Servicemember's Group Life Insurance (SGLI) provides automatic traumatic injury coverage to all Servicemembers covered full-time or part-time under the Servicemembers' Group Life Insurance (SGLI) program who are severely injured (on or off duty) and suffer a loss as the result of a traumatic event. It provides short-term financial assistance to severely injured Servicemembers and Veterans to assist them in their recovery from traumatic injuries. TSGLI is not only for combat injuries, but provides insurance coverage for injuries incurred on or off duty. See Web site <https://www.hrc.army.mil/TAGD/TSGLI>.

#### **Triad meetings**

Triad meetings are in addition to scrimmage and FTR meetings and serve as a critical communication mechanism for members of the interdisciplinary team, the Soldier, and Family. Attendance can include members of the interdisciplinary team and other individuals such as TC, FRSA, Veterans Health Administration representative, or career counselor, as directed by the company commander in order to accomplish the objective of effective communication and collaboration.

#### **Triad of Care**

Triad of Care normally refers to the SL, NCM, and PCM assigned to a WTU. The SL leads the Soldiers, the NCM

coordinates his or her care, and the primary care physician oversees the care. The Triad creates the familiar environment of a military unit and surrounds the Soldier and his or her Family with comprehensive care and support, all focused on the wounded warrior's sole mission to heal.

### **Triad of Leadership**

The Triad of Leadership consists of SCs and CSMs, MTF commanders and CSMs, and WTU commanders, CSMs, and ISGs. This Triad executes refinements to the WTU entry, management, and exit policy in order to develop a balanced WTU structure and capability that is enduring, expandable, collapsible, and responsive to the medical needs of every Soldier.

### **unaccompanied**

Housing provided to personnel not residing with Family members. Includes: (1) WTU barracks, and (2) Barracks, dormitories, and transient unaccompanied housing. May include privately-leased housing.

### **unit assignment**

To place personnel in an organization where such placement is relatively permanent, and where the organization controls and administers the personnel primary functions.

### **Veterans Benefits Administration**

Veterans Benefits Administration advisors are positioned in WTUs to provide outreach benefits assistance and services to Soldiers and their Families.

### **Veterans Health Administration**

VHA liaisons for health care are located at major MTFs to support the transfer of wounded, ill, and injured Soldiers to VA health care. The purpose of VHA liaisons at MTFs is to coordinate care and provide consultation about VA resources and treatment options. VHA liaisons at MTFs are also responsible for contacting a Soldier's local VA medical center and OEF/OIF/OND care management team to ensure that appointments and care plans are in place before a Soldier leaves an MTF. VHA liaisons are also stationed at WTUs to coordinate ancillary care through their local VA Medical Center.

### **Vocational Rehabilitation and Employment**

Vocational Rehabilitation and Employment assists Veterans with service-connected disabilities to prepare for, find, and keep suitable jobs. Vocational Rehabilitation and Employment also offers services to Veterans with severe service connected disabilities with abilities to improve his or her lives as independently as possible.

### **Warrior Transition Unit**

WTUs provide critical support to Regular Army Soldiers who are expected to require 6 months or more of rehabilitation care and complex M2 in an inpatient or outpatient status and to RC Soldiers who are in need of definitive health care based on medical conditions identified, incurred or aggravated while in an active duty status, in support of the Global War on Terrorism and non-GWOT activity (for example, active duty for training, active duty for special work, Extended Combat Training, battle assembly).

### **work site**

A CER work site is where a WTU Soldier participates in a work activity that aligns with the Soldier's CTP track and supports the Soldier's long-term career goals.

### **Warrior Transition Unit cadre**

Qualified personnel who are assigned to occupy a tables of distribution and allowances position at a WTU.

## **Section III**

### **Special Abbreviations and Terms**

#### **CBR**

contingency battle roster

#### **ITP**

individual transition plan

#### **OND**

Operation New Dawn

**PHA**

periodic health assessment

**RFP**

responsible force provider

**RIAWA**

remain in the Army work assignments

**SPP**

Sole Provider Program

**TDY**

temporary duty assignment

**VR&E**

Vocational Rehabilitation and Employment

**WTO**

Warrior Transition Office

**UNCLASSIFIED**

**PIN 105103-000**