

Army Regulation 40–58

Medical Services

Army Recovery Care Program

**Headquarters
Department of the Army
Washington, DC
12 May 2020**

UNCLASSIFIED

SUMMARY of CHANGE

AR 40–58

Army Recovery Care Program

This major revision, dated 12 May 2020—

- o Changes the title from Warrior Care and Transition Program to Army Recovery Care Program (cover).
- o Renames Warrior Transition Office to Recovery Care Office (paras 1–6, 2–7, 2–17, and throughout).
- o Renames Army Wounded Warrior Program to Army Recovery Care Coordination and Army Wounded Warrior Advocates to Recovery Care Coordinators (paras 1–7, 2–3, 2–10, and throughout).
- o Redefines members of the Triad of Leadership and replaces military treatment facility commander with designated military treatment facility Triad of Leadership representative (paras 1–7, 2–25, and throughout).
- o Changes the care management process for Army Reserve National Guard Soldiers who do not meet the Army Recovery Care Program to the Reserve Component Managed Care (paras 1–15, 7–2, and chap 13).
- o Establishes Remote Medical Management and changes the care management process for United States Army Reserve Soldiers who do not meet the Army Recovery Care Program entry criteria (paras 1–16, 2–9, 7–3, chap 13, and throughout).
- o Establishes a Headquarters Platoon, Complex Care Platoon, Veteran Track Platoon, and a Return to Duty Platoon in Soldier Recovery Units (para 2–8 and throughout).
- o Renames Army Warrior Care and Transition System to Army Recovery Care System (paras 2–9, 2–12, chap 8, and throughout).
- o Establishes the role of the Soldier Recovery Unit medical provider and distinguishes it from the role of primary care manager (para 6–1 and throughout).
- o Establishes an Army Recovery Care Program single entry criteria that is based on complex case management (para 7–2).
- o Inserts language to clarify the intent of program restructure where applicable (throughout).
- o Removes language no longer applicable to the program following the restructure (throughout).
- o Renames Warrior Care and Transition Program to Army Recovery Care Program (throughout).
- o Renames Warrior Transition Units to Soldier Recovery Units (throughout).
- o Removes Community Care Units (throughout).
- o Renames Comprehensive Transition Plan to Comprehensive Recovery Plan (throughout).

Medical Services
Army Recovery Care Program

By Order of the Secretary of the Army:

JAMES C. MCCONVILLE
General, United States Army
Chief of Staff

Official:


KATHLEEN S. MILLER
Administrative Assistant
to the Secretary of the Army

Sections 1611, 1613, 1614, and 1615, Title XVI; Section 12301(h) Title 10, United States Code; Section 481K Title 37, United States Code; DODI 1300.24; and DODI 6010.24..

Applicability. This regulation applies to the Regular 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 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 app B).

Supplementation. Supplementation of this regulation and establishment of command and local forms is prohibited without prior approval from The Surgeon General, 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 the Deputy Chief of Staff, Army Recovery Care (Policy and Procedures), 2530 Crystal Drive, Suite 10167, Arlington, VA 22202.

Distribution. This regulation is available in electronic media only and is intended for the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

History. This publication is a major revision.

Summary. This regulation prescribes the policy and standards for the Army Recovery Care Program. Establishes revised entry criteria for Soldier Recovery Units and prescribes the daily operations for the care management and rehabilitation of wounded, ill, and injured Soldiers. This mandated revision renames Warrior Care and Transition Program to Army Recovery Care Program and includes changes to program structure and units. This regulation implements Public Law 110–181,

Contents (Listed by paragraph and page number)

Chapter 1

Introduction, page 1

Section I

Overview, page 1

Purpose • 1–1, *page 1*

References and forms • 1–2, *page 1*

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

Responsibilities • 1–4, *page 1*

Records management (recordkeeping) requirements • 1–5, *page 1*

Principles of support • 1–6, *page 1*

General • 1–7, *page 1*

Section II

Responsibilities, page 2

*This regulation supersedes AR 40–58, dated 23 March 2015.

Contents—Continued

Assistant Secretary of the Army (Financial Management and Comptroller) • 1–8, *page 2*
Assistant Secretary of the Army (Manpower and Reserve Affairs) • 1–9, *page 2*
Chief, National Guard Bureau • 1–10, *page 3*
Deputy Chief of Staff, G–1 • 1–11, *page 3*
The Deputy Chief of Staff, G–3/5/7 • 1–12, *page 4*
Deputy Chief of Staff, G–9 • 1–13, *page 4*
Chief of Army Reserve or Commanding General, U.S. Army Reserve Command • 1–14, *page 4*
The Surgeon General and/or Commanding General, U.S. Army Medical Command • 1–15, *page 4*
Commanding General, U.S. Army Materiel Command • 1–16, *page 5*
Senior commanders • 1–17, *page 6*

Chapter 2

General, *page 6*

Section I

Organization of the Army Recovery Care Program, page 6

Mission • 2–1, *page 6*

Purpose of the Army Recovery Care Program • 2–2, *page 6*

Army Recovery Care Coordination Center • 2–3, *page 6*

Section II

Major Components of the Army Recovery Care Program, page 6

General • 2–4, *page 6*

Goal • 2–5, *page 6*

Medical Command Deputy Chief of Staff-Army Recovery Care Program • 2–6, *page 7*

Regional Health Command Recovery Care Office • 2–7, *page 7*

Soldier Recovery Units • 2–8, *page 7*

Remote Medical Management • 2–9, *page 8*

Army Recovery Care Coordination • 2–10, *page 8*

Comprehensive Recovery Plan • 2–11, *page 9*

Army Recovery Care System • 2–12, *page 10*

Career and Education Readiness Program • 2–13, *page 10*

Adaptive Reconditioning Program • 2–14, *page 10*

Organizational Inspection Program and Staff Assistant Visits • 2–15, *page 10*

Soldier and Family Assistance Centers • 2–16, *page 10*

Section III

Roles and Responsibilities within the Army Recovery Care Program, page 11

Regional health command • 2–17, *page 11*

Regional Health Command Recovery Care Office • 2–18, *page 12*

Designated military treatment facility Triad of Leadership representative • 2–19, *page 12*

Soldier Recovery Unit Commanders • 2–20, *page 13*

Headquarters Platoon • 2–21, *page 14*

Soldier • 2–22, *page 14*

Triad of Care • 2–23, *page 16*

Lead coordinator • 2–24, *page 16*

Triad of Leadership • 2–25, *page 17*

Family readiness support assistants • 2–26, *page 17*

Religious and spiritual care • 2–27, *page 18*

Section IV

Command Communication with Soldiers, page 18

Army goals • 2–28, *page 18*

Town hall meetings and open door policy • 2–29, *page 18*

Contents—Continued

Section V

Unaccompanied Housing and Lodging Assignment and Termination, Facility Maintenance, Inspection Standards, Inventory, and Reporting, page 18

Policy • 2–30, *page 18*

Unaccompanied housing and lodging assignment • 2–31, *page 18*

Assignment of Soldiers to housing and lodging • 2–32, *page 19*

Maintenance standards • 2–33, *page 19*

Inspection standards • 2–34, *page 19*

Inventory Management • 2–35, *page 20*

Reporting requirements • 2–36, *page 21*

Section VI

Medical Command Medical Assistance Group Ombudsman Program, page 21

Background • 2–37, *page 21*

Ombudsman Program • 2–38, *page 21*

Chapter 3

Comprehensive Recovery Plan, page 22

Policy • 3–1, *page 22*

Comprehensive Recovery Plan structure • 3–2, *page 22*

Intake and • 3–3, *page 22*

Goal setting • 3–4, *page 23*

Transition review • 3–5, *page 23*

Rehabilitation • 3–6, *page 24*

Reintegration • 3–7, *page 24*

Post-transition • 3–8, *page 24*

Triad meetings • 3–9, *page 24*

Accountability • 3–10, *page 25*

Chapter 4

Risk Assessment and Mitigation Planning, page 26

Section I

General, page 26

Background • 4–1, *page 26*

Policy • 4–2, *page 26*

Management and mitigation • 4–3, *page 27*

Reassessment • 4–4, *page 27*

Execution of managing risk levels and mitigation plans • 4–5, *page 28*

Section II

High-Risk Medication Review and Sole Provider Program, page 31

Policy • 4–6, *page 31*

Medication review and Sole Provider Program enrollment • 4–7, *page 31*

Chapter 5

Adaptive Reconditioning Program, page 31

Background • 5–1, *page 31*

Adaptive reconditioning team • 5–2, *page 32*

Policy • 5–3, *page 32*

Adaptive reconditioning equipment • 5–4, *page 32*

Establishing the Adaptive Reconditioning Program • 5–5, *page 33*

Chapter 6

Medical Care Management, page 35

Contents—Continued

Section I

Primary Care, page 35

SRU medical provider • 6–1, page 35

Medical retention determination point • 6–2, page 35

Medical evaluation board referral • 6–3, page 35

Transition standards • 6–4, page 36

Medically optional surgeries, procedures, and treatments • 6–5, page 36

Service animals in Soldier Recovery Units • 6–6, page 36

Profile Adherence • 6–7, page 37

Security and storage of medication • 6–8, page 37

Section II

Case Management, page 39

Nursing case management • 6–9, page 39

Education and training and certification • 6–10, page 39

Case management standards • 6–11, page 39

Section III

Clinical Social Work Care Management, page 40

Policy • 6–12, page 40

Licensed clinical social worker team collaboration • 6–13, page 40

Provision of behavioral health care standards and timelines • 6–14, page 40

Non-Duty hour arrival standards and timelines • 6–15, page 42

Case complexity estimate • 6–16, page 43

Supportive counseling, brief treatment intervention, and referral • 6–17, page 43

Care management • 6–18, page 43

Clinical documentation in the medical record • 6–19, page 44

Limits of confidentiality for clinical information and consent to assessment and/or treatment • 6–20, page 44

Behavioral health information release • 6–21, page 44

Resources • 6–22, page 44

Section IV

Occupational Therapy, page 44

Policy • 6–23, page 44

Occupational therapist and certified occupational therapist assistant team collaboration • 6–24, page 44

Provision of occupational therapy registered care standards and timelines • 6–25, page 45

Section V

Physical Therapy, page 47

Policy • 6–26, page 47

Physical therapist and therapist assistant team collaboration • 6–27, page 47

Provisions of physical therapy care standards and timelines • 6–28, page 47

Chapter 7

Human Resources and Administrative, page 48

Section I

Entry, Exit, and Transfer into the Army Recovery Care Program, page 48

General • 7–1, page 48

Army Recovery Care Program Entry • 7–2, page 49

Management of Reserve Component Soldiers • 7–3, page 49

Ineligibility • 7–4, page 49

Medical retention for all Component Soldiers • 7–5, page 50

Senior grade entry approval into the Soldier Recovery Unit • 7–6, page 50

Assigned versus attached • 7–7, page 50

Location of care determination • 7–8, page 50

Exit criteria for component 1, and component 2 and 3 Active Guard Reserve Soldiers • 7–9, page 50

Contents—Continued

Exit criteria for component 2 and 3 Soldiers not in Active Guard Reserve status • 7–10, *page 51*
Unit notification • 7–11, *page 51*
Coordinating instructions and screening for entry into a Soldier Recovery Unit • 7–12, *page 52*
Exception to eligibility for transfer • 7–13, *page 52*
Care in a non-Army medical facility • 7–14, *page 53*
Return to Duty of component 1 Soldiers assigned to Soldier Recovery Units • 7–15, *page 54*
Disposition of non-mobilized Reserve component personnel • 7–16, *page 54*
Non-Army personnel • 7–17, *page 54*
Geographically dispersed personnel • 7–18, *page 54*
Enrollment of Soldier Recovery Unit cadre and Deputy Chief of Staff-ARC Personnel into the Army Recovery Care Program • 7–19, *page 54*

Section II

Cadre Assignments and Utilization, page 55
Cadre selection • 7–20, *page 55*
Approval authorities for assignments of cadre • 7–21, *page 56*
Component mismatch assignments • 7–22, *page 56*
Component mismatch execution • 7–23, *page 57*
Cadre stability • 7–24, *page 57*
Exemption from Professional Filler System • 7–25, *page 58*
Collateral duty exemption • 7–26, *page 58*

Section III

Career and Education Readiness Worksite Selection, page 58
Definition • 7–27, *page 58*
Policy • 7–28, *page 58*

Section IV

Leave and Passes, page 61
Leave and Pass Management Program • 7–29, *page 61*
Respite Pass Program • 7–30, *page 61*
Medical care while on leave or pass • 7–31, *page 61*
Convalescent leave • 7–32, *page 62*

Section V

Non-Compliance with the Army Recovery Care Program, page 62
Background • 7–33, *page 62*
Removal from the Army Recovery Care Program • 7–34, *page 62*

Section VI

Army Body Composition Program, page 63
General • 7–35, *page 63*
Exemption • 7–36, *page 63*

Section VII

Inspection Programs, page 64
Organizational Inspection Program • 7–37, *page 64*
Staff Assistance Visits • 7–38, *page 64*

Chapter 8

Automation Systems Supporting the Army Recovery Care Program, *page 65*

Section I

The Army Recovery Care System, page 65
General • 8–1, *page 65*
Upload of documents • 8–2, *page 65*
Control Measures • 8–3, *page 65*

Contents—Continued

Army Recovery Care System document upload management • 8–4, *page 65*
Quality assurance and reporting • 8–5, *page 66*

Section II

Medical Operational Data System-Warrior Transition, page 66
Medical Operational Data System application management • 8–6, *page 66*

Chapter 9

Donations, page 67

General • 9–1, *page 67*
Acceptance of donations • 9–2, *page 67*
Solicitation of gift and donation • 9–3, *page 68*

Chapter 10

Family Programs, page 68

Section I

Family Support Groups, page 68
Family readiness groups • 10–1, *page 68*
Soldier Recovery Unit Family Readiness Support Assistant • 10–2, *page 68*

Section II

Memorial Ceremonies and Services, page 68
Background • 10–3, *page 68*
Policy • 10–4, *page 69*

Chapter 11

Benefits and Special Compensation, page 69

Section I

Special Compensation for Assistance with Activities of Daily Living, page 69
Background • 11–1, *page 69*
Appeal process • 11–2, *page 69*

Section II

Family Caregiver Benefit and Compensation, page 69
Direct billing for non-medical attendant lodging expenses at Veterans Health Administration Polytrauma Rehabilitation Centers • 11–3, *page 69*
Military escorts for Family members or non-medical attendants traveling on official orders at Soldier Recovery Units only • 11–4, *page 69*
Medical care benefit for caregivers of members of the Armed Forces recovering from serious injuries or illnesses • 11–5, *page 70*

Section III

Non-medical Attendants, page 70
Background • 11–6, *page 70*
Entitlements • 11–7, *page 70*
Non-medical attendant administrative management • 11–8, *page 71*
Non-medical Attendant Program command control • 11–9, *page 72*
Non-medical attendant designation • 11–10, *page 74*
Removal from non-medical attendant status • 11–11, *page 74*
Non-medical attendant training • 11–12, *page 74*

Chapter 12

Training Requirements, page 74

Contents—Continued

Section I

Soldier Recovery Unit Orientation and Sustainment Training, page 74

Soldier Recovery Unit training requirements • 12-1, *page 74*

Training priorities • 12-2, *page 75*

Cadre and staff training • 12-3, *page 75*

Major training events • 12-4, *page 76*

Training safety • 12-5, *page 76*

Section II

Comprehensive Soldier and Family Fitness, page 76

General • 12-6, *page 76*

Unit requirement • 12-7, *page 76*

Responsibilities • 12-8, *page 76*

Chapter 13

Reserve Components Remote Care, page 77

General • 13-1, *page 77*

Reserve Component Managed Care • 13-2, *page 77*

Remote Medical Management • 13-3, *page 77*

Appendixes

A. References, *page 78*

B. Internal Control Evaluation, *page 86*

Table List

Table 7-1: Current location fields, *page 53*

Figure List

Figure 6-1: Algorithmic summary of the management of optional surgeries, *page 38*

Glossary

Chapter 1 Introduction

Section I

Overview

1–1. Purpose

This regulation prescribes policies, standards, and responsibilities for the entry, exit, and transfer into the Army Recovery Care Program (ARCP), and provides policies, standards, and responsibilities for the organization and functions of the Soldier Recovery Unit (SRU) to include the Remote Medical Management (RM2). It specifies regulatory guidance and establishes standards for the operational activities conducted by assigned and attached cadre personnel in supporting the Comprehensive Recovery Plan (CRP), including all clinical and non-clinical care management. This regulation further provides guidance regarding expectations for the personal conduct of SRU Soldiers and component force providers to identify, screen, and select officers and cadre members.

1–2. References and forms

See appendix A.

1–3. Explanation of abbreviations and terms

See glossary.

1–4. Responsibilities

Responsibilities are listed in section II of this chapter.

1–5. Records management (recordkeeping) requirements

The records management requirement for all record numbers, associated forms and reports required by this regulation are addressed in the Army Records Retention Schedule-Army (RRS–A). Detailed information for all related record numbers, forms and reports are located in Army Records Information Management System (ARIMS)/RRS–A at <https://www.arims.army.mil>. If any record numbers, forms, and reports are not current, addressed and/or published correctly in ARIMS/RRS–A, see DA Pam 25–403 for guidance.

1–6. Principles of support

a. The Deputy Chief of Staff (DCS)-Army Recovery Care (ARC) as a principal staff element within the Medical Command (MEDCOM) headquarters, provides strategic oversight and policy development support for the Office of The Surgeon General (OTSG)/MEDCOM Army Recovery Care Program and provides a focal point for the coordination and support of the ARCP's mission.

b. Regional health commands (RHCs) exercise mission command of SRUs except for the National Capital Region (NCR).

c. The SRU provides mission command and medical management (M2) for Soldiers; establishes through the CRP the conditions for their healing; and promotes timely return to the force and/or transition to Veteran status.

d. SRUs within the NCR are directly subordinate to the RHC-Atlantic.

e. The regional Recovery Care Offices (RCOs) 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.

f. The Army Medical Department Center and School (AMEDDC&S)-Health Readiness Center of Excellence (HRCoE) is subordinate and reports directly to the Commander of the MEDCOM. The School is the education and training proponent for the MEDCOM.

g. Cadre, lead coordinator, 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.

1–7. General

a. SRUs are designed to meet the needs of Soldiers who are wounded, ill, or injured and who require medical case management through the Triad of Leadership (TOL), Triad of Care, and other medical and nonmedical providers forming an interdisciplinary team (IDT).

b. The TOL consists of the SRU commander/CSM, Army senior commander/CSM, and a designated MTF TOL representative/CSM. The MTF TOL representative will be determined as follows: When the MTF Director is an Army officer and is dual-hatted to function as the MTF's Army Service Commander, then he or she will be designated as the MTF TOL representative. When the MTF Director is not an Army officer, the respective RHC commander will coordinate with DHA to designate a senior Army medical officer assigned to the MTF as the MTF TOL representative. The TOL executes policy for the SRU entry, management, and exit of a Soldier in order to maintain a balanced SRU structure and capability that is dynamic and responsive to the medical needs of every Soldier.

c. The Triad of Care consists of the SRU medical provider, SRU nurse case manager (NCM), and squad leader (SL) or platoon sergeant (PSG) forming the M2 and mission command (MC). This Triad of Care works in concert with the TOL 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 SRU Soldier receives a Triad of Care to direct and supervise the healing process.

d. The IDT, includes the Triad of Care, a lead coordinator (LC), command representative, and all personnel that play a role in the Soldier's healing, recovery, and transition.

e. The lead coordinator (LC), designated as the Recovery Care Coordinator (RCC) advocates for all eligible Soldiers and outpatient SRU Soldiers. The LC serves as the primary point of contact for non-clinical complex care coordination for Soldiers, their Families and/or caregivers. The lead coordinator for inpatient Soldiers is the SRU NCM.

f. A SRU Soldier is a wounded, ill, or injured Soldier who meets ARCP entry criteria. A SRU Soldier falls under the MC and M2 of a SRU. A SRU Soldier's primary mission is to heal and transition.

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

Section II

Responsibilities

1–8. Assistant Secretary of the Army (Financial Management and Comptroller)

The ASA (FM&C) will—

a. Assist the DCS, G–1 in developing personnel policy for SRU operations in coordination with the DCS, G–9; CG, AMC; CG, IMCOM; CG, HRC; Deputy Commander, USAPDA; CNGB; CG, USARC; CG, USAFMCOM; and Director, 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 RHC, SRU, and SFAC to obtain SRU 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 software, and so forth) and operations.

f. Brief SRU commanders, staff, and cadre personnel, when necessary, on the requirements and timely processing of military pay, travel pay, continuation of special 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.

1–9. Assistant Secretary of the Army (Manpower and Reserve Affairs)

The ASA (M&RA) will—

a. Provide overall policy oversight for the organization and functions of the ARCP.

b. Coordinate, as necessary, personnel policy for SRUs with Headquarters, Department of the Army (HQDA) staff elements, other Army commands (ACOMs), Army service component commands (ASCCs), and direct reporting units (DRUs).

c. Coordinate with the TSG in developing the organization and functions of the SRU in coordination with DCS, G–9; Commanding General (CG), U.S. Army Materiel Command (AMC); CG, Installation Management Command

(IMCOM); CG, U.S. Army Human Resources Command (HRC); Deputy Commander, U.S. Army Physical Disability Agency (USAPDA); Chief, National Guard Bureau; CG, U.S. Army Reserve Command (USARC); CG, U.S. Army Financial Management Command (USAFMCOM); and Director, Defense Finance and Accounting Service (DFAS).

1–10. Chief, National Guard Bureau

The Chief, NGB or the Director, ARNG if so delegated will—

- a.* Serve as the primary point of contact (POC) among DA and The Adjutant Generals.
- b.* Assist DCS, G–1 in developing personnel policy for wounded, ill, or injured warrior policies in coordination with CG, MEDCOM; DCS, G–9; CG, AMC; CG, IMCOM; CG, HRC; Deputy Commander, USAPDA; CG, USARC; CG, USAFMCOM; and Director, DFAS.
- c.* Provide personnel resources in support of the ARCP.
- 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 and DFAS offices to assist the local Defense Military Pay Offices and SRUs resolve military pay and travel pay inquiries, to include Family member travel voucher processing and payment.
- g.* Ensure the ARNG Financial Service Center provides overall pay support to ARNG Soldiers attached to SRUs.
- 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 CRP.
- 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, transit- ton assistance, Veterans Affairs (VA) adaptive housing and vehicle assistance, VA education and training, VA Vocational Rehabilitation and Employment (VR&E), and Department of Labor (DOL) programs.
- m.* Provide quality candidates to fill all ARCP coded ARNG positions within a timely manner.
- n.* Manage ARNG Soldiers under the Reserve Component Managed Care (RCMC) program who do not meet the ARCP entry criteria but are entitled to remain on (or return to) active duty to complete medical evaluation and treatment.

1–11. Deputy Chief of Staff, G–1

- a.* The DCS, G–1 will—
 - (1) Assist the TSG in developing policy for the organization and functions of the ARCP in coordination with ASA (M&RA); CG, IMCOM; DCS, G–9; CG, AMC; CG, HRC; Deputy Commander, USAPDA; CNGB; CG, USARC; CG, USAFMCOM; and Director, DFAS.
 - (2) Provide policy guidance for SRU Soldiers as directed by ASA (M&RA).
 - (3) Monitor and update Department of Army personnel policies pertaining to the ARCP.
 - (4) Advocate and implement Department of Army policies that support the ARCP.
 - (5) Develop and implement policies for the management of the Disability Evaluation System (DES).
 - (6) Ensure that Comprehensive Soldier and Family Fitness (CSF2) provides resilience training policy and guidance for ARCP staff, SRU Soldiers, and Families (see chap 12).
- b.* The DCS, G–1 delegates ARCP personnel administrative oversight to the Commanding General (CG), HRC. The CG, HRC will—
 - (1) Assist the DCS, G–1, in developing personnel policy for the operations of the ARCP in coordination with ASA (M&RA); CG, MEDCOM; DCS, G–9; CG, AMC; Deputy Commander, USAPDA; CNGB; CG, USARC; CG, USAFMCOM; and Director, DFAS.
 - (2) Develop procedures for SRUs for technical and quality control of personnel actions, assignment, and attachment, and to ensure accountability and Soldier welfare.
 - (3) Provide military personnel administrative support for SRU operations.
 - (4) Ensure the PDA coordinates with DCS, G–1 and develops policies, procedures, and programs for the management of the DES.

(5) Ensure PDA managed SRU 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 (SFL–TAP).

c. U.S. Army PDA Director will—

(1) Assist the DCS, G–1 in developing personnel policy for SRU operations in coordination with ASA (M&RA); MEDCOM; CG, IMCOM, CG, HRC; CNG; CG, USARC; CG, USAFMCOM; and Director, DFAS.

(2) Coordinate with DCS, G–1 and develop policies, procedures, and programs for the management of the DES.

(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.

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

The DCS, G–3/5/7 will ensure that the DA Military Operations Force Management Directorate 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.

1–13. Deputy Chief of Staff, G–9

The DCS, G–9 will—

a. Collaborate as required with the DCS, G–1 in developing personnel policy for SRU operations in coordination with ASA (M&RA); CG, AMC; CG, MEDCOM; CG, HRC; Deputy Commander, USAPDA; CNGB; CG, USARC; CG, USAFMCOM; Director, Installation Defense Military Pay Office; and CG, IMCOM.

b. Provide administrative policy guidance and procedures in support of Warrior Care operations as directed by ASA (M&RA); DCS, G–1; and CG, HRC.

1–14. Chief of Army Reserve or Commanding General, U.S. Army Reserve Command

The CAR or the CG, USARC will—

a. Assist the DCS, G–1 in developing personnel policy for SRU operations in coordination with CG, MEDCOM; DCS, G–9; CG, AMC; CG, IMCOM; CG, HRC; USAPDA; CNGB; CG, USAFMCOM, and Director, 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 and, DFAS Offices to assist the local Defense Military Pay Offices and SRUs resolve military pay and travel pay inquiries, to include Family member travel processing and payment.

e. Provide, upon request, personnel for SRU operations on installation sites.

f. Provide quality Triad of Leadership (TOL) candidates to fill all ARCP coded USAR positions within a timely manner.

g. Coordinate with SRU to provide duty site and duty site supervisor for RM2 Soldiers.

1–15. The Surgeon General and/or Commanding General, U.S. Army Medical Command

a. TSG/CG, MEDCOM will—

(1) Assist the DCS, G–1 in developing personnel policy for the operations of the ARCP in coordination with the ASA (M&RA); DCS, G–9; GC, AMC; GC, IMCOM; CG, HRC; Deputy Commander, USAPDA; CNGB; CG, USARC; CG, USAFMCOM; and Director, DFAS.

(2) Support synchronizing efforts of the CNGB, the Chief, Army Reserve (CAR), and the heads of other organizations in support of SRU operations.

(3) Coordinate with the Director, Defense Health Agency (DHA) to develop and implement medical standards and policy to support SRU 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 ARCP.

(5) Manage and provide manpower and funding requirements to support SRU operations.

(6) Maintain ownership of SRU 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 RHCs provide mission command, personnel, logistical, fiscal, legal, chaplain, and communications coordination and support to SRUs.

(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 SRU operations.

(11) Exempt SRU cadre and the office of the DCS–ARC staff from Professional Officer Filler System (PROFIS), medical augmentee, and individual assignments. Exceptions apply (see chap 7).

(12) Exempt SRU 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 chap 7 for additional details).

b. DCS–ARC will—

(1) Act as the proponent for policies on the ARCP.

(2) Establish, revise, and set the conditions for the implementation of policies to execute the Army’s ARCP.

(3) Set the strategic mission and vision for the SRUs.

(4) Conduct command and staff inspections, as well as staff assistance visits (SAVs) to ensure SRUs 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 SRU and cadre.

(8) Provide personnel and finance support for SRU operations.

(9) Manage the ARCC for the severely wounded, injured, or ill Soldiers and Veterans.

(10) Synchronize the efforts of NGB, OCAR, and other agencies in support of SRU operations.

c. The AMEDDC&S-HRCoE will design, develop, and conduct SRU and cadre training in collaboration with the office of the DCS –ARC.

1–16. Commanding General, U.S Army Materiel Command

The CG, AMC will ensure that the CG, IMCOM and the CG, USAFMCOM will support ARCP policies and procedures. Specifically, the CG, AMC, through the CG, IMCOM, will ensure—

a. Collaborate as required with the DCS, G–1 in developing personnel policy for SRU operations in coordination with ASA (M&RA); DCS, G–9; CG, IMCOM; CG, MEDCOM; CG, HRC; Deputy Commander; USAPDA; CNGB; CG, USARC; CG, USAFMCOM; and the Director, Installation Defense Military Pay Office.

b. Provide administrative, logistical, housing facility, and finance support for SRU operations.

c. Conduct IMCOM specific redeployment, and tasks for SRU 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>.

d. Ensure Army Community Services (ACS) and the Soldier and Family Assistance Center (SFAC) provide a continuum of services to SRU Soldiers, their Families, and caregivers.

e. Work with installation or garrison commander to provide appropriate buildings and support to SRU and SFAC operations, and to resident SRU Soldiers and caregivers.

f. Ensure appropriate development of inter-service support agreements (ISSA) to support Warrior Care and SRU SFAC operations.

g. Ensure facilities meet Soldiers accessibility needs in accordance with the American with Disability Act and Architectural Barriers Act (ADA–ABA).

h. Ensure Army Substance Abuse Program (ASAP) personnel work closely with the Triad of Care and the TOL on SRU Soldiers utilizing ASAP services.

i. Through the Installation SFL–TAP will—

(1) Help eligible Army wounded, ill, or injured Soldiers, their Family members, and caregivers successfully transition from military service.

(2) Provide personalized transition and employment counseling and assistance.

(3) Assist Soldiers in applying to Federal jobs, and learning how to locate and review vacancy announcements, create and submit resumes, and track application status.

(4) Provide Veterans benefits briefings.

(5) Ensure Soldiers meet Veteran Opportunity Work and career readiness standards in accordance with AR 600–81.

(6) Assist Soldiers to enroll in Career Skills Programs.

1–17. Senior commanders

SCs will—

- a.* Ensure all SRU Soldiers on their installation are properly managed.
- b.* Ensure quality officers and NCOs are selected to serve as commanders, First Sergeants (1SGs), PSGs, and SLs for SRUs.
- c.* Ensure the SRU is staffed with the specified cadre assignment ratio.
- d.* Serve as a member of the TOL.
- e.* Attend semiannual SRU town halls with Soldiers and Families.
- f.* Conduct sensing sessions with cadre, at a minimum, annually.
- g.* Provide personnel, logistical, and finance support for SRU operations.
- h.* Exempt SRU cadre and the office of the DCS–ARC Staff from PROFIS, medical augmentee, and individual assignments. Exceptions apply (see chap 7).
- i.* Exempt SRU 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 chap 7 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.* Take appropriate action on reports received on Soldiers who have 12 months assigned or attached to the SRU without a MEB referral.

Chapter 2

General

Section I

Organization of the Army Recovery Care Program

2–1. Mission

The office of the DCS–ARC provides centralized oversight, guidance, and advocacy empowering wounded, ill, or injured Soldiers, Veterans, Families and/or caregivers through a CRP for successful reintegration back into the force or into the community with dignity, respect, and self-determination.

2–2. Purpose of the Army Recovery Care Program

To provide policy and guidance for the Army Recovery Care Program (ARCP). The office of the DCS–ARC has policy development and oversight for the operations of the ARCP and conducts command and staff inspections and SAVs to validate proper policy execution, standardize continuous operational improvement, and identify and propagate best practices among the SRUs.

2–3. Army Recovery Care Coordination Center

The Army Recovery Care Coordination (ARCC) Center is a component of the ARCP under the office of the DCS–ARC that manages ARCC by providing supervision and guidance to RCCs in order to provide long term individualized support to severely wounded, ill, or injured Soldiers, Veterans, and their Families and/ or caregivers who meet the ARCC criteria (see eligibility criteria in para 2–9).

Section II

Major Components of the Army Recovery Care Program

2–4. General

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

2–5. Goal

The goal of the ARCP is to successfully transition Soldiers, their Families, and/or caregivers 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 ARCP. At the same time, the SRU 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. Medical Command Deputy Chief of Staff-Army Recovery Care Program

The office of the DCS-ARC serves as the lead proponent for the ARCP. 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 office of the DCS-ARC 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/or caregivers.

2-7. Regional Health Command Recovery Care Office

The RHC Recovery Care Offices (RCOs) provide operational and programmatic support to the ARCP within their respective regions RHCs. RCOs support 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 RCOs provide oversight, synchronize operations, ensure manning is consistent with required ratios, and provide staff assistance to the support, care and healing of wounded, ill, or injured Soldiers, their Families and/or caregivers.

2-8. Soldier Recovery Units

a. SRUs provide critical support to wounded, ill, or injured Soldiers. A SRU 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 -SRU medical provider, SRU NCM, and SL - who coordinate their care with other clinical and non-clinical professionals. The SRU is designed to care for Soldiers who are in need of complex case management and rehabilitation in an inpatient or outpatient status. These Soldiers meet the complex care single entry criteria (see chap 7 for the entry criteria) and are qualified to receive all the resources that are available in the ARCP as a resident or non-resident complex care Soldier. SRUs are composed of four platoons:

(1) Headquarters (HQ) platoon. The HQ Platoon focuses on the initial intake and in-processing, assessing initial Soldier risk, orientation, and ensuring the immediate needs of the Soldier are met. The HQ Platoon also manages USAR Soldiers on 12301(h) Title 10 United States Code (10 USC 12301(h)) orders for medical evaluation as well as the Remote Medical Management (RM2) population and their cadre. Within five training days, once the initial intake and assessment are completed, Soldiers are generally assigned to the Complex Care Platoon (with the exception of RM2 and medical evaluation Soldiers).

(2) Complex Care Platoon. The focus of the Complex Care Platoon is medical case management of the Soldier to the Medical Retention Determination Point (MRDP). The Complex care Platoon also completes the Soldier's SRU in-processing within 30 days. Once the Soldier reaches the MRDP, he or she is evaluated for transfer to either the Veteran Track Platoon or Return to Duty (RTD) Platoon. Soldiers who continue to require complex case management and those classified as "high risk" generally will remain in the Complex Care Platoon after they reach MRDP.

(3) Veteran Track Platoon. The focus of the Veteran Track Platoon is completion of the Integrated Disability Evaluation System (IDES) process and preparation for Soldier transition (either separation or retirement). Career and education readiness resources and a VA handoff are used to ensure successful transition.

(4) Return to duty Platoon. The focus of the RTD Platoon is short-term medical management and reconditioning for Soldiers who no longer require complex case management and are expected to return to duty. The RTD Platoon prepares Soldiers to return to their previous unit or to move to their next duty station. Soldiers assigned to the RTD Platoon are expected to return to duty or return to the force (USAR and ARNG).

b. Non-resident SRU Assignment. The SRU commander may consider extenuating circumstances for non-resident SRU assignment. Non-resident Soldiers are managed outside the SRU footprint. Generally, non-resident Soldiers have special circumstances, such as terminal illness, medical conditions requiring specialty care not available in the SRU footprint, or exceptional family/personal circumstances. "Non-resident" is a separate designation from "Remote Medical Management." Non-resident Soldiers are considered "ARCP Soldiers" as they have met entry criteria, and any ARCP Soldier is eligible for non-resident care.

c. The SRU commander assigns the Soldier to the platoon appropriate to the stage of recovery.

d. See chapter 3 for further details on the SRU and the functions of each platoon.

- e. Eligibility criteria for assignment or attachment and transfer to a SRU is outlined in chapter 7 of this regulation.

2–9. Remote Medical Management

Remote medical management is a section in the HQ Platoon under the SRU that manages only the Reserve Component (RC) Soldiers with non-complex medical treatment needs who are entitled to remain on active duty orders for further evaluation or treatment, but do not meet the complex care single entry criteria. The primary focus of RM2 is on medical management to direct progress toward MRDP and return the Soldier to duty or begin the DES process. Soldiers in the RM2 will be attached to the HQ Platoon of the SRU closest to the Soldier's home of record. RM2 Soldiers are not entitled to the full resources of the SRU (for example, CER, Adaptive Reconditioning, and CRP) as they do not meet SRU entry criteria, but they will receive Nurse Case Management and have an assigned Squad Leader. Regular Army (RA) and Active Guard Reserve (AGR) Soldiers are ineligible for RM2.

2–10. Army Recovery Care Coordination

The ARCC offers support to severely wounded, ill, or injured Soldiers, Veterans, and their Families and/or caregivers. Eligible Soldiers and Veterans are assigned a RCC 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 Disability Evaluation System (DES) for one of the categories listed in 2–9a(1) through 2–9a(10) below:

- (1) Blindness or severe loss of vision.
- (2) Loss of limb.
- (3) Severe hearing loss or deafness.
- (4) Burns or permanent disfigurement.
- (5) Paralysis/spinal cord injury.
- (6) Traumatic brain injury.
- (7) 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.
- (11) The director of the RCC Center has the authority to approve an exception to policy to allow management of a Soldier or Veteran not meeting the above criteria on a case by case basis.

b. *Services.* RCCs, along with other staff subject matter experts (SMEs) in critical areas, medical policy, military human resources (HR), finance, employment, education, and VA, provide support to Soldiers/Veterans and their Families and/or Caregivers by navigating and finding Federal, State, and private benefits and resources, such as, but not limited to—

- (1) Facilitating a Servicemembers' Group Life Insurance Traumatic Injury Protection 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 ARCC for Soldiers, Veterans, and their Families and/or caregivers.
- (7) Assistance with coordinating changes to retirement dates.
- (8) Assistance with applying for continuation on active duty (COAD) or continuation 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 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 the ARCC database.

(19) Providing to RCC clients job vacancy information and assistance with resume development for hiring programs and authorities.

(20) Referring Soldiers or Veterans to a designated VA liaison or program manager for educational and coordination of health care.

(21) Providing career guidance to RCC clients.

(22) Referring Soldiers or Veterans to the VA Transition and Care Management Team (TCM) for coordination of health care.

(23) Serving as the lead coordinator in synchronizing the delivery of care, benefits, and services for recovering outpatient SRU Soldiers and their Families and/or caregivers.

c. Army Recovery Care Coordination Locations. Services to eligible Soldiers and Veterans, their Families and/or caregivers are not limited by geography or physical locations or constrained by recovery or rehabilitation timelines. RCCs provide assistance wherever the Soldier or Veteran is located. Soldiers may not necessarily be assigned or attached to a SRU. RCCs are embedded into major Army installations, Army medical centers, VA clinics and VA Polytrauma Medical Centers (Tampa, Florida; Richmond, VA; Minneapolis, Minnesota; Palo Alto, California; and San Antonio, Texas), and some National Guard and Reserve centers.

d. Army Recovery Care Coordination database. ARCC eligible clients, SRU Soldiers and Veterans are tracked and managed utilizing the Army Recovery Care System (ARCS) and/or any other designated system of record. Authoritative data from other sources are fed directly into the ARCS database to empower ARCC Center-staff with the vital information needed to assist a Soldier's or Veteran's situation.

e. Army Recovery Care Coordination Contact Center. ARCC Contact Center's primary focus is to locate and sustain connection with the eligible Soldiers or Veterans. Throughout the Wounded Warrior Lifecycle, many Veterans become transient and lose contact after transition. The ARCC 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 and/or caregivers, and then referring them to the appropriate ARCC staff member. The Contact center personnel also provide administrative support to the ARCC Center during special events and projects.

2-11. Comprehensive Recovery Plan

The Comprehensive Recovery Plan (CRP) 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 SRU cadre assists the Soldier in developing realistic goals, executing those goals, and validating the Soldier's CRP. The CRP is owned by the Soldier and empowers the Soldier to take charge of their own transition with the support of their Family or caregiver and the IDT. The CRP 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. See chapter 3 for further details on the CRP.

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/Resilience. 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.

2–12. Army Recovery Care System

The ARCS is the Army's web-based system of record for documentation of the CRP. It is the common platform for communicating Soldier status across the ARCP. ARCS is incorporated in the CRP and is discussed throughout this regulation and specifically in chapter 8.

2–13. Career and Education Readiness Program

a. The Career and Education Readiness (CER) Program supports the career domain and prepares each SRU Soldier for success in a career that is personally meaningful, rewarding, and enables the Soldier to achieve self-determination and financial independence. SRUs will implement a disciplined and purposeful CER Program by evaluating Soldiers' goals and connecting them with a CER activity that is therapeutic and contributes to their rehabilitation and reintegration. Soldiers will participate in one or more CER activities as soon as they are determined to be eligible. Soldiers' CER activities must be consistent with their career goals and CRP career track.

b. CER eligibility is based on two distinct evaluations made by the M2 and SRU commander which will be documented in the ARCS.

(1) The medical evaluation must conclude that the Soldier is medically, emotionally and physically ready to participate in a CER activity while continuing medical treatment. The SRU NCM in collaboration with the IDT is responsible for coordinating the evaluation of CER eligibility with all members of the IDT. The SRU NCM is also responsible for documenting the decision in the CER Tab of ARCS.

(2) The SRU commander's evaluation must conclude that the Soldier demonstrates the initiative and self-discipline required to participate in a CER activity. The SRU commander is responsible for the CER eligibility evaluation and the SL is responsible for documenting the decision in CER Tab of ARCS. CER is further discussed throughout the CRP in chapter 3 and worksite selection is discussed in chapter 7 of this regulation.

c. Soldiers are deemed ineligible from CER participation if one or more of the following long term conditions exist:

(1) The M2 determines the Soldier has a medical prognosis that will not resolve or allow them to participate in CER activities during the projected length of stay at the SRU. The decision must be approved by the SRU commander, and documented by the SRU NCM in the CER Tab of ARCS.

(2) The SRU commander determines the Soldier cannot participate in CER activities due to administrative actions restricting participation for a minimum of 90 days. The SRU commander must review and update the CER eligibility within 90 days of the CER ineligible determination. The decision must be approved by the SRU commander and documented by the SL in the CER tab of ARCS.

(3) A Soldier who becomes ineligible after being determined eligible due to a change in circumstance (for an example, convalescent leave, Uniform Code of Military Justice (UCMJ), and so forth). The reason(s) for ineligibility status will be documented in ARCS. After being determined ineligible, CER eligibility must be resubmitted to resume participation in the CER program.

2–14. Adaptive Reconditioning Program

The Adaptive Reconditioning Program helps Soldiers in the SRUs achieve a successful transition through alternate rehabilitation methods with the included guidance of the CRP. An Adaptive Reconditioning Program can offer several adaptive reconditioning activities that supplement a Soldier's recovery. All Soldiers in SRUs 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, 5, and 6 of this regulation.

2–15. Organizational Inspection Program and Staff Assistant Visits

a. Inspections conducted are generally one of two types: a command or staff inspection is characterized by a formal process of inspection, unit corrective action, and follow-up on corrective actions as needed. Although most inspections will be planned in advance, some may be "no-notice" inspections. A Staff Assistant Visit (SAV) is a more informal process and may either be directed by higher headquarters or requested by a unit commander.

b. 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 AR 1–201, this regulation, and MEDCOM policies on Command OIP. OIPs and SAVs are further discussed in paragraphs 7–37 and 7–38.

2–16. Soldier and Family Assistance Centers

a. SFAC services are outlined in AR 608–1 and in paragraph 2–26 of this regulation.

b. SFAC services are non-clinical services to the SRU Soldiers, their Family members, and or other support personnel (for example, non-medical attendants). SFACs were originally designed to be co-located where there is an operational SRU. In order to optimize the workforce during times of reduced SRU Soldier population and challenging fiscal constraints, many of the garrison commanders opted to allow SFAC services to be conducted in conjunction with Army Community Services operation.

c. SFAC services will be provided at a site convenient and accessible to the SRU Soldier or Family member, typically at a facility within the SRU footprint.

Section III

Roles and Responsibilities within the Army Recovery Care Program

2–17. Regional health command

The RHC provides MC, logistical, fiscal, legal, chaplain, and communications coordination and support to SRUs. The Commander, RHC will—

- a.* Provide oversight of all SRUs in their region and the implementation of the ARCP.
- b.* Conduct SAVs to all SRUs within the region and provide personnel to assist DCS–ARC with OIPs.
- c.* Ensure all SRUs are appropriately staffed.
- d.* Ensure all SRUs have the appropriate facilities to do their mission.
- e.* Ensure all SRUs have an ISSA in place with their installation.
- f.* Serve as the supported command synchronizing SRU operations.
- g.* Synchronize the efforts of ARNG Directorate, OCAR, and other agencies in support of SRU operations.
- h.* Execute and implement medical standards and ARCP policy to support SRU 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 ARCP.
 - j.* Manage and provide manpower and funding requirements to support SRU operations.
 - k.* Maintain ownership of SRU dedicated assets, tasking authority, and funding responsibility.
 - l.* Identify, monitor, and analyze trends and conditions affecting timely and efficient DES processing for Soldiers assigned to SRUs.
 - m.* Ensure MTFs provide medical, personnel, logistical, and finance support for SRU operations.
 - n.* Attend annual SRU town halls with Soldiers and Families and/or caregivers.
 - o.* Attend annual SRU town halls with cadre.
 - p.* Provide oversight of SRU Soldiers within the DES process. Approve or disapprove continuation in the ARCP for all Soldiers that have been in the program for more than 270 days without entering into the DES process.
 - q.* Develop and conduct training for SRU Soldiers and cadre (see chap 12).
 - r.* Exempt SRU cadre staff from PROFIS, medical augmentee, and individual assignments. Exceptions apply (see chap 7).
 - s.* Ensure non-SRU commanders at all level do not task SRU cadre for collateral duties (for example staff duty officer, staff duty NCO, charge of quarters, financial liability investigation of property loss (FLIPL), funeral duties, and so forth) (see chap 7 for additional details).
 - t.* Ensure SRU commanders utilizing Soldiers in the ARCP to perform unit level tasking comply with chapter 7 of this regulation.
 - u.* Coordinate with Soldier Transfer and Regulating Tracking Center (STARTC) and resolve any Soldier transfer issues that negatively impact the Soldier’s movement between SRUs.
 - v.* Ensure designated MTF TOL representative designate personnel by roles who will be authorized to release information to unit surgeons and/or unit command officials.
 - w.* Ensure all SRU 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) and Department of Defense Manual 6025.18–R.
 - x.* Monitor policy execution and track risk levels and appropriate mitigation plans across their commands (see chap 4).
 - y.* Integrate RCCs under the operational control of the SRU commander by ensuring RCCs provide support and lead coordinators are trained and embedded in the SRU operation as part of the IDT.
 - z.* Establish a Program Budget Advisory Committee to review SRU over hire position requests based on End Strength Target Distribution Plan.
 - aa.* Approve or disapprove SRU over hire requests.

2–18. Regional Health Command Recovery Care Office

The RCO provides staff assistance to support the SRUs in the areas of MC, HR, and M2 of SRU Soldiers in the RHC area of responsibility. RCO duties include but are not limited to the following:

- a.* Facilitate the execution of the ARCP and ensure SRU Soldiers receive appropriate medical care and services.
- b.* Advise RHC commanders on policies and issues related to the ARCP.
- c.* Support SRUs to ensure compliance with ARCP policies and procedures.
- d.* Serve as the principle element for SRUs in ARCP issues, taskers, and information flow.
- e.* Monitor and ensure appropriate staffing ratios are within standards.
- f.* Conduct SAVs in SRUs.
- 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 the office of the DCS–ARC on SRU issues.
- i.* Collaborate with MEDCOM STARTC, other RHCs, ARNG, OCAR, RA Units, and the office of the DCS–ARC on patient movement, entry, and exit matters.
- j.* Collaborate with RHC clinical operations to ensure enhanced access to care standards for Soldiers are met.
- k.* Coordinate and participate in organizational inspections of SRUs to identify risks and vulnerabilities, to provide recommended course of action, and to ensure standardized best practices across all SRUs in accordance with paragraph 7–37 of this regulation.
- l.* Coordinate and facilitate meetings between RHC, the office of the DCS–ARC, and SRUs.
- 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, OCAR, ARNG, and support groups.

2–19. Designated military treatment facility Triad of Leadership representative

Designated MTF TOL representative will—

- a.* Provide mission command to SRUs and provide oversight of all medical and administrative care of Soldiers assigned to the SRUs.
- b.* Provide oversight to SRU activities and the implementation of the ARCP.
- c.* Ensure the SRU is appropriately staffed, to include direct support clinical personnel as needed.
- d.* Assist with the development of an ISSA to support SRU functions with garrison.
- e.* Attend at minimum, semiannually, SRU town halls with Soldiers, Families, and/or caregivers.
- f.* Conduct, at minimum, semi-annual town halls with SRU cadre.
- g.* Provide oversight of SRU Soldiers within the DES process. Approve or disapprove continuation in the ARCP for all Soldiers that have been in the program for more than 180 days without entering into the DES process.
- h.* Ensure barracks inspections are completed monthly.
- i.* Coordinate with TRICARE Management Activity and the DVA to optimize access to care to SRU Soldiers being released from active duty or separated from the Army.
- j.* Exempt SRU cadre staff from PROFIS, medical augmentee, and individual assignments. Exceptions apply (see chap 7).
- k.* Ensure non-SRU commanders at all level do not task SRU cadre for collateral duties (for example, staff duty officer, staff duty NCO, charge of quarters, FLIPL, funeral duties) (see chap 7 for additional details).
- l.* Ensure SRU commanders utilizing Soldiers in the ARCP to perform unit level tasking comply with the exemption from collateral duties in chapter 7.
- m.* Ensure SRU providers are trained and have access to eProfile system, and ensure that all profiles (both temporary and permanent) are entered into eProfile.
- n.* Ensure enhanced access to care standards are met for SRU 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).

2–20. Soldier Recovery Unit commanders

SRU commanders 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.* Provide regular updates to RC Soldiers’ units of assignment for both SRU and RM2 Soldiers.
- h.* Provide a network of Triad of Care and TOL working together to ensure advocacy for SRU Soldiers, continuity of care and a seamless transition back to the force and/or to Veteran status.
- i.* Ensure the IDT works 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, 4, and 6.
- 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 CRP. (See AR 600–9 and/or chap 7, 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. 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 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.
- n.* Ensure Soldiers participate in CER activities once CER eligibility is determined.
- o.* Develop policy to ensure at a minimum, SRU SLs contact Soldiers’ worksite supervisor monthly and visit the worksite quarterly.
- p.* Ensure all performance data (whether submitted manually or by way of ARCS) reported to higher authorities is accurate and factual.
- q.* Direct and support the Commanders’ Safety Program that incorporates risk management and accident prevention to reduce accidents, illnesses, and worker compensation costs in accordance with AR 385–10.
- r.* Provide clear guidance regarding expectations for the personal conduct of Soldiers and outline Soldier and SRU cadre responsibilities in supporting the CRP, including all clinical and non-clinical care.
- s.* Maintain good order and discipline, and enforce all applicable ARs and policies.
- t.* Seek IDT input on the impact, if any, of prescribed medications and the Soldier’s medical condition on performance when considering disciplinary action for misconduct.
- u.* Consult with servicing judge advocate as part of the disciplinary process.
- v.* Coordinate activities that are supported in the ISSA with garrison and MTF.
- w.* Develop a health and welfare inspection program that provides for the safety of Soldiers and their Families and/or caregivers and is respectful to Soldiers’ healing needs.
- x.* Ensure SRU cadre staff are exempt from PROFIS, medical augmentee, and individual assignments. (Exceptions apply in chap 7.)
- y.* Ensure SRU Soldiers and cadre complete DD Form 2796 (Post Deployment Health Assessment (PDHA)), DD Form 2900 (Post Deployment Health Re-Assessment (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 chap 7).
 - aa.* Ensure the command verifies with STARTC the requirements to transfer a Soldier between SRUs.
 - bb.* Ensure all patients arriving by air evacuation receive an initial clinical review within 24 hours of landing.
 - cc.* Conduct quarterly briefs to O–6 level command teams on their installation to ensure all SRU eligible Soldiers get the opportunity to receive the right level of care and to ensure leaders understand the ARCP entrance criteria. SRU commanders will maintain a memorandum for record of completed briefs which will be reviewed during SRU organizational inspections. Possible briefing venues include unit status reports (USRs), officer professional development (OPD), and desk side. At a minimum, the brief will include the following information:

- (1) Entry and exit criteria (see chap 7 of this regulation).
 - (2) ARNG and USAR Soldiers eligible for entry into the ARCP on 10 USC 12301(h) orders; USAR Soldiers eligible for medical evaluation and RM2 on 10 USC 12301(h) orders.
 - (3) Benefits of assignment to a SRU for the Soldier, unit, and Army.
 - (4) ARCC overview of benefits, eligibility criteria, number of eligible Soldiers from the unit(s) being briefed, and number of Soldiers enrolled from the unit(s) being briefed.
 - (5) Number of Soldiers from the unit(s) being briefed that are assigned to the SRU.
 - (6) Common Soldier issues for Soldiers such as medical evacuation, awards paperwork, evaluations, LODs, 179-day limit for COMPO 1 Soldiers.
- dd.* Ensure the executive officer and/or designate staff member monitors and reports the USR.
 - ee.* Ensure all clinical and non-clinical cadre that have access to Soldiers PHI are trained and are in compliance with the HIPAA standards.
 - ff.* Designate personnel by roles who will be authorized to release information to unit surgeons and/or unit command officials.
 - gg.* Ensure the SRU's 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.
 - hh.* Ensure profiles written by authorized personnel in accordance with AR 40-502 are adhered to by cadre and Soldiers (see para 6-7 for additional instructions).
 - ii.* Ensure all required data and documents are entered in ARCS for all SRU Soldiers in the prospective command.
 - jj.* Allow only medications 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.
 - kk.* Ensure medications are stored in either the original labeled container or a dispensing container specifically and professionally designed and approved for the purpose of dispensing medications.
 - ll.* Ensure medications are taken or administered according to the label instructions.
 - mm.* Ensure disposal of unused or unneeded medications is conducted according to applicable law and policy.

2-21. Headquarters Platoon

- a.* Headquarters Platoon 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 SRU; for the intake of Soldiers assigned to the SRU within five training days of assignment; and for the medical evaluation and medical management of 10 USC 12301(h) orders for USAR Soldiers attached to the SRU for RM2.
- b.* 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 SRU, or attached temporarily to the HQ platoon. In all cases, action will be initiated to return to duty (RTD), release from active duty (REFRAD), or attach or assign to the SRU within 30 days of the report date.
- c.* Evacuated Soldiers are not automatically considered a SRU Soldier. The TOL will determine if the patient is qualified for entry into the SRU based on the nature of the clinical status, treatment, recovery, and rehabilitation. This applies to all SRU Soldiers regardless of the means or mode of arrival.
- d.* Ensure in a timely manner, Soldiers arriving for medical evaluation are appropriately evaluated, prescribed the required care, transitioned back to their unit, or placed on required 10 USC 12301(h) orders.
- e.* Provide mission command of all medical TDY Soldiers in accordance with AR 40-400.

2-22. Soldier

- a.* The ARCP is a voluntary program for RC Soldiers and can be directed for COMPO 1 Soldiers. Regardless of component, non-compliance with any aspect of transition may result in removal from the program, administrative separation, or UCMJ action. Soldiers own their CRP and are empowered to take charge of their own transition with the support of their Families and the IDT.
- b.* Soldiers will—
 - (1) Begin their CRP within the first 45 days of their report date to a SRU and will be accountable for establishing and meeting their goals. At the commander's discretion, Soldiers on 10 USC 12301(h) orders may begin this process if it is likely that Soldier is eligible to enter into the ARCP.
 - (2) Complete all of the requirements related to their CRP 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 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 (examples include: unit formations, assigned worksite educational program or internship, and 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 Primary Care Manager (PCM) must approve the use of all over-the-counter medications (to include herbals, supplements, and energy drinks), 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, in a manner contrary to their intended medical purpose, 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. Further, dispose of unused or unneeded medication according to applicable law and policy.

(7) Obtain SRU medical provider referral and approval prior to scheduling initial or specialty medical or surgical appointments.

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

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

(10) Make daily contact with SL and weekly contact with SRU NCM.

(11) Comply with 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.

(12) When eligible, participate and be actively engaged in a CER activity (internship, education and training, credentialing, apprenticeships Remain-in-the-Army work assignments (RIAWA), and on-the-job-training) that align with their track and career goal(s). Soldiers will treat these locations as their place of duty.

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

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

(15) 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.

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

(17) Remain subject to and are expected to adhere to all ARs, customs and courtesies, administrative policies, the Joint Ethics Regulation (JER), and the UCMJ.

(18) Attend formations, town halls, and other SRU-sponsored activities.

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

(20) Engage SRU leadership on issues as early as possible.

(21) Obtain medical clearance authorization and commander's counseling on all therapeutic and leisure trips and/or events (see chap 5 for further details).

(22) Maintain all individual medical readiness requirements.

(23) 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.

(24) Attend all DES appointments, if in the DES process.

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

(26) Comply with all individual medical readiness requirements and complete DD Form 2796 and DD Form 2900, as required.

(27) Incorporate TSG's Performance Triad into their daily routine. The components of the Performance Triad include activity, nutrition, and sleep. Soldiers are required to participate in Adaptive Reconditioning per their individualized plan developed by the PT and should strive to improve their sleep and their nutrition habits.

(28) Be accountable and actively participate in meeting their goals outlined in their individual CRP.

(29) Do not solicit for donations in an official capacity.

2–23. Triad of Care

The Triad of Care, which includes the SRU medical provider, SRU NCM, and 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, support needs and disposition, and develops and implements a CRP. Specific roles and responsibilities are outlined throughout this regulation. In general—

a. The SRU medical provider (primary care physician, physician assistant, or nurse practitioner) facilitates the Soldier's, holistic medical recovery plan, collaborates with medical specialists and the Soldier's PCM to determine recovery needs, timeliness, and occupational ability; updates profiles; and oversees all Soldiers' care during their time in the SRU. The relationship developed between the Soldier and their SRU medical provider is the basis for successful recovery. The SRU medical provider's medical coordination, review of Soldier's records, and knowledge of Soldier duties are instrumental to determining the Soldier's prognosis to move to platoons of either Return to Duty or Veteran Track. The SRU medical provider 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 (RTD or REFRAD) or referred to a MEB.

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

c. The SL and/or PSG is accountable for the personal conduct of the SRU Soldier. The NCO works as part of the Triad of Care providing for the care of Soldiers and their Family and/or caregiver. 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 their report date 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 per their individualized plan developed by the PT and should strive to improve their sleep and their nutrition habits.

(4) Maintains accountability of Soldiers' whereabouts and their equipment. Links Soldiers to SFAC for services and benefits. Soldiers may also use local administrative services and benefits through their National Guard services, their regional support centers, and veteran organizations.

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

(6) Inspects the condition of Soldier's billeting, clothing, and equipment (not applicable to RM2).

(7) Keeps immediate leadership informed on Soldier's medical status and requirements.

d. The Triad of Care ensures CER eligible Soldiers treat their CER worksite as a place of duty. 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. The Triad of Care completes mandatory PHI and the HIPAA training upon the reporting date to the SRU and annually thereafter.

f. Triad of Care 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 CRP are outlined in chapter 3 of this regulation.

2–24. Lead coordinator

Lead coordinator was implemented by DOD to ensure coordination of care among all services in the areas of medical and rehabilitation care, benefits, and other services. In the SRUs, the RCC is designated as the lead coordinator for outpatient SRU Soldiers. The lead coordinator for inpatient Soldiers is the SRU NCM. The Lead Coordinator serves as the primary point of contact for Soldiers, their Families, and/or caregivers for coordination of entitlements, services, and benefits; identifies potential conflicts; and facilitates resolution within the IDT. The respective RHC will ensure lead coordinators are trained and embedded as part of the IDT (see paragraph 2–16). The lead coordinator will—

a. Ensure a process is established to initiate and complete the lead coordinator checklist (LCC) on all SRU Soldiers in the Complex Care and Veteran Platoon. The lead coordinator checklist is located at <https://rcpss.csd.disa.mil/rcpss/documentlibrary/browse.action?directoryid=141>; where it can be obtained with appropriate permissions.

- b.* Ensure LCC is reviewed periodically, at a minimum, upon discharge from the ARCP, transfer, or upon significant change in Soldier's condition.
- c.* Ensure accountability of care and information about the course of the recovery to date and details are accomplished with person-to-person communication between transferring and receiving lead coordinators and data is annotated in the LCC.
- d.* Provide statistical data on the program as directed.

2–25. Triad of Leadership

a. The TOL (SRU Commander/Command Sergeant Major (CSM), designated MTF TOL representative/CSM, and the SRU installation's Army Senior Commander/CSM) will—

- (1) Execute SRU entry, management, and exit policy.
 - (2) Establish an appropriate process to review, approve, and track requests for entry and exit within SRUs. The TOL will determine the following dispositions:
 - (a)* Assign or attach Soldiers that meet eligibility criteria to a SRU.
 - (b)* Consider assignment of a former SRU Soldier as SRU cadre.
 - (c)* Disapprove SRU entry for Soldiers who have routine medical requirements that do not meet entry criteria.
 - (d)* Evaluate and determine when Soldiers depart the SRU 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 their report date to the unit.
 - (f)* Meet the Army-directed timelines of 14 training days for the processing of SRU entry packets and 7 training days for Reserve Component Soldiers and Soldiers not assigned to SRU installations.
 - (3) Maintain good order and discipline in SRUs, 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 or command judge advocate as part of the disciplinary process.
 - (6) Ensure Soldiers not meeting the ABCP 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 CRP. 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) 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 SRU is the first O–6 commander in the chain of command, normally the designated MTF TOL representative. 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, conducting written counseling with corrective training, or initiating separation action. Enlisted administrative separation during DES processing will be in accordance with AR 635–40, DA Pam 635–40, AR 635–200, AR 600–8–24, AR 135–78, and AR 135–175.
 - (9) Create an alcohol-free zone around SRU 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 5).
 - (11) Establish a CER program and ensure CER eligible Soldiers are placed in a CER activity that supports their CRP career track and career goals.
- b.* Roles and responsibilities are further defined in chapters 3 and 4.

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). FRSA's responsibilities and services are described in AR 608–1, and in paragraph 2–25 and chapter 10 of this regulation. FRSAs will—

- a.* Execute well-being calls to Families of SRU Soldiers, and by referring Family members to services located at the SFAC and ACS.
- b.* Provide various command sponsored Family events and FRG activities.

2–27. Religious and spiritual care

Religious support and spiritual care are important components of the ARCP. A holistic approach to health care requires that chaplains and other spiritual caregivers sponsored by a chaplain be integrated into the transition process (see paragraph 2–25 of this regulation).

Section IV

Command Communication with Soldiers

2–28. Army goals

The Army seeks to provide a SRU 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 exhibit these attributes, individual Soldiers' healing and transition are uninhibited, and they turn to their chain of command as an avenue to address their issues instead of turning to external resources.

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 CRP 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.

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

c. In accordance with AR 600–20, commanders will establish an open door policy within their commands that allows SRU 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

Unaccompanied Housing and Lodging Assignment and Termination, Facility Maintenance, Inspection Standards, Inventory, and Reporting

2–30. Policy

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

2–31. Unaccompanied housing and lodging assignment

a. Commanders will ensure arriving Soldiers are welcomed professionally and accommodated properly in SRU barracks and other Government-owned or -leased lodging facilities in accordance with the Army Barracks Management Program (ABMP) Handbook or current Barracks Management Program as executed by the Garrison Directorate of Public Works (DPW) Housing Division.

b. At locations where the Garrison Housing Manager maintains responsibility for Soldier assignments and terminations, the SRU is to be proactive and work in partnership with the housing manager to identify appropriate room assignments for SRU Soldiers and authorized caregivers. This includes customer focused room assignment procedures to ensure Soldiers are assigned to lodging commensurate with their personal and medical requirements, expected duration of treatment, dependency status, authorization of a non-medical attendant, component and pay grade, and the staff is courteous and responsive to unique furniture arrangement needs. Focus is to be given to the change in environment for the Soldier, Family member, and/or authorized caregiver.

c. A positive first impression is essential and every effort must be made to allow Soldiers, their Families, and/or caregivers to focus on their well-being and transition goals. The following related issues at a minimum should be addressed in the command created policies and procedures:

- (1) Assign a Battle Buddy and consider Battle Buddies assigned to the same barracks apartment.

(2) Assign SRU Soldiers with authorized NMAs into apartments configured as two bedrooms and two bathrooms to allow the NMA to have a private bedroom and bathroom.

(3) Appropriately assign SRU Soldiers to rooms commensurate with the SRU Soldier's risk assessment, medical needs, authorization for a NMA, and possession of a certified service animal.

(4) Work with S-1, to ensure that the Soldier, Family, and/or caregiver understand the entitlement to Basic Allowance for Housing as it relates to assignment of a barracks apartment. This will differ from SRU Soldier to SRU Soldier depending on the issues, to include component, rank, assigned or attached, accompanied or unaccompanied, and so forth. SRU barracks are designated as unaccompanied housing. As such, occupants are assigned a single bedroom within an apartment. Apartments may be shared with another SRU Soldier based upon space and amenity requirements identified in AR 420-1, and may be shared with authorized (on orders) caregivers. SRUs are authorized to allow SRU Soldiers a single visitor, 18 years of age or older, for up to 14 nights.

2-32. Assignment of Soldiers to housing and lodging

Commanders must ensure SRU Soldiers' in-processing procedures, as they relate to provision of adequate housing or lodging, are efficient, consolidated, customer service focused, and reflect a positive command climate. Commanders must coordinate with the M2 staff to ensure a smooth transition occurs between inpatient and outpatient environments. This transition must be rehearsed and must support the needs of the Soldier and any non-medical attendant and/or Family requirements. These procedures should apply to Soldiers and their Families and caregivers initially entering into the ARCP and those Soldiers at vulnerable points of transition (from inpatient to outpatient, Soldiers returning from treatment in the ASAP, SRU to RM2, RM2 to SRU, and so forth). The following related issues at a minimum will be addressed in the command created policies and procedures:

- a. Minimize SRU Soldier moves within the barracks.
- b. Accommodate SRU Soldier needs for special medical service requirements to address accessibility, cognition, visual and auditory issues, burns, and other physical limitations.

2-33. Maintenance standards

SRU Commanders must employ proactive Government owned and leased unaccompanied housing problem identification and ensure deficiencies do not distract SRU Soldiers from their recovery and rehabilitation. Procedures to address unaccompanied housing problems affecting quality of life must include a decision point to move the affected SRU Soldier to alternate lodging. This plan must be coordinated with the Garrison DPW and the Garrison Emergency Control Center operations. Soldiers should be the best source of information for deficiencies but cannot be the only method employed to identify and report problems with facilities. SRU Commanders must ensure that policies identify how maintenance standards will be enforced. The following related issues at a minimum should be addressed in the command created policies and procedures:

- a. Ensure 1SGs are accountable for health, welfare, and security of all assigned Soldiers and all personnel residing in barracks.
- b. Command teams are accountable for appropriate work order tracking and resolution. Appoint a barracks NCO or an individual on each floor for Soldiers to report deficiencies to and designate barracks NCO to report, manage, and track completion of all work orders reported to the DPW.
- c. Assign charge of quarters.
- d. Establish rules and procedures for barracks NCO to report unresolved deficiencies to 1SG for further action with Garrison DPW.
- e. 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 the installation DPW, however commanders must ensure the supporting installation support team is aware of the enhanced necessity and sensitivity toward correction of SRU 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 may require faster attention from facilities personnel than a standard barracks).
- f. Establish standards that ensure good order and discipline in the barracks and that ensure the barracks are maintained at all times.
- g. Ensure a contingency plan is in place for potential Soldier relocation while significant maintenance problems are addressed.

2-34. Inspection standards

Inspections must be thorough, involve the chain of command, and consider seasonal impacts (for example, heating, cooling, and hot water). Relying on room sampling or another organization's inspection program is not sufficient to

ensure that Government owned and leased facilities housing for SRU Soldiers, their Families, and authorized caregivers are at the standard of a SRU Soldier's entitlement. Commanders must know the inspection process and areas of emphasis of the various lodging facility inspections, and must look for and address gaps.

a. At a minimum, all Government owned and leased facilities housing for SRU Soldiers, Families, and authorized caregivers must be inspected monthly by the chain of command and at least weekly by the SL and/or PSG. Inspections of privatized housing and lodging containing SRU Soldiers, Families, and authorized caregivers should be accomplished only with prior coordination with the project partner or owner. Random room checks and walk through between inspections are highly encouraged.

b. Inspections must determine whether Soldiers, where applicable, secure their prescription and non-prescription medications in their original containers in a safe or other locked storage container when not being taken or administered.

c. SRU commanders will assist with Congressionally mandated annual inspections of Government owned and leased facilities housing when occupied by SRU Soldiers. These inspections are conducted by the MEDCOM Inspector General for each RHC and IMCOM using established standards.

2–35. Inventory Management

As the SRU Soldier population fluctuates at each SRU location, commanders must remain cognizant of the need to optimize the utilization of Government owned and leased facilities for housing SRU Soldiers, their Families, and authorized caregivers. The need for and utilization of these facilities must be coordinated with the Garrison DPW Housing Division. Garrison commanders are tasked with determining the SRU Unaccompanied Housing (UH), facility category code 72112, space requirements. In coordination with MEDCOM and SRU leadership, garrison commanders have the responsibility to recommend to the installation SC the allocation of SRU barracks to be diverted to Permanent Party UH, facility category code 72111, in order to maximize UH utilization rates across the garrison. Other requests for conversion or diversion of SRU facilities must be coordinated with MEDCOM at installations with an inactivated SRU, prior to submission for approval. Garrisons will process requests for conversion or diversion of all SRU facilities. Diversion of a SRU Barracks is limited to Permanent Party Barracks, facility category code 72111. No other category code is authorized for diversion without solid justification and approval. Leasing of facilities to house SRU Soldiers, their Families, and authorized caregivers is the responsibility of Garrison DPW Housing Division and not the SRU, the MTF, RHC, or MEDCOM. Military construction provided new SRU campuses with barracks designed and constructed specifically for the SRU Soldier, Family, and authorized caregiver population. SRU Barracks are authorized for occupancy of SRU Soldiers and authorized caregivers only. At no time are Families authorized occupancy in SRU Barracks as these Barracks are designated as Unaccompanied Housing. Every effort should be made to optimize the occupancy of barracks constructed for SRU Soldiers. Commanders must ensure that policies and procedures are in place to maintain command and control responsibilities and ABMP, or current Barracks Management Program, responsibilities of the barracks in the event that through approved diversion requests, personnel other than SRU Soldiers are assigned to these barracks. These following related issues at a minimum should be addressed in the SRU commander's policies and procedures:

a. Ensure that SRU Soldier and authorized caregiver assignments to and terminations from barracks are entered into the enterprise Military Housing database within 24 hours of the occurrence.

b. Participate in periodic ABMP, or current Barracks Management Program, meetings with the Garrison DPW Housing Division to foster a good working relationship and assist with the understanding of the nuances associated with housing the SRU Soldier and authorized caregiver population.

c. Employ strong risk mitigation measures through the development of a safety or security plan, for when non-SRU Soldiers are assigned to SRU Barracks after diversion request has been approved by AMC, and to address command and control of the SRU Soldiers. This is paramount in maintaining the safety of this vulnerable population. The safety or security plan is developed by the SRU in coordination with MEDCOM and the garrison, and requires the SC's concurrence.

d. Ensure a non-alcohol policy is in place for SRU barracks. Designate SRU Soldier 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 be subject to UCMJ actions. SRU Soldiers are a potentially vulnerable population with many high-risk Soldiers with diagnoses and prescribed medications that should not be combined with alcohol. Having non-SRU Soldiers that do not have alcohol restrictions housed in SRU designated barracks or housing may pose a threat to SRU Soldiers' well-being recovery and rehabilitation.

e. Ensure Family members and or authorized caregivers are familiar with barracks policies. SRU Soldiers may require a NMA to provide assistance with activities of daily living. Often times, the NMA is the spouse or parent that is permitted to live in the barracks with the SRU Soldier. NMAs are not familiar with Army policies that govern

barracks. Living in the same barracks as Soldiers who follow different rules than SRU Soldiers may cause confusion and anxiety among the NMAs.

f. Non-SRU Soldiers who are entitled to on-installation, Government-owned, Unaccompanied Housing, who also require American with Disabilities Act-Architectural Barriers Act (ADA-ABA) accessible or fully compliant barracks space shall be considered appropriately housed in the SRU Barracks Management Program. Non-SRU Soldiers residing in SRU Barracks, will be notified upon assignment to the SRU Barracks, in writing, that they may be required to relocate on short notice to accommodate a SRU Soldier in the event a housing requirement exists and there are no alternative quarters available that would meet the needs of the SRU Soldier.

2-36. Reporting requirements

a. Commanders must establish and rehearse commander's critical information requirements (CCIRs) 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 SRU, including Government owned or leased housing, clinical or administrative support (for example, SFAC) activities to MEDCOM as a Commander's Critical Information Requirement item.

b. The RHC Inspector General will inspect quarters and housing facilities under their jurisdiction annually, and will—

(1) Submit a copy of the annual report of their inspection to the post commander, the commanding officer of the hospital affiliated with the facility, TSG, the SECARMY, and other authorities as appropriate.

(2) Post each report of inspection on the respective RHC's Internet website.

(3) Provide the office of the DCS-ARC a copy of their annual inspection dates and findings.

Section VI

Medical Command Medical Assistance Group Ombudsman Program

2-37. 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 MTFs and serve as a liaison between MEDCOM, the Soldier and Family member, the designated MTF TOL representative, and the SRU commander, acting as a communicator, facilitator and problem solver. Ombudsmen have a collaborative relationship with the MTF Patient Advocacy Office and work closely with the MEDCOM Medical Assistance Group, to assist with the resolution of issues that come through the Army Wounded Soldier and Family Hotline.

2-38. Ombudsman Program

a. The Ombudsman Program provides assistance to all Soldiers and their Families 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 all Soldiers and their Families as well as any other Soldiers seeking assistance.

(2) For Soldiers assigned or attached to a SRU, Ombudsman is expected to assist with any issue, medical and nonmedical, for which the SRU 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 tenets of the ARCP.

(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 for commanders and senior leaders.

(12) Attend meetings, conferences, and town hall sessions.

(13) Keep local commanders informed as to the type of cases that are being worked and how resolution was or will be achieved, as well as any trends or patterns that have 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 Recovery Plan

3–1. Policy

a. All Soldiers assigned or attached to a SRU will begin the CRP process upon the reporting date to a SRU. The CRP is a dynamic living plan of actions that focuses on the Soldier's future. The CRP uses six domains which include 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 2–10 of this regulation.

b. As owners of the CRP, 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 2–22.

c. The Triad of Care (see para 1–6c) will lead the IDT supporting the Soldier with training, guidance, and counseling.

d. The IDT, cadre, staff, and Soldier will use the ARCS, counseling records, the MODS–WT module, the PBH–TERM and AHLTA, as appropriate, to document all key aspects of the CTP. ARCS is HIPAA compliant. However, entry of PHI into ARCS should be limited to the absolute minimum necessary.

e. SRU commanders will ensure weekly Triad meetings are held to discuss individual Soldiers' needs, risk assessments, risk mitigation plans, and so forth (see chap 4, section I for risk assessment and mitigation). Required tasks are detailed in paragraph 3–9.

3–2. Comprehensive Recovery Plan structure

a. The CRP applies only to Soldiers who have entered the program through the TOL. The CRP does not apply to Soldiers in the RM2 or on medical evaluation orders or active duty Soldiers in a medical TDY/evaluation status. Soldiers, regardless of CRP track, will complete six CRP processes that include: in-processing, goal setting, transition review, rehabilitation, reintegration, and post-transition. Each process has specific stand-alone requirements that all WTU Soldiers must meet. The processes serve as components of the CRP system which overlap, interrelate, and interconnect. Soldiers utilize assessments, goal setting, and transition review throughout their CRP, and receive support from the SRU IDT to ensure that the plan is resourced and timely managed.

b. All Soldiers will complete in-processing within 30 days of their report date to a SRU, which includes an initial self-assessment, Phase I goal setting training, CRP track selection, and initial scrimmage. These actions will be documented using IDT counseling records, ARCS, PBH–TERM, and AHLTA. The initial self-assessment will be initiated within 24 hours of the report date to the SRU; completed and documented within the first 7 days of report date to the SRU.

c. Redeploying Soldiers on evaluation orders that are not yet approved by the TOL for entry into the ARCP, may have their in-processing requirements abbreviated by their SRU commanders until the Soldier's attachment or assignment to the SRU is established.

d. Soldiers on section 12301 (h), Title 10 orders for medical evaluation and RM2 will complete risk assessment and mitigation, as well as intake appointments with a SRU medical provider, SRU NCM, and the SRU LCSW. Further in-processing will continue upon formal acceptance into the SRU by the TOL.

3–3. Intake and In-processing

a. Intake occurs in the HQ platoon upon arrival to the SRU and lasts up to five training days. Intake consists of clinical and non-clinical assessments and risk mitigation to ensure there is a plan in place to resolve the basic needs of the Soldier and their Family. (See chap 4, sec I, for risk assessment and mitigation.) Soldiers eligible to enter into the ARCC will be supported by an RCC throughout the process, starting with in-processing. Assessments will be documented in ARCS, 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' risk assessments (within 24 hours of the report date to the WTU), culminating with the successful completion of the initial scrimmage.

c. Soldiers transferring into the SRU while inpatient will be administratively in-processed into MODS and ARCS for accountability and documentation of care management activities. Soldiers will be seen for the initial risk assessment within 24 hours of discharge from an inpatient facility and will complete in-processing requirements at this time. (See chap 4, sec I, for risk assessment and mitigation.)

d. Soldiers entering RM2 from outside the SRU evaluation process will complete in-processing at the SRU. SRU commanders will ensure that all Soldiers in RM2 understand their duties and responsibilities as well as the capabilities and support expected from RM2 cadre.

e. Once intake is complete, Soldiers meeting the SRU eligibility entry are generally transferred to the Complex Care Platoon to complete their in-processing. The SRU in-processing checklist will be completed within 30 days.

f. SRU commanders may waive some or all of the initial requirements of in-processing for Soldiers in an inpatient status.

3–4. Goal setting

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

b. Phase I goal setting begins upon entry in the Complex Care Platoon and will be completed within 21 days, and facilitated by an OT or COTA. Phase I goal setting is more individualized to the Soldier, and it establishes a foundation of functional and occupational goals to be reviewed during the initial scrimmage (on, or before day 30). All goals must be documented in ARCS.

c. Phase II goal setting will be facilitated after the initial scrimmage, between days 31 to 90, by Comprehensive Soldier and Family Fitness Master Resiliency Trainer (MRT) or performance experts. Phase II goal setting affords Soldiers the opportunity to expand their 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 SMART 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. Phase II goal setting completion should be annotated in ARCS and certificate uploaded as an attachment.

3–5. Transition review

Transition review provides the SRU commander and the IDT with opportunities to ensure the Soldier's CTP is on track, the Soldier's concerns are identified and resolved, and the plan is resourced. Minimum attendees at all scrimmages will include: Soldier and their Family, Soldier's SL and/or PSG, SRU LCSW, SSA, OT or COTA, PT or PTA, SRU NCM, company TC (minimum attendance at initial, 90 day scrimmages, and all FTRs), and RCC for all SRU Soldiers unless directed otherwise. The specific tasks of the transition review are:

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

b. Completion of self-assessments within 7 days and follow-up as directed by the commander (at a minimum monthly).

(1) The SL and SRU NCM must validate each self-assessment in ARCS and input validation comments in ARCS for all self-assessment items not in agreement with.

(2) The SL and SRU NCM must document all action plans for red and amber items in ARCS. These action plans must identify the issue, identify a plan to address the issue, designate a facilitator that will be the lead for resolving the issue, and establish a suspense date for completion of the task.

c. Scrimmages include—

(1) Initial scrimmage completed within 30 days of the report date to the SRU. In addition to the minimum required attendees listed above, participants in the initial scrimmage will include, HHC SL and NCM, assigned SL and SRU NCM, the assigned SRU LCSW, SSA, OT or COTA, and PT or PTA.

(2) At 60 days after the initial scrimmage, a 90 day scrimmage is facilitated with SRU commander oversight to validate the transition plan.

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

d. The SRU commander will facilitate a FTR with CSM, executive officer, or operations officer oversight within two weeks of the Medical Retention Determination Point (MRDP) determination to assess the Soldier's progress, status of the transition plan, and the proficiency of the IDT's efforts. The FTR serves to review scrimmage goals, provide Soldiers with a target transition date, finalize their transition plan, and to introduce the transition readiness checklist that will help map Soldiers' final tasks. When a FTR is completed, the scrimmage cycle is reset to occur 90 days after the FTR.

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

(2) The SRU commander, IDT 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 SRU commander and the Soldier. This applies to all FTRs conducted with the Soldier.

3–6. Rehabilitation

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

a. Successful completion of transition readiness requirements includes developing a SFL–TAP Individual Transition Plan (ITP) prior to transition.

b. All Soldiers must participate in adaptive reconditioning activities in accordance with chapter 5, as well as their local command and their IDT 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 SRUs 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 CRP goals.

(2) Therapeutic event must provide a reasonable expectation of a specific beneficial effect on the Soldier's medical condition and outcome. The Soldier's SRU medical provider is the authority for designating whether a given activity is therapeutic. (See chap 5).

c. CER eligible Soldiers will participate in one or more CER activities. Categories of CER activity include: internship, education and training, credentialing, apprenticeships, RIAWA, on-the-job training (OJT), and entrepreneurship. The physical location where a CER activity is conducted is considered a CER worksite. Worksite is defined as "where a Soldier participates in a work activity that aligns with their CRP Track and long term goals" (see chap 7, sec III). Eligibility for CER activity is based upon two distinct evaluations made by the medical team and the SRU commander.

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

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

3–7. Reintegration

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

a. Cadre will initiate ARCP transition readiness checklists no later than MRDP or 180 days prior to anticipated transition date, whichever comes first.

b. No later than 90 days prior to anticipated transition date, cadre will ensure completion of SFL–TAP requirements are documented on a DD Form 2648 (Service Member Pre-Separation/Transition Counseling and Career Readiness Standards Eform for Service Members Separating, Retiring, Released from Active Duty (REFRAD)). This form is signed by the SFL–TAP counselor, Soldier, and SRU commander.

c. Additionally, prior to Soldiers' transition from the SRU, cadre will review with Soldier to ensure all transition readiness requirements (ITP, SFL–TAP, and so forth) are completed and validated by the SRU commander.

d. The SRU NCM and the lead coordinator will coordinate to ensure all eligible Soldiers are referred to VHA.

3–8. Post-transition

Post-transition is the period after a Soldier exits the SRU. During this process, the Soldier is under the mission command of their follow on unit, or the care of the VA while participating in the ARCC if eligible.

3–9. Triad meetings

IDT coordination is paramount to the successful execution of the CRP. The weekly Triad meeting serves as a critical communication link for members of the IDT. The weekly Triad meeting is a meeting in which Soldiers in the SRU

are discussed among the IDT 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 meeting; lower risk Soldiers will be discussed at least monthly and ideally, more frequently.

c. The SRU commander is ultimately responsible for the successful execution of Triad meetings. At a minimum, the SRU commander, SL and/or PSG, SRU medical provider, SRU LCSW, PT or PTA, OT or COTA, SRU NCM OIC, SRU NCMs, TC and RCCs or lead coordinators, 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, and or Ombudsman, should attend as directed or invited by the SRU commander in order to accomplish the objective of effective communication and collaboration. The TC will attend a minimum of one triad meeting per month. 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 IDT will identify:

(1) Soldiers identified as high risk and risk mitigation plans with highlights of any significant life changes (marital separations, divorce, death in the Family, and identification 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) Any Soldier receiving care at a civilian inpatient facility. For Soldiers receiving care at an inpatient BH facility, the SRU 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 SRU commander for their review and resolution).

(5) Soldiers with expired or expiring profiles (this can be accomplished by providing a list to the SRU medical provider and SRU 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 IDT know of the determination (specifically the Soldier's chain of command) prior to notifying the Soldier and their 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 CRP track, and any needed adjustments.

(c) Career and Education Readiness and education plans, schedule, and worksite.

(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 SRU or RM2 assignment.

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

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

3-10. Accountability

Accountability and tracking are accomplished by using standard reporting requirements, ARCS reports, manual CRP data calls, and MODS-WT. Every leader shares responsibility to ensure all appointments and documents are accounted for after each meeting. This assists in de-conflicting appointments scheduled and ensures Soldiers have the information they need to succeed in their individual CRP. The SL will ensure the Soldier completes adaptive reconditioning activities.

a. Daily. The SL will ensure Soldiers attend all formations conducted by the platoon or squad. The only exceptions are those Soldiers with physical activity restrictions annotated on their profile DA Form 3349 (Physical Profile) 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 SRU commander. If a Soldier is high risk, the Soldier must be contacted in accordance with the SRU commander's risk mitigation plan. RM2 SL will make regular calls to Soldiers to verify that they are at their place of duty. This verification establishes accountability.

b. Weekly. The Soldier, with support from their SL and SRU NCM, will maintain and refine their daily schedule and CRP accomplishments. This schedule is an inspectable item by SL and/or PSG. Changes to the Soldier's mitigation plan or the individual Soldier's CRP during periodic CRP scrubs with the Soldier, will be made in ARCS by the SL and the CRP management analyst. The SRU NCM will inform all members of the key IDT of these changes by way of email or telephone. The SRU NCM or the appropriate IDT member is responsible for entering the updates into AHLTA.

c. Monthly. SRU medical provider will ensure the medical care plan for each Soldier is updated. This will be accomplished at the Triad of Care meeting following the SRU medical provider's monthly contact with the Soldier; the Triad of Care will then discuss significant concerns and/or changes to the risk level. Additionally, the SLs will counsel their Soldiers on their performance and review ARCS self-assessment for completeness. This counseling will be documented on a DA Form 4856 (Developmental Counseling Form). SRU SLs and/or PSGs will contact each worksite supervisor monthly and visit the worksite quarterly to assess Soldiers' work performance and participation. The RM2 SL will contact the Soldier's worksite supervisor regularly and document the encounter to ensure the Soldier is present and performing to standard.

Chapter 4

Risk Assessment and Mitigation Planning

Section I

General

4-1. Background

The Army 2020 Report on Generating Health and Discipline in the Force Ahead, published in 2012 (<http://www.armyg1.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 Center, and the DOD Risk Management Task Force.

4-2. Policy

a. Concept. Risk assessment and mitigation management is a commander's responsibility, in collaboration with the Soldier's Triad of Care, IDT, and the Soldier beginning with an initial screening risk assessment on the day the Soldier arrives at the SRU, 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 SRU NCM; SRU BH provider (typically the Soldier's SRU LCSW); and a medical provider. Each of the four will make an independent evaluation of the Soldier's risk level; the SRU commander will make a commander's risk assessment from these assessments. Once screening is complete, the SRU 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 ARCS, AHLTA, and PBH-TERM. The ARCS contains specific modules for risk assessment entries by the SRU LCSW, SRU NCM, SL, and the SRU commander. The ARCS risk levels color codes include: low (green), moderate-low (amber), moderate (red), and high (black). The SRU NCM assessment includes input from the medical provider's assessment. The SRU commander uses the information from the SRU LCSW, SRU NCM, and PSG or SL assessments to prepare the commander's risk assessment and risk mitigation plan. The SRU commander selects mitigation actions specific to the Soldier's level of risk and extenuating circumstances. The SRU commander's mitigation plan contains recommended actions based on the risk level that he or she assigns. (If the Soldier is high risk (black), the first 10 items of the risk mitigation plan are automatically populated in ARCS). Completed assessments are maintained within the ARCS risk module and may be viewed by specified cadre members.

d. 24 hour screening assessment. The initial screening risk assessment is completed within 24 hours of the Soldier's report date as an outpatient to the SRU. For those arriving as inpatients, the screening will be completed within 24 hours of discharge from the facility (para 3-3). 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 condition

and that are after hours, Soldiers will be screened by their SL and SRU NCM and then escorted to the on-call BH and medical providers by their SRU SL. SRU organic assets will enter their assessments into ARCS. The SRU NCM is responsible for locating medical documentation completed by non-organic BH and medical providers. The SRU NCM will inform the SRU commander of the findings and annotate identified risks in an ARCS entry to assist the SRU commander in preparing the Soldier's first commander's risk assessment and mitigation plan.

e. The full intake assessment. No later than 5 calendar days after the Soldier's report date to the SRU, the SRU Provider SRU NCM and SRU LCSW conduct 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 SRU LCSW SRU NCM and SL update risk assessments in ARCS. The SRU NCM's assessment includes any pertinent information from the PCM evaluation. The SRU commander uses this new information to update the Soldier's risk assessment and mitigation plan as appropriate.

f. Regularly scheduled assessments review. The SRU commander and the IDT review all SRU Soldier risk assessments and mitigation plans monthly, and all high-risk SRU Soldiers at the weekly Triad meetings. The SRU NCM is responsible for communicating information findings from medical providers. For Soldiers identified as high risk by the SRU, the SRU 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 IDT on a weekly basis. If the Soldier is seen by a network provider, the SRU LCSW will communicate with the network provider on a weekly basis as well.

g. Oversight responsibilities.

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

(2) SRU 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.

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

(4) Within 30 days of each SRU Soldier and cadre member's report date, SRU 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.

4-3. Management and mitigation

a. Commanders will select risk mitigation actions specific to the level of risk and presence of specific risk factors. Completed commander assessments are maintained within the ARCS risk module and viewable to specific cadre members. The ARCS 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) Issuance of a no alcohol order.

(4) Designation of NMA, or Family member as Soldier battle buddy.

(5) Requirement for battle buddy to travel off post (sign in or out with staff duty NCO).

(6) Referral to the chaplain.

(7) Initiation of safety counseling.

(8) Consideration of BH referral for evaluation and follow-up.

b. Additional mitigation actions that the SRU commander deems necessary can be added to the risk mitigation plan for any Soldier.

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

4-4. Reassessment

a. Reassessment will occur whenever there are significant life changes or new information that would warrant risk reassessment. Reassessment also occurs weekly for Soldiers deemed high risk, monthly for Soldiers deemed moderate risk, and quarterly for Soldiers deemed moderate-low or low-risk. Risk assessments will be documented in ARCS, PBH-TERM, and AHLTA. 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.
- (11) Discharge from an inpatient facility.

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

4–5. Execution of managing risk levels and mitigation plans

- a.* The office of the DCS–ARC as the lead proponent will share feedback and best practices with RHCs.
- b.* RHCs will monitor policy execution and track risk levels and appropriate mitigation plans across their commands.
- c.* Health Readiness Platform 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 Sole Provider Program (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 health promotion risk reduction suicide prevention in accordance with AR 600–63.
- d.* SRU commanders will—
 - (1) Ensure compliance with the risk assessment and mitigation policy.
 - (2) Complete Soldiers' risk assessments and mitigation plans within 24 hours of the report date to the SRU, and ensure SRU 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 imminent (red) is equivalent to commander's risk level of high (black)).
 - (4) Determine the overall risk designation based on the assessments of the designated SRU 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 ARCS case log after making a risk designation.
 - (6) Ensure compliance with chain of command safety programs.
 - (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, HQDA physical security directives, and installation policy requirements. Additionally, SRU commanders will—
 - (a)* Not collect, inquire, or record any information related to personally owned weapons or ammunition that are kept off post.
 - (b)* Seek legal advice from the servicing office of the staff judge advocate or legal office on appropriate actions to take in cases involving Soldiers who the command reasonably believes are at high risk to harm the Soldier or cause harm to others.

(c) Ensure SLs and the key IDT members provide information to Soldiers, Soldiers' Family members/caregivers at Family Readiness Group meetings or during Family/Caregivers Welcome In-processing regarding the option to store their personally owned weapons in the unit's arms room.

(13) Ensure redeployed or transferred Soldiers assigned or attached to the SRU have a current DD Form 2796 within 30 days of redeployment in accordance with AR 40–66. SRU Soldiers assigned or attached to the SRU without a completed DD Form 2796, and whose redeployment exceeds 30 days must complete one within 5 days of their report date to the SRU. Additionally, redeployed Soldiers assigned or attached to the SRU 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 SRU 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 the Soldier 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 SRU 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 is 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 SRU. 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 medical recovery providers and the designated MTF TOL representative, 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 SRU is not located in an area with a MTF pharmacy. SRU commanders will provide MTF EDs with a current roster of Soldiers ensuring medications are only issued with PCM, SRU medical provider, and SRU NCM knowledge. Designated MTF TOL representative will request that local civilian EDs that may treat SRU Soldiers contact designated MTF POC to ensure that the SRU 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 SRU medical provider, interdisciplinary inpatient staff and the SRU IDT, implement a comprehensive discharge plan that assesses the Soldier's risk and develop a mitigation plan that addresses the risk. A transition of care plan will be communicated between inpatient IDT and SRU 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 polypharmacy, narcotics, and mixing of alcohol with medications.

(17) Ensure Soldiers are informed of 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 SRU 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 SRU LCSW for a reassessment.

(18) Ensure Soldiers considered for transfer to SRU have a risk assessment and mitigation plan completed prior to transfer.

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

(20) Include the USA SLRRT assessment when conducting periodic performance counseling for SRU 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 Army Suicide Prevention Month website, to assist SRU commanders to determine Soldiers level of functioning can be obtained at: http://www.armyg1.army.mil/hr/suicide/spmonth/risk_assessment_tool.asp.

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

1. Within 30 days of the report date to the SRU.
 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 conduct risk assessment within 24 hours of the Soldier's report date to the SRU.
 - (2) Implement increased risk mitigation plans for Soldiers based on acute changes in the Soldier risk indicators as described in paragraph 4–6 of this regulation, and/or upon the request of any member of the Triad of Care and/or SRU LCSW.
 - (3) Work with the SRU finance NCO to review Soldier's pay to determine if there are any indicators of financial issues to corroborate SL, SRU NCM and/or SRU LCSW risk assessment.
 - (4) Notify the SRU commander telephonically or in person within 1 hour of any increase to high risk or an initial assessment of high risk and document in ARCS.
 - (5) Validate self-assessments and assign tasks appropriately.
- f.* The SRU medical provider will—
- (1) Inform the SRU commander and the IDT 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, and 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 the report date to the SRU.
 - (3) Ensure medical, BH, and rehabilitation plans are in synergy and are consistent with risk mitigation.
 - (4) In coordination with SRU LCSW and SRU 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 IDT.
 - (6) Where clinically appropriate, initiate entry of high-risk Soldiers into the SPP.
- g.* The SRU NCM will—
- (1) Initiate a risk assessment and a medication review within 24 hours of Soldier's report date to the SRU.
 - (2) Document the risk level in AHLTA.
 - (3) Inform the SRU commander telephonically or in person within 1 hour of any high risk determination and document in ARCS.
 - (4) Include Family and social support assessment during in-processing and during weekly SRU 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) Validate Soldier's self-assessments and ensure action plans are created for all Amber and Red items within ARCS.
- h.* The SRU LCSW will—
- (1) Conduct the preliminary BH needs and risk assessment during duty hours and as assigned on-call within 24 hours of the Soldier's report date to the SRU and complete the assessment within 5 calendar days.
 - (2) At locations where the Soldier arrives during non-duty hours and/or SRU 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 provide support to the Family or caregivers regarding behavioral health care. The SRU commander is the final decision authority in risk determination and mitigation.
 - (4) Complete the risk assessment in ARCS and document the corresponding risk level in AHLTA. Chapters 4 and 6, section III, further outline the duties and responsibilities of the SRU LCSW.
 - (5) Inform the SRU commander telephonically or in person within 1 hour of any of high risk determinations and document in ARCS.

Section II

High-Risk Medication Review and Sole Provider Program

4–6. Policy

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

4–7. Medication review and Sole Provider Program enrollment

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

a. The SRU medical provider 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 the SRU medical provider, a specialist, sub-specialist, or other provider.

(1) Only a Soldier's PCM, SRU medical provider, 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) SRU 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's discretion. In such cases, non-refillable prescriptions for antimicrobials may be written for up to 14 days. SRU 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 SRU Soldiers in the SPP.

(3) For MTF-based SRUs, the Soldier's sole provider will coordinate enrollment with the supporting MTF pharmacy according to the SPP policy and will comply with 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 SRU medical provider will perform a medication review for high-risk or sole provider Soldiers at least weekly and, as needed, when the SRU staff identifies new high-risk Soldiers. The SRU medical provider and staff will consult the clinical pharmacist for assistance in the delivery of safe and appropriate medication therapy for SRU 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).

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

Chapter 5

Adaptive Reconditioning Program

5–1. Background

Adaptive reconditioning utilizes activity to help increase mental, emotional, and physical wellbeing in order to build resiliency and achieve individual CRP goals. The intent is to provide holistic/comprehensive care to include cognitive, emotional, and physical activities within each Soldier's individual abilities in order to facilitate a successful transition in which Soldiers achieve optimal well-being and maximum functional return. At a minimum, the program will get each SRU Soldier to start in the right path toward improving within their six CRP domains. NOTE: RM2 Soldiers are not eligible to participate in the Adaptive Reconditioning.

5–2. Adaptive reconditioning team

The adaptive reconditioning team consists of the SRU's PT, PTA, OT, COTA, NCM, TC, LCSW, Surgeon, SRU medical provider and noncommissioned officer in charge (NCOIC), in collaboration with the Triad of Care. The SRU PT will assume the role as the lead for the Adaptive Reconditioning Program. In the absence of an ARU PT, another rehabilitation professional will assume the role based on designation from the SRU commander.

5–3. Policy

a. SRU commanders will oversee the Adaptive Reconditioning Program and team. The SRU surgeon will advise the adaptive reconditioning team. The SRU PT will serve as the Adaptive Reconditioning Program manager and lead the team in planning, coordinating, and executing the Adaptive Reconditioning Program.

b. The Adaptive Reconditioning Program will include activities designed to meet the individual Soldier's CRP goals and needs of the SRU population. Individual Soldier needs include but are not limited to CRP short term and long term goals. The program will include mandatory events on a weekly basis that are integrated into the unit's rhythm of military operations. All Soldiers, once cleared by the PT, will attend the mandatory scheduled events. These adaptive reconditioning events are therapeutic and part of the Soldier's recovery, however, medical appointments take priority. SRU 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 CRP domains. The program consists of a variety of adaptive sports, CER activities, 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. All Soldiers, within the limits of their physical profile, will participate in a physical adaptive reconditioning regimen consistent with the Soldier's diagnoses and related to the Soldier's transition goals in the CRP domains. In addition, All Soldiers will participate in two adaptive reconditioning activities per week within the specified domains of the CRP.

e. Therapeutic events are one of the many adaptive reconditioning activities used to help Soldiers achieve their short or long-term CRP goals. As noted in paragraph 3–6c(2), therapeutic events must provide a reasonable expectation of a specific, beneficial effect on the Soldier's medical condition and outcome. The SRU medical provider, in collaboration with the IDT within the triad meetings, will determine if an activity is therapeutic or leisure; however, the SRU commander is the authority to release the Soldier to attend that activity. These events are considered mandatory and must be attended once prescribed and can only be superseded by medical appointments or command approval for excusals.

f. Therapeutic events that involve travel away from the Soldier's unit or quarters require approval from the Soldier's SRU commander or their 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.

g. Leisure activities are those activities determined by the SRU medical provider, in collaboration with the IDT, that provide general relaxation and diversion, but have no specific therapeutic benefit. 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 activities will use leave or pass in accordance with AR 600–8–10.

5–4. 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 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 standard operating procedure (SOP) 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.

5–5. Establishing the Adaptive Reconditioning Program

a. The SRU will establish an Adaptive Reconditioning Program in accordance with this regulation and, when directed, report adaptive reconditioning metrics through the chain of command to MEDCOM.

b. The SRU commander will—

- (1) Oversee the development and implementation of an Adaptive Reconditioning Program that includes activities across the CRP domains.
- (2) Designate an Adaptive Reconditioning Program NCOIC (E–6 or above) to assist with ensuring participation in the Adaptive Reconditioning Program.
- (3) 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.
- (4) Conduct after action reviews with the adaptive reconditioning team to evaluate the program effectiveness with respect to specified diagnosis and CRP goals.
- (5) Ensure all Soldiers have completed leisure event and/or trip documentation prior to participation, including: medical clearance, trip authorization, DA Form 4187 (Personnel Action), therapeutic trip counseling (DA Form 4856), and a list of therapeutic trips taken in the past 6 months, a 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 nontherapeutic trips, Soldiers must complete DA Form 31.

c. The SRU surgeon will provide oversight and guidance for the adaptive reconditioning team, to include advising the SRU commander on programs most appropriate for the SRU population and overseeing their implementation.

d. The SRU medical provider 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.
- (4) In collaboration with the IDT, determine if an activity is therapeutic or leisure.

e. The PT is the Adaptive Reconditioning Program manager. The PT or representative, will—

- (1) Lead the adaptive reconditioning team in planning and executing all adaptive reconditioning events and activities.
- (2) Collaborate with the IDT on adaptive conditioning matters.
- (3) Evaluate each Soldier within 21 days of in-processing to determine base-line physical fitness.
- (4) Assign each Soldier to an ability group in accordance with field manual (FM) 7–22, and establish goals for physical fitness and health maintenance for those Soldiers with profile(s).
- (5) Ensure Soldiers have an appropriate profile based on the eProfile written by the PCM and provide the Soldier a copy of their individual profile to carry at all times.
- (6) Design and provide an Adaptive Reconditioning Activity Plan (ARAP) outlining an individualized exercise program and adaptive reconditioning activities. Generate updated ARAPs based on Soldier's change in functional status as per reassessments.
- (7) Evaluate individual Soldier participation in MTF clinics to determine if clinics can be credited toward weekly Adaptive Reconditioning Program requirements.
- (8) Reevaluate the Soldier's progress every 90 days to determine the effectiveness of the individualized Adaptive Reconditioning Program and adjust the program to meet the needs of the Soldier. These recurring 90-day reevaluations will be documented in AHLTA.
- (9) Ensure Composite Risk Management assessments are completed and approved by the SRU commander prior to adaptive reconditioning events and activities, as required.

- (10) Prepare an annual budget (for example, spending plan) on adaptive reconditioning events and activities for the SRU commander's approval and track expenditures.
 - (11) Ensure command approved events are reflected on the SRU training calendar.
 - (12) Ensure all adaptive reconditioning opportunities and equipment offered by donors are reviewed and approved by the SRU commander and servicing command or staff judge advocate prior to acceptance.
 - (13) Conduct after action reports for adaptive reconditioning events and activities, as required.
 - (14) Prepare reports, and collect and report metrics on the Adaptive Reconditioning Program as required or directed.
- f.* The PTA will—
- (1) Assist in executing the individualized Adaptive Reconditioning Program designed by the PT for the Soldier.
 - (2) Educate the Soldier on maintaining an active and healthy lifestyle.
 - (3) Attend the unit's adaptive reconditioning events and activities to assist the unit with providing safe, effective physical training for their Soldiers.
 - (4) Assist with collecting and reporting metrics for the Adaptive Reconditioning Program.
 - (5) Assist with adaptive reconditioning equipment storage, maintenance, and inventory.
 - (6) Ensure all Soldiers have a completed medical clearance prior to participating in any activities.
 - (7) As requested by the PT, provide fitness assessment to the PT to assist with ARAP updates.
- g.* The OT will assist with and support the execution of the Adaptive Reconditioning Program. The OT will—
- (1) Collaborate with the adaptive reconditioning team to identify, manage, and support adaptive reconditioning activities for the Adaptive Reconditioning Program.
 - (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) Collaborate with the adaptive reconditioning team to identify activities that benefit Soldiers by addressing CRP goals.
 - (4) Collaborate with the adaptive reconditioning team to modify any aspect of the activity to facilitate Soldiers' achievement of their goals.
 - (5) Manage the Adaptive Reconditioning Program in the absence of the PT.
- h.* The COTA will—
- (1) Educate the Soldier on the six domains of the CRP and explore each domain with the Soldier based on their CRP goals.
 - (2) Assist in the planning and execution of adaptive reconditioning events.
 - (3) Assist with collecting and reporting metrics for the Adaptive Reconditioning Program.
- i.* The SRU NCM will—
- (1) Coordinate all medical appointments to determine Soldiers' availability to participate in an adaptive reconditioning event.
 - (2) Inform the adaptive reconditioning team of any Soldier medical appointment that would prevent the Soldier from participating in a scheduled adaptive reconditioning activity or event.
 - (3) Ensure all Soldiers have therapeutic or leisure trip or event clearance prior to commencement of the trip or event, including: medical clearance, a print out of the Soldier's medical appointments, and a print out of the Soldier's no show history for medical appointments.
- j.* The Adaptive Reconditioning Program NCOIC will—
- (1) Be an E-6 or above assigned to the SRU.
 - (2) Coordinate with adaptive reconditioning team to conduct risk assessments for adaptive reconditioning events and activities.
 - (3) Assist PT in ensuring adaptive reconditioning equipment is properly accounted for and secured as required.
 - (4) Assist with collecting and reporting metrics for the Adaptive Reconditioning Program.
 - (5) Assist adaptive reconditioning team in setup and teardown of events and activities.
 - (6) Assist in the accounting of Soldiers participating in adaptive reconditioning events and activities.
- k.* The SL will—
- (1) Communicate with the adaptive reconditioning team the Soldier's availability to attend adaptive reconditioning activities and events.
 - (2) Ensure each Soldier carries a copy of their profile on them at all times.
 - (3) Ensure each Soldier participates in an adaptive reconditioning, per their individualized plan developed by the PT and should strive to improve their sleep and their nutrition habits, aligned with CRP goals and domains.
 - (4) Inform the POC for the adaptive reconditioning event if the Soldier is unable to attend.

(5) Ensure all Soldiers have completed leisure event and/or trip documentation prior to participation including: trip authorization (DA Form 4187), therapeutic trip counseling (DA Form 4856), and list of therapeutic trips taken in the past 6 months. For leisure or nontherapeutic trips, Soldiers must complete DA Form 31.

l. The Soldier will—

- (1) Participate in the adaptive reconditioning regimen prescribed by the Soldier's medical team.
- (2) If and when medically cleared, participate in moderate intensity physical adaptive reconditioning, and, in addition, a minimum of two adaptive reconditioning activities per week within the specified domains of the CRP.
- (3) Be on time, in the correct uniform, and at the right location for the adaptive reconditioning activity and event.
- (4) Carry a copy of their individual profile at all times.
- (5) Advise the SL prior to the scheduled event if transportation is required.
- (6) Notify the SL prior to the event if unable to attend a scheduled adaptive reconditioning activity or event.
- (7) Participate in after action reviews of adaptive reconditioning activities or events.

Chapter 6

Medical Care Management

Section I

Primary Care

6–1. SRU medical provider

The SRU medical provider is a separate medical provider who lays the foundation and direction of the Soldier's recovery care plan for the recovery care team. This will be accomplished through the SRU medical provider's initial comprehensive assessment; review of medical notes, tests, and reports; creation of a medical recovery care plan note and updates; update of profiles; review of ability to do Soldier task; assessment of Soldier's occupational ability; and discussions with other medical providers. The SRU medical provider's focus is the full medical recovery plan and as needed will reach out to the PCM for medical treatment clarifications that will facilitate recovery discussion at Triad meetings, ensuring clear and continuous two-way communication of health care plans and issues with the SRU NCM, SRU SL and/or PSG, SRU BH providers, and other members of the IDT. Key roles and responsibilities of the providers are outlined in paragraphs 2–23, 3–9, chapter 4, and throughout the regulation.

6–2. 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 6–2*b*, 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 SRU medical provider'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 DES 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 DES is mandatory.

6–3. Medical evaluation board referral

a. Conditions discovered by a medical provider after identification of the medically disqualifying condition that is determined to be at MRDP will not delay initiation of a permanent 3 or 4 profile, initiation of a MEB, and hence referral into DES. Referral into DES does not preclude ongoing evaluation and treatment of Soldier's medical conditions.

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

c. The designated MTF TOL representative will provide to the SC a monthly by-name report on Soldiers who have 1 year assigned or attached to the SRU without a MEB referral.

d. The SC will provide a numerical installation summary report to commanders of ACOMs, ASCCs, or DRUs on Soldiers who have 18 months assigned or attached to the SRU without a MEB referral.

e. DCS–ARC will provide to 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 635–40 governs the policy on the MEB and the PEB.

6–4. Transition standards

Soldiers exceeding 12–month assignments or attachment to a SRU without an MEB referral will require the SC (their 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 their 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.

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

b. At the end of each month, a report will be submitted identifying Soldiers assigned or attached to a SRU without a MEB referral, whose MEB was stopped, or who do not have an endorsed treatment plan as required by paragraph 6–4a:

(1) SRU commanders will submit a by-name report to the designated MTF TOL representative on Soldiers that have reached 6 months in the SRU.

(2) Designated MTF TOL representative will provide a by-name report to the SC on Soldiers exceeding 12 months in the SRU.

(3) SCs will provide a numerical installation summary report to ACOM, ASCC, or DRU commander on Soldiers remaining in the SRU for 18 months.

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

c. The MODS–WT module is the data source that supports all reporting requirements stated. SRU commanders will ensure the MODS–WT module is maintained to allow all installations with SRUs to pull by-name reports to meet this requirement.

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

6–5. 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 SRU admission, will not be considered optional.

c. The mission of a Soldier in the SRU 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 military 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 CRP completion.

d. An algorithmic summary of the management of optional surgeries, procedures and treatment can be found in Figure 6–1.

e. Cases that cannot be adequately resolved at the SRU level will be referred to the designated MTF TOL representative, with the MTF CMO or designee serving as medical SME.

6–6. Service animals in Soldier Recovery 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 IDT may approve the Soldier to begin training with a service dog while residing at a SRU in coordination with SRU 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, SRU medical provider, and IDT, with approval by the first O-6 in the Soldier's chain of command.

c. Service dogs and Service dogs-in-training may reside in the SRU barracks with Soldiers assigned to the SRU at the discretion of the Garrison commander.

6-7. Profile Adherence

a. Soldiers assigned to SRUs have the primary responsibility to comply with their medical treatment plan, heal, rehabilitate and either return back to the Force or transition to Veteran status with dignity. To that end, Soldiers will be afforded every opportunity to do so in a safe manner that does not put them or commanders at risk. Many Soldiers have medical profiles that restrict them from certain activities due to their injuries or illnesses. They also are prescribed medications that limit their level of alertness, cognitive function, and impact their sleep wake cycle in a significant manner. This policy clarifies commanders' responsibilities with regards to profile management and the process to validate or revise equivocal profiles.

b. Commanders will ensure profiles written by authorized personnel in accordance with AR 40-502, are adhered to by cadre and Soldiers. Adhering to the guidelines of the profile, and allowing for reasonable adjustments to report times, formations, and so forth, will ensure the safest, most conducive healing environment within the SRU.

c. Commanders and cadre must consider a Soldier's medical condition and medication profile when determining duty and accountability (reporting times/formations) requirements, including, where applicable, specific duty locations and the nature of the Soldier's activity. For example, a Soldier's prescribed narcotics or sleep medication may cause cognitive dysfunction and sedation placing the Soldier's safety and that of other drivers at risk. Requiring Soldiers to drive while still under the influence of these types of medications is an unnecessary risk that is alleviated by careful consideration of and adherence to a Soldier's mitigating profile (for example, no driving profile, and delayed reporting). Commands are encouraged to have delayed reporting personnel conduct adaptive reconditioning or physical training at the end of the day. Additionally, profiles requiring a defined number of hours for sleep per day preclude 24 hours duty. Commands will not put duty over adhering to profiles.

d. Commanders and cadre having concern(s) about any portion of a Soldier's profile, must address the issue with the profiling physician, in accordance with AR 40-502 chapter 3, for verification or revision. Commanders are responsible for addressing profiles in controversial or equivocal cases (for example no uniform, no shaving, and so forth) with the profiling physician directly, in coordination with the surgeon. If an issue is not resolved for a controversial or equivocal profile, the SRU commander may address the issue with the designated MTF TOL representative. The designated MTF TOL representative is the final authority on profile adjudication.

6-8. Security and storage of medication

Soldiers and cadre in SRUs 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 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 container. Commanders are to ensure SRU Soldiers secure their prescription and non-prescription medications in their original containers and in a safe or other locked storage container when not being taken or administered.

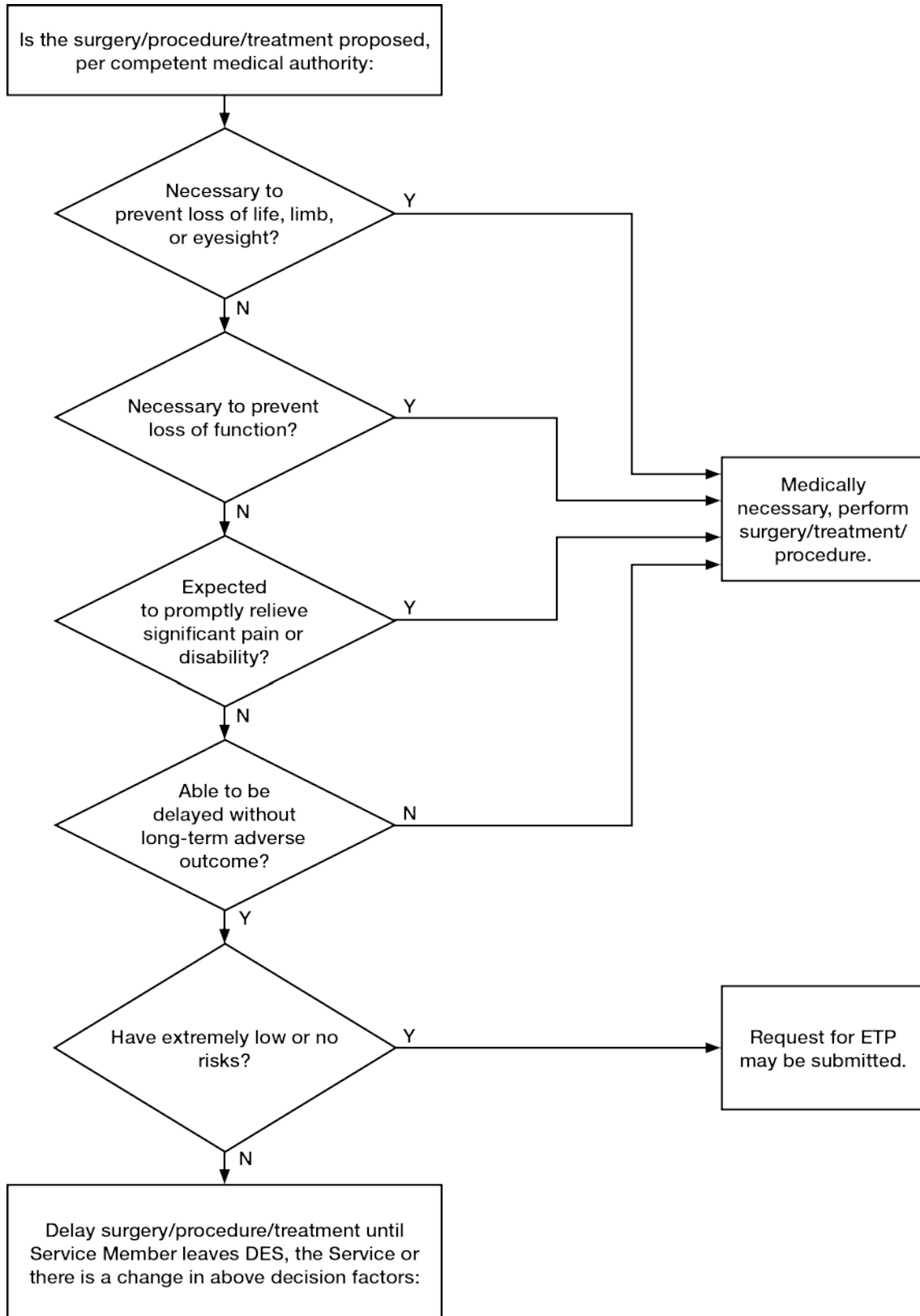


Figure 6-1. Algorithmic summary of the management of optional surgeries

Section II

Case Management

6–9. Nursing case management

a. In accordance with the DOD TRICARE Management Activity, the Medical Management Guide 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.

6–10. Education and training and certification

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

b. SRU NCM must complete the following education and training modules located on the Joint Knowledge Online training platform at <https://health.mil/military-health-topics/technology/support-areas/mhs-specific-coding-guidelines>:

- (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 and long term deployment effects.
- (6) Psychological Impacts of Deployment working with wounded, ill, and injured.
- (7) Veterans Health Administration Overview.
- (8) Introduction to the IDES for Case Managers.
- (9) DOD Recovery coordination Program.
- (10) SRU NCMs must complete the NCM course before accepting a patient for case management services, and must complete the course within 90 days of the report date to the SRU.

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

6–11. Case management standards

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 ensure necessary support is provided to the lead coordinator program for all medical-related transition of care and management for Soldiers and their Families. The SRU NCM will ensure health and service needs of all Soldiers and Families are effectively and efficiently communicated. SRU NCM will use appropriate handoff tools to facilitate the continuum of communication and documentation of care transition to the VA or a M2 team at the Soldiers unit, installation, or civilian medical team. All case management services for Soldiers evaluated for, or enrolled in, case management will be documented in AHLTA.

a. 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.

b. 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 SRU, the comprehensive care plan supports the CRP 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 short and 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”.

c. Termination of case management services. Normally, case management services will continue until the Soldier completes their medical care and has RTD, or completes the DES 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, SRU NCMs will document case closure in AHLTA and in ARCS as well as any other patient tracking systems of record.

(3) Based on the risk assessment, Soldiers deemed as low risk will be contacted and documented in the AHLTA at a minimum monthly while in a transitional leave status until they are RTD or discharged from the military.

d. The SRU NCM will validate the Soldier’s self-assessment, ensure action plans are created for all Amber and Red items within ARCS in accordance with chapter 4 and assign tasks appropriately to meet the needs of the Soldier and Family. (see chaps 2, 3, and 4 for roles and responsibilities of the SRU NCM).

Section III

Clinical Social Work Care Management

6–12. Policy

The SRU LCSWs and SRU 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 Families or caregivers.

6–13. Licensed clinical social worker team collaboration

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

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

b. Attend IDT and treatment meetings.

c. Provide input into the CRP.

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.

h. Attend scrimmages and FTRs.

6–14. Provision of behavioral health care standards and timelines

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

b. The SRU LCSW will—

(1) Within 24 hours of the Soldier’s report date to the SRU, meet and welcome the Soldier; ensure the Soldier completes and signs DA Form 8001 (Limits of Confidentiality) and DD Form 2005 (Privacy Act Statement–Health Care Records); conduct the preliminary BH needs and risk assessment; and complete a safety plan (as appropriate to assess risk level). Minimally, the Soldier (and Family/Caregiver) is to be informed of emergency procedures and provided relevant contact information such as; location and phone number of the ER, on-post emergency services phone number, and on-call provider contact information. In the absence of the SRU LCSW, this function may also be performed by an on-call MTF BH provider.

(a) Where applicable, Soldiers will complete and sign DD Form 2870 (Authorization of Disclosure of Medical or Dental Information).

(b) Where applicable, Soldiers will complete and sign consent to send and receive medical information by electronic mail as outlined by the local MTF policy requirements.

(2) Schedule an appointment for the Soldier to meet with the SRU LCSW within 5 calendar days of the Soldier's report date to the SRU 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/imminent, high, moderate, or low).

(5) Enter results of BH needs and preliminary risk assessment into AHLTA.

(6) Convert the BH risk assessment into the ARCP BH Social Work Risk Assessment (SWRA) four-point scale (high, moderate, moderate-low, or low) using ARCS. The SRU LCSW will select the appropriate radio buttons within ARCS and add any additional comments. Following submission, the results of the SWRA will be displayed on the SRU commander's dashboard for final determination of risk assessment and risk mitigation, as necessary. In general, the paper-based SRU SWRA will be provided to the commander only when ARCS is down or not available.

(7) Notify the SRU commander, within 1 hour, by telephone or in person, if the Soldier is assessed as "severe" or "high" risk and document in ARCS. In the absence of the commander, notify the next commander in the chain of command.

(8) Act as a consultant to the SRU commander to implement a BH safety and risk mitigation plan for the Soldier.

c. The SRU commanders will develop and implement risk management and mitigation plans for Soldiers as necessary and required; these plans will be adjusted based on recommendations provided by the SRU LCSWs that are developed from comprehensive BH risk and psychosocial assessments of SRU Soldiers.

d. The Soldier will—

(1) Bring the completed BHI-PHA worksheet to their scheduled appointment with the SRU LCSW.

(2) Review and sign DD Form 2005, if not previously signed.

(3) Review and sign DD Form 2870, as applicable. The SRU 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.

e. The SRU LCSW, at the first scheduled appointment with the Soldier, will—

(1) Meet with the Soldier and reassess the BH needs; review and obtain the Soldier's signature on all required documentations and complete SRU 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. Document consultation efforts in AHLTA.

(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 SRU 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 SRU LCSW in estimating the immediate risk level (low, moderate, high, or severe or imminent). The SRU LCSW will provide the results of the BH risk assessment SWRA to the SRU commander and/or the Triad of Care by entering the SWRA results into ARCS. If the Soldier is assessed as "high" or "severe" risk, the SRU LCSW will notify the SRU 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 SRU LCSWs entitled "Behavioral Health Social Work-Care Management" as soon as possible, but no later than 72 hours after the comprehensive BH assessment appointment with the Soldier. Additional comments and care management notes may be placed in the "Add Note" section of the encounter. The PBH-TERM risk estimate will be "cut and pasted" into the "Add Note" section of the AHLTA encounter.

(6) Enter the diagnosis in AHLTA according to coding guidelines established by the MTF. The SRU LCSWs may diagnose a Soldier's BH condition in accordance with their clinical license to practice independently. Include mention of any psychosocial and environmental problems as well as details about general functioning.

(7) Enter the Soldier's detailed management plan 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 also be annotated.

f. The SRU LCSW will conduct ongoing BH risk assessments. Soldiers assessed at a BH risk of "severe or imminent" or "high" risk will be reassessed on a weekly basis; those assessed as "moderate" on a monthly basis; and those assessed as "moderate-low" or "low" on a quarterly basis. The SRU 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 SRU LCSW will document the BH risk assessment and update the SRU commander and/or Triad of Care regarding current risk assessments using ARCS and during Triad meetings.

(1) A Soldier considered as "severe or imminent" or "high" risk for BH concerns on any risk screen or assessment will be reassessed 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 "moderate," moderate-low, or "low."

(a) A Soldier considered "severe or imminent" or "high" risk, will not enter the RM2. 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 SRU installation level of care.

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

(c) Soldiers estimated as "moderate" BH risk will be evaluated by the SRU LCSW on a monthly basis (every 30 days), using the SWRA-Q and PBH-TERM for the risk estimate, until the risk level is estimated to be "moderate-low" or "low."

(d) Soldiers estimated as "moderate-low" or "low" BH risk will receive a risk estimate using the SWRA-Q and PBH-TERM on a quarterly basis (every 90 days).

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

(3) The SRU 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. ARCS and PBH-TERM will be updated when each risk assessment is conducted.

(a) If the Soldier is unavailable to complete a risk assessment due to leave status, the SRU LCSW will contact the Soldier and assess the risk level by way of telephone.

(b) 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 SRU. The closing risk estimate from PBH-TERM will be entered into the "Add Note" section of the AHLTA encounter.

(4) For each BH risk assessment, the SRU 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 website is restricted and requires an individual provider code. The SRU LCSW will also enter the BH risk assessment in HER.

(5) The SRU LCSW will enter the estimated risk level of the Soldier into the ARCS.

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

6-15. Non-Duty hour arrival standards and timelines

a. At locations where the Soldier arrives during non-duty hours and SRU LCSW on-call support is limited, the designated on-call provider will—

(1) Meet with the Soldier to assess BH immediate needs, provide the Soldier the SWRA-Q and DA Form 8001 to complete; assess the risk on the SWRA; and complete safety and treatment plans, as appropriate.

(2) Complete appropriate referrals, consults, collateral contacts or notifications to mitigate risk and facilitate the provision of appropriate BH care.

(3) Provide the results of the needs assessment and the BH and SRU risk assessment to the SRU commander or designee by way of ARCS or direct notification.

(4) Notify the SRU commander or designee within 1 hour, by telephone or in person, if the Soldier is assessed as "severe" or "high" BH risk.

(5) Act as a consultant to the SRU commander to implement a BH safety and risk mitigation plan for the Soldier.

(6) Enter the BH risk assessment findings derived from completion of the SWRA–Q (severe/imminent, high, moderate, or low) and the treatment plan into AHLTA in the patient encounter note.

b. In instances where an on-call provider completes the preliminary BH needs and risk assessment, the SRU LCSW will (on the next duty day)—

(1) Review the care provided and the BH needs of the Soldier; and implement safety and risk mitigation plans, if provided by the SRU 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; to address any additional BH needs; ensure the Soldier completes DA Form 8001 and DD Form 2005; schedule an appointment for the Soldier to meet with the SRU LCSW within 5 calendar days of the Soldier’s report date to the SRU for the initial BH risk assessment and comprehensive assessment; and provide the Soldier with the BHI–PHA worksheet 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 SRU LCSW) in AHLTA; enter the SRU SWRA current risk assessment (as assigned by the on-call provider or adjusted by the SRU LCSW) into ARCS. If ARCS is not available, document such and ensure that the SWRA is provided to the SRU commander and the Triad of Care.

6–16. Case complexity estimate

a. The SRU 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 SRU 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 SRU LCSW will use the paper-based CMCW to determine the case complexity and place the CMCW in the AHLTA.

6–17. Supportive counseling, brief treatment intervention, and referral

a. The SRU 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 SRU LCSW will continue to provide BH care management of the Soldier.

c. Installations with SRU 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 SRU LCSWs identify that Soldiers’ BH needs are beyond their privileging and scope of practice, SRU LCSWs will, in coordination with the PCM or the SRU medical provider and SRU NCM, refer the Soldier and Family to the appropriate health care discipline for further assessment and intervention. Mandatory referral programs include the ASAP and Substance Abuse Disorder Clinical Care program for alcohol and/or drug problems, the Family Advocacy Program (FAP) for suspicion of child or intimate partner abuse and/or neglect, and the Exceptional Family Member Program (EFMP).

e. The SRU LCSW will conduct a Family needs assessment to ensure that the Family’s or caregiver’s needs and goals are addressed. The SRU LCSW may use SRU BH–Family Needs Assessment to assist in identification and management of the Family’s or caregiver’s goals.

f. The SRU LCSW will document all assessment and interventions into AHLTA.

6–18. Care management

The SRU 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 SRU 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 SRU 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 IDT meetings and regularly interface with the Triad of Care and the chain of command. Provide input into the CRP. Update management and intervention treatment plans so that they are in agreement with team meeting recommendations and the CRP.

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.

6–19. Clinical documentation in the medical record

a. *Behavioral health records.* The BH records will be maintained in the AHLTA in accordance with AR 40–66 and MEDCOM policies.

b. *Closing note.* 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. Additionally, documentation of the organization and individual providing follow on care for the Soldier and all other referrals is required. Documentation will be in accordance with AR 40–66, local MTF and command policies.

c. *Transfer note.* The transfer note is used when the Soldier is transferred to another SRU or provider within the SRU. The transfer note will 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.

6–20. Limits of confidentiality for clinical information and consent to assessment and/or treatment

Providers will inform Soldiers regarding limits of confidentiality. Providers will use DA Form 8001 to document that Soldiers understand the limits of confidentiality and are providing informed consent regarding their assessment, treatment, and care.

6–21. Behavioral health information release

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

6–22. Resources

a. The BH care manager resource list and the website for the National Resource Directory (www.nationalresourcedirectory.gov) should be provided to all Soldiers, their Families, or caregivers.

b. The BH International Classification of Diseases coding guide.

c. SRU BH resource of references is located at <https://www.us.army.mil/suite/grouppage/526>.

d. ARCS access. For access to ARCS for Soldiers in a designated SRU, contact the local management analyst.

Section IV

Occupational Therapy

6–23. Policy

The SRU OT and COTA will abide by the policies and procedures outlined in this chapter and throughout this regulation, in evaluation, supporting, and managing individual Soldiers, their Families, or caregivers.

6–24. Occupational therapist and certified occupational therapist assistant team collaboration

SRU OT or COTAs will work cooperatively and collaboratively with others involved in the care of the Soldiers and their Families or caregivers. OT will reevaluate Soldier’s progress towards their CER goals every 90 days. Reevaluation of goals will be reflected at subsequent scrimmages and FTRs.

a. The SRU OT responsibilities include, but are not limited to—

(1) Communicate routinely with the IDT and other SRU medical staff and ensure CER activity is coordinated with the medical treatment plan.

(2) Complete initial Phase I goal setting training for all SRU Soldiers no later than 21 days of entry into the Complex Care Platoon.

(3) Attend IDT and treatment meetings.

- (4) Assist the medical team in Traumatic Service member's Group Life Insurance ADL evaluation, as needed.
- (5) Assist the medical team in SCAADL ADL evaluations.
- (6) Assist the medical team with the determination of the need for a NMA.
- (7) Provide input towards the CRP by communicating the effects Soldiers' conditions may have on their career goals and keep the SRU NCM informed of all clinical conditions that may affect the recovery plan.
- (8) Act as SME for referral for assistive technology, and provide consultation for Americans with Disability Act requirements.
- (9) Interface with and coordinate with other OTs on and off the installation.
- (10) 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.
- (11) Attend scrimmages and FTRs.
 - b. The SRU COTA responsibilities include, but are not limited to:
 - (1) Communicate routinely with the IDT and other SRU medical staff and ensure CER activity is coordinated with the medical treatment plan.
 - (2) Complete initial Phase I goal setting training for all SRU Soldiers no later than 21 days after the report date to the SRU.
 - (3) Attend IDT and treatment meetings.
 - (4) Assist OT in SCAADL ADL and Traumatic Servicemember Group Life Insurance (TSGLI) ADL evaluations as directed to the extent allowed by state license.
 - (5) Provide input towards the CRP by communicating the effects Soldiers' conditions may have on their career goals and keep the SRU NCM informed of all clinical conditions that may affect the recovery plan.
 - (6) Act as SME for referral for assistive technology, and provide consultation for Americans with Disability Act requirements.
 - (7) Attend scrimmages and FTR.

6–25. Provision of occupational therapy registered care standards and timelines

- a. The OT will—
 - (1) Complete an initial evaluation within 14 days of Soldiers' report date at the SRU to determine Soldiers' functional ADL status and areas of ability for work reintegration (see chapter for makeup and responsibilities of the adaptive reconditioning team). This will be charted in AHLTA. Initial evaluation will include—
 - (a) Assessment of functional status.
 - (b) Performance in ADLs, to include Sleep.
 - (c) Pain assessment.
 - (2) Provide additional screenings and assessments in collaboration with OT initial evaluation. Items can include, but are not limited to:
 - (a) Fatigue assessment.
 - (b) Perceived deficits questionnaire.
 - (c) Leisure skill index.
 - (d) Functional status questionnaire.
 - (e) Modified occupational self-assessment.
 - (f) Musculoskeletal screen.
 - (g) Learning style assessment.
 - (h) Barriers to learning.
 - (i) Screening for accommodations and/or assistive technology needs.
 - (3) Plan of care will include—
 - (a) Phase I goal setting training.
 - (b) Phase II goal setting training recommendations.
 - (c) Life skills groups.
 - (d) CER preparatory activities.
 - (e) Request to medical provider for referral for MTF OT intervention, if needed.
 - (f) Request to medical provider for referral for any care or discrepancies found during evaluation, as needed.
 - (g) Request to medical provider for referral for any procurement of equipment if needed.
 - (h) Computer/Electronics Accommodations Program Assessment as needed.
 - (i) Military occupational specialty (MOS), professional qualification skills, and functional work assessments if needed.

(4) Consult and collaborate with other 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 CRP process by providing Phase I goal-setting training no later than 21 days from entry into the Complex Care Platoon. The OT may delegate the Phase I goal-setting to the COTA. The OT (or COTA if designated) will assist the Soldier with entering goal into ARCS upon completion of the Phase I goal-setting training.

(6) Provide supervision and oversight to the line COTA, as required by their state license to implement the plan of care. The OT will conduct all reevaluations, coordinate CER with the TC, assist with planning and implementing Adaptive Reconditioning Programs and provide supervision of the COTA as required by their State licensure.

(7) Assist the PT and other members of the adaptive reconditioning team (SRU surgeon SRU commander, and others designated by the SRU 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 IDT and adaptive reconditioning teams to grade and modify Adaptive Reconditioning Programs to ensure the program addresses the Soldier's transition goals. In the absence of a PT, the OT will serve as the Adaptive Reconditioning Program Manager.

(8) Communicate with the SRU NCM on the Soldier's clinical CER eligibility status and will provide input on the Soldier's functional abilities to the SRU NCM for CER eligibility determination. The OT and TC will collaborate on the career goals and engage the Soldier in CER preparatory activities based on the Soldier's CRP goals. The OT will complete a functional evaluation to assist the IDT with CER eligibility determination, as well as recommendations based on appropriate and supportive work assignments. This is communicated by way of CER eligibility (as documented in ARCS) as well as documenting in AHLTA. The OT will use objective assessments, evaluations, observations, and if available, results of functional evaluations by other providers in determining the Soldier's readiness. The OT will consider factors involving, but is not limited to—

(a) Soldier demonstrating good self-management organization, communication, and analytic skills to positively contribute to a work environment.

(b) OT reviewing the functional demands of the proposed worksite.

(c) Soldier's ability to get to and from CER worksite.

(9) If the OT, along with the IDT, determine that a functional capacity evaluation is required, the OT will coordinate the assessment. The functional capacity evaluation will assist in determination of:—

(a) RTD track assessment, in consultation with the career counselor.

(b) Physical demands of the Soldier's MOS and area of concentration.

(c) Critical tasks related to the Soldier's MOS and area of concentration.

(d) For transition out of the Army, the physical and mental demands of the potential job description. OT will reevaluate Soldier's progress towards their CER goals every 90 days. Re-evaluation of goals will be reflected at subsequent scrimmages and FTRs.

(10) The OT will work with the TC for referrals to VA VR&E counselors for vocational testing and counseling. The OT will work with the IDT to assist in facilitating Soldier's successful completion of the ARCP requirements to include referrals to ACES for education assistance.

b. The COTAs, under the supervision of the OT, will conduct life skills groups aligned to each individual Soldier's needs.

(1) The Life Skills Groups will be functional and goal oriented. The OT or COTA will refer Soldiers to Life Skills groups as indicated by the OT during intake and follow-up evaluations. They will be conducted either one-on-one or in a group depending on the needs of the individual Soldier.

(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.

(k) The CER preparatory skills. The COTA, under the guidance of the OT, will provide preparatory skills related to the career or education track and in alignment with the Soldier's CRP goals. These activities will not replace SFL-TAP transition requirements, but are intended to run in conjunction with SFL-TAP and other programs that

support transition. If the Soldier receives skilled training in other forums (classes provided in the SFAC, local community courses, and so forth), they are not required to duplicate the process, classes, or skill training. CER preparatory skills will be documented in AHLTA and in ARCS. CER preparatory skills will include, but are not limited to—

1. Self-management skills (to include sleep hygiene, medication management, financial management, etcetera).
2. Interview skills. Communication skills (to include, but not limited to: interview skills, communication styles of military and civilians, conflict management, conflict resolution, family communication, relationship building, and so forth).
3. Organizational skills (such as: resume writing, work space management, study skills, task planning).
4. Analytical skills (such as: multitasking, problem solving skills, and so forth).
5. Relationship building.
6. MOS Crosswalk in accordance with SFL–TAP completion.

Section V

Physical Therapy

6–26. Policy

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

6–27. Physical therapist and therapist assistant team collaboration

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

- a. Complete the initial physical conditioning evaluation and screen for all new Soldiers while assigned during in-processing, but no later than 21 days from entering the Complex Care Platoon.
- 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 IDT meetings.
- d. Provide input into the CRP physical domain goal setting process.
- e. Advise command on adaptive reconditioning issues.
- 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 SRU commander.
- i. Attend scrimmages and FTRs.
- j. The PTA should assist the PT in reevaluation of physical fitness as directed to the extent allowed by his or her license as a military PTA.

6–28. Provisions of physical therapy care standards and timelines

a. The PT will complete an initial physical conditioning assessment and screening within 21 days from entry into the Complex Care Platoon 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 CRP 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 to the IDT for the development of sub-goals, in any of the six CRP domains, and the Soldier's transition outcome goal.
- (5) Ensure the Soldier's profile is appropriate to the Soldier's abilities and limitations.
- (6) Modify the Soldier's profile, or consult with the physical profile's originating provider for modifications or changes when appropriate in accordance with AR 40–501.
- (7) Assist with the neuro-musculoskeletal care coordination, as appropriate.
- (8) Provide ongoing consultation with all IDT members to ensure completion of all physical therapy requirements.
- (9) Communicate initial evaluation and screen results to the IDT members prior to the initial scrimmage.

- (10) Reevaluate the Soldier's physical fitness health every 90 days.
 - b.* The PT's initial reevaluation and screening will include, but is not limited to—
 - (1) Soldier goals for physical domain.
 - (2) Height and body composition.
 - (a)* Body mass index.
 - (b)* Army body composition standards.
 - (c)* Profile.
 - (3) Pain assessment.
 - (4) Current exercise plan and level.
 - (5) Most recent Army physical fitness training score.
 - (6) Soldier goals while assigned to the SRU.
 - (a)* Return to current MOS.
 - (b)* Change MOS.
 - (c)* Transition from the Army.
 - (7) Musculoskeletal screen.
 - (8) Plan of care will include—
 - (a)* Request to medical provider for referral for physical training evaluation at MTF for orthopedic concerns, if needed.
 - (b)* Referral request to medical provider for physical training evaluation or concussion care, if needed.
 - (c)* Physical reconditioning ability group.
 - (d)* A list of activities related to the Adaptive Reconditioning Program that the Soldier may participate in, to address interests and goals pertaining to the physical domain, in accordance and agreement with the Soldier's physical profile. This information will be noted on the Adaptive Reconditioning Activity Plan.
 - c.* The PTA will—
 - (1) Carry out the Soldier's plan of care as per the PTs guidance.
 - (2) Assist the adaptive reconditioning team, as required.
 - (3) Assist the PT in reevaluation the Soldier's physical fitness health.

Chapter 7

Human Resources and Administrative

Section I

Entry, Exit, and Transfer into the Army Recovery Care Program

7–1. General

- a.* The mission of a SRU 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 SRU Soldier falls under the mission command (MC) and M2 of a SRU. A SRU Soldier's primary mission is to heal and transition.
- b.* Soldiers already at the Medical Retention Determination Point (MRDP), or Soldiers already in the Integrated Disability Evaluation System (IDES) or pending enrollment into IDES before packet submission, are eligible for SRU entry only as an exception to policy. Minimize the use of exception to ensure that SRU resources are available to manage Soldiers with complex case management requirements to reach MRDP. The Army senior commander is the exception approval authority for SRU entry.
- c.* The Triad of Care works in concert with the TOL (see para 2–25) to ensure advocacy, continuity of care for SRU Soldiers, and a seamless transition of SRU Soldiers either back to the Force or to Veteran status.
- d.* Assignment or attachment to a SRU will not be performed solely to facilitate the early requisitioning of personnel replacement or for purely compassionate reasons.
- e.* The TOL, which is comprised of a SC on their installation, the designated MTF TOL representative, and the SRU commander, 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 SRU meet the entrance criteria specified in this section.
- f.* At locations without a SRU, commanders will send entry packet to the RHC RCO for entry eligibility decision and appropriate TOL location based on current guidance from STARTC.

7-2. Army Recovery Care Program Entry

a. The Single entry criteria applies to all COMPO Soldiers and is based on complex case management. ARCP Single Entry Criteria. 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; the complexity of the Soldier's condition requires either clinical case management or the Soldier's psychological condition is evaluated by a qualified licensed medical or behavioral health (BH) provider as posing a substantial danger to self or others if Soldier remains in the parent unit.

b. Complex Care is defined by TSG as: "A medical professional aggregate assessment based upon the severity of illness, degree of impairment, required level of comprehensive care management, and commitments of time and resources." Definition allows medical professionals to make assessments based on each Soldier's overall medical situation, treatment needs, and the availability of care in geographically dispersed locations.

c. The TOL will review applications according to standard timelines. Entry decisions for Soldiers assigned to SRU installations will be made no later than 14 training days after the SRU receives the packet. Entry decisions for RC Soldiers and Soldiers not assigned to SRU installations will be made no later than 7 training days after the SRU receives the packet.

7-3. Management of Reserve Component Soldiers

a. RC Soldiers (COMPO 2 and 3) not in AGR status who do not meet the eligibility criteria above will be managed remotely utilizing the Reserve Component Managed Care (RCMC) program (COMPO 2) and the Remote Medical Management (RM2) (COMPO 3).

(1) Qualifying criteria for entry into RCMC or RM2 are as follows:

(a) The Soldier's medical condition is incurred or aggravated in the line of duty (LOD).

(b) There is a need for evaluation, treatment, and/or disability evaluation processing while in an active duty status.

(c) The Soldier's condition requires definitive care. Definitive care is defined as a specific treatment plan of greater than 30 days, which has been reviewed and validated by a military medical authority. The treatment plan is expected to direct progress towards the MRDP and either return the Soldier to duty or begin the IDES process.

(d) The Soldier's condition(s) must prevent the Soldier from performing his or her Military Occupational Specialty (MOS), Area of Concentration (AOC), or at least one of the functional activities listed on the DA Form 3349, which all Soldiers must perform regardless of MOS or AOC.

(2) National Guard Reserve Soldiers (COMPO 2) will be managed in the RCMC program.

(3) USAR Soldiers (COMPO 3) will be managed in the RM2 program.

b. 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 active duty (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 DES process. Soldiers in the DES process will not be automatically assigned or attached to the SRU; they must meet the entry criteria stated for assignment or attachment into the SRU.

7-4. Ineligibility

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

a. Soldiers expected to reach MRDP or enter the IDES process within 60 days are eligible for entry *ONLY as an exception to policy* (see 7-1b).

b. Pregnant Soldiers. Pregnancy alone is not a criterion for attachment or assignment to a SRU. However, pregnant Soldiers who meet ARCP entrance criteria in paragraph 7-2a or 7-3 may enter the SRU if the treatment for qualifying conditions can be conducted without interfering with the pregnancy.

c. Soldiers in initial entry training, advanced individual training, or one station unit training. The TOL, or designated authority may approve, by exception, initial military training Soldiers into the SRU.

d. Soldiers pending MAR2.

e. Soldiers in temporary disability retirement list status.

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

g. Soldiers approved for COAD or COAR status.

h. Soldiers who are pending or undergoing UCMJ, or actions prohibiting a PCS move (Soldier is flagged), and/or LODs require a general officer member of the TOL and/or General Court-Martial Convening Authority with jurisdiction to approve the assignment or attachment to the SRU. Approval for RC Soldiers is CG, HRC.

7-5. Medical retention for all Component Soldiers

a. RA 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). The authority for attachment and assignment of AGR Soldiers to a SRU is the CG, HRC.

b. COMPO 2 and 3 Soldiers may voluntarily apply for 10 USC 12301(h) orders under one of the medical care processing programs outlined in AR 600-77.

7-6. Senior grade entry approval into the Soldier Recovery Unit

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 SRU TOL. The SC is the approval authority; however, an endorsement from the first GO in the chain of command to the TOL must accompany the request, with the following exception: CG, HRC is the approval authority for all MRP2 or ADME orders. These requests are reviewed by the Medical Review Board (MRB) and forwarded to HRC for final adjudication and orders processing.

b. General officers will not be relieved from duty assignment and assigned or attached to a SRU without the approval of the DCS, G-1.

7-7. Assigned versus attached

COMPO 1 Soldiers may be attached or assigned, depending on the duration of estimated stay in the SRU. COMPO 1 Soldiers may be attached up to 179 days, but must be assigned at the 180th day. COMPO 2 or 3 Soldiers who meet the Complex Care entry criteria as well as COMPO 3 Soldiers who meet the RM2 criteria are always attached regardless of the length of stay.

7-8. 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. For RA Soldiers, this will be their home station. For RC Soldiers, this will normally be their home of record. HRC, in coordination with the MTFs, will assist in determining the SRU location based on the ability to provide necessary evaluation for treatment, the available capacity, and the proximity to the Soldier's duty station, home, or support system 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 (see paras 7-11 and 7-12).

a. COMPO 1 Soldiers will primarily be assigned to the SRU 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 granted a non-resident exception by the SRU commander. Soldiers classified as non-resident exceptions will be managed remotely from the SRU on a case-by-case basis depending on their medical needs, Family location, and support needs. The SRU commander will make the determination if a Soldier is to be classified as non-resident. (see para 7-12 for the ETP criteria). Soldiers from any COMPO who meet the criteria for Complex Care are eligible to be classified as a non-resident exception. Non-resident exceptions meet the ARCP entry criteria and receive the full benefits of the ARCP. The non-resident exception classification is distinct from the Remote Medical Management (RM2) program, which is available only to eligible non-AGR USAR (COMPO 3) Soldiers.

b. For RC Soldiers returning through demobilization stations requiring SRU placement, the STARTC will directly arrange placement at the SRU closest to the Soldier's home or support system that has the medical capability and capacity to care for the Soldier. The selected SRU should take into consideration whether the Soldier's home is within its assigned geographic area.

c. The RC Soldiers considered high risk for safety or BH should remain attached to a SRU.

d. All initial orders and extensions will be coordinated with HRC for processing.

7-9. 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 SRU medical provider 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.

(4) Soldier is in non-compliance with program requirements.

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 SRU until a final DES determination is rendered and the Soldier is retired or separated.
- (2) Soldier receives final determination on UCMJ or adverse administrative actions in accordance with ARs.
- (3) Soldier's eligibility for, and election to accept, a nonmedical retirement.

7–10. Exit criteria for component 2 and 3 Soldiers not in Active Guard Reserve status

a. A RC Soldier should be recommended to the CMO for REFRAD when any one of the following situations exists:

- (1) Soldier's written, voluntary election to REFRAD after being counseled on their right to DES or IDES processing and the associated benefits of a medical discharge should the PEB find the Soldier unfit for duty.
- (2) Permanent profiles with a designator of 1 or 2 in all categories (medical readiness classes 1 and 2).
- (3) Soldiers with an expired temporary profile that will not be renewed.
- (4) Temporary profile expected to resolve within 30 days and meet the conditions of (2) or (3) above.
- (5) All medical conditions with an associated line of duty determination have been resolved by meeting the conditions of paragraphs 7–10*a*(2), (3), or (4) above.
- (6) Incarceration expected to exceed 30 days in duration which prevents the Soldier from participating in the CRP.
- (7) Completion of the DES process with a finding of fit for duty or COAR status.
- (8) Documentation of non-compliance with program requirements.

b. Recommendation for retirement or separation should be used when one of the following situations exists for an RC Soldier:

(1) Completion of the DES process with a finding of not fit for duty. COMPO 2 and 3 Soldiers who do not meet Army retention standards described in AR 40–501 will remain attached to the SRU until a final DES 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. The following Soldiers are not eligible for involuntary REFRAD:

(1) Soldiers who have an unresolved 3 or 4 profile designators.

(2) Soldiers who have a temporary profile greater than 30 days in which the Soldier is unable to perform one or more of the functional activities.

(3) Soldiers who do not fall under one of the categories listed in paragraphs 7–8*a* and 7–8*b*.

d. Soldiers who voluntarily request to leave the SRU 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 SC after consideration by the TOL, and concurrence of the respective ARNG deputy State surgeon or regional support command surgeon or designated medical officer. Additionally, the Soldier must—

(1) Submit a DA Form 4187 (Personnel Action) for declination to remain on 10 USC 12301(h) orders, or withdrawal statement through their 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 will be required to sign the withdrawal statement only after counseling by MEB legal advisor about the benefits of 10 USC 12301(h) orders programs to include the incapacitation pay, and transitional medical benefits concerning the consequences of voluntarily leaving the SRU prior to receiving a fit for duty rating.

7–11. Unit notification

a. The designated MTF TOL representative will ensure that the parent unit is notified any time a Soldier enters a SRU. 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 SRU. Another notification is made when the patient is returned to duty or another disposition is made.

b. The designated MTF TOL representative must ensure procedures are in place for the SRU to receive notification when a Soldier is admitted to the MTF during periods of mobilization or named operations, if the deployed unit cannot be determined or contacted.

c. Designated MTF TOL representative must ensure procedures are in place for the SRU to receive notification when a patient is admitted while enroute overseas.

7-12. Coordinating instructions and screening for entry into a Soldier Recovery 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 SRU.

b. Screening.

(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 TOL.

c. Coordinating instructions.

(1) SCs will ensure Soldiers who may qualify for assignment or attachment to the SRU are referred to the TOL for evaluation.

(2) Unit commanders will provide a completed nomination packet to the TOL.

7-13. Exception to eligibility for transfer

a. Policy.

(1) All COMPO 1 Soldiers will be assigned or attached to the SRU at the installation of their parent unit. If a SRU does not exist on that installation or medical capability or capacity is not available, an alternate SRU with medical capability and capacity commensurate with Soldier's needs closest to their support network may be requested. If medical capabilities are not available at current SRU, 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 SRU with medical capability and capacity commensurate with their needs that is closest to their support network. Any transfer action that does not meet criteria outlined in paragraph 7-11 will be considered an ETP.

b. The originating MTF or SRU 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 the 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 representing the Soldier stating the general nature of the legal matter and the reason why transfer of the Soldier will be beneficial to the legal matter at hand.

(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; or

(b) 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 the Soldier or 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 of the Soldier or Family member.

(11) Adequate documentation supporting movement of Soldier more than one time within the same fiscal year, if applicable.

d. Soldiers will submit a signed 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, will be submitted through the governing RHC to the STARTC. If the ETP involves more than one RHC, then both RHC's must provide input.

e. Approval authority for all ETP transfers of Soldiers is the respective RHC commander.

f. Responsibilities.

(1) *Leadership involvement.* Leaders will actively support the entire spectrum of a Soldier's movement among SRUs; identifying the goal of healing "closest to home" as a priority.

(2) *The Recovery Care Office.* The Recovery Care Office will process ETP transfers to the respective RHC commander for approval and —

(a) Provide recommendation for resolution of discrepancies and disputes.

(b) Coordinate and collaborate for overall process improvement and subsequent changes to policy and documentation regarding SRU transfers. Monitors MODS transfer module to identify Soldier transfer eligibility.

(3) *Regional health 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 from request for information.

(4) *Soldier Recovery Unit commanders.* Ensure MC and M2 and lead coordinator coordination and communication between gaining and losing unit. The gaining unit must acknowledge the report date of the Soldier and be proactively involved in the warm handoff of the inbound Soldier and their Family.

(5) *Soldier Recovery 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 SRU Soldier transfers. Additionally, the STARTC will—

(a) Request assistance from RHCs as necessary and ensure submitted PMRs are resolved within three business days.

(b) Update Soldier movements within the TRANSCOM Regulating and Command and Control Evacuation System database within three business days upon receipt of disapproval response from the OTSG.

(7) *Medical Command Human Resources.* In coordination with STARTC, publish attachment orders for all COMPO 2 and 3 SRU Soldiers within three business days of notification from STARTC with the goal of moving Soldiers closest to their home of record or support system.

7–14. Care in a non-Army medical facility

The SRU Soldiers outside a 50-mile radius to a DHA MTF may be admitted to a VA or civilian medical facility. The SRU having geographical area of responsibility will place the Soldier in the status of absent sick in accordance with AR 40–400 guidance. The responsible SRU will evaluate the need to attach the Soldier and if appropriate, prepare the order and forward it to the Soldier's assigned unit and the facility at which the Soldier is hospitalized.

a. Table 7–1 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 to include address of the remote medical facility where the Soldier is receiving treatment.

(2) The SRU case manager will document each contact with the Soldier receiving remote care.

(3) The SRU 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 or other non-Army medical facility.

(4) The Soldier's SRU NCM will contact the Soldier in remote medical facilities weekly.

(5) The SRU will provide assigned or attached Soldiers and their Family members with standardized SRU information containing SRU 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 AHLTA and MODS–WT module.

(7) Return to duty clearance. Soldiers attached while absent sick will not be released from attachment without the SRU medical provider documenting (and/or concurring with documentation from discharging facility) of both a physical assessment at discharge and determination of duty status.

c. The Lead coordinator is responsible to track and manage Soldiers receiving outpatient treatment at any VA or civilian medical facility using the LCC.

Table 7–1
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.

Table 7-1
Current location fields—Continued

VA inpatient	For all Soldiers receiving inpatient treatment in a VA facility (non-Polytrauma Rehabilitation Centers).
VA Polytrauma Center	For all Soldiers receiving inpatient treatment at a VA Polytrauma Rehabilitation Center.
VA rehab	For all Soldiers receiving outpatient treatment at any VA medical facility.

7-15. Return to Duty of component 1 Soldiers assigned to Soldier Recovery Units

COMPO 1 Soldiers who are returned to duty and assigned to a SRU will be reported to HRC by the SRU 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 designated MTF TOL representative 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 the 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 SRU solely to await the results of these actions. Designated MTF TOL representative 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 SRU until instructions are received from HRC. The designated MTF TOL representative will promptly report such officers to CG, HRC (AHRC-PDT-R).

7-16. Disposition of non-mobilized Reserve component personnel

Inpatient non-mobilized RC personnel on active duty orders and not approved for 10 USC 12301(h) orders for (medical evaluation, SRU, or RM2) status will not be attached to the SRU. Such Soldiers may remain in a MTF in an inpatient 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.

7-17. Non-Army personnel

The SRU 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 SRU at the request of the Service. The SRU will account for attached personnel from other Services in MODS-WT.

7-18. Geographically dispersed personnel

- a. Geographically dispersed Soldiers assigned or attached to units that are not based on an installation with a SC or designated MTF TOL representative may be eligible for entry to a SRU, provided they meet eligibility criteria in paragraph 7-2 or 7-3.
- b. Requests for SRU entry should be submitted through the requesting command’s G-1, and command surgeon or psychologist, and through DCS-ARC for review and validation. The SC is the final approval authority for geographically dispersed personnel.

7-19. Enrollment of Soldier Recovery Unit cadre and Deputy Chief of Staff-ARC Personnel into the Army Recovery Care Program

- a. SRU cadre and DCS-ARC staff requesting enrollment into the ARCP will follow the following guidance:
 - (1) Meet the entry criteria in accordance with paragraphs 7-2 and 7-3.
 - (2) Submit for enrollment into the ARCP and assignment or attachment to a SRU with relevant medical documentation accompanying the DA Form 4187 through the requesting SRU commander or DCS-ARC.
- b. The approval or disapproval authority for RCO staff and Cadre is the SC at the gaining SRU. For DCS-ARC staff, the interim approval authority is the OTSG-Deputy Surgeon General with final approval or disapproval from the SC.

c. This does not apply to RC cadre and staff that are processing through a Mobilization Force Generation Installation (MFGI) for REFRAD. These Soldiers are treated like any other Soldier processing through the MFGI for REFRAD which may be considered for entry into a SRU and processed in accordance with paragraph 7–2.

Section II

Cadre Assignments and Utilization

7–20. Cadre selection

a. In accordance with AR 614–200 for enlisted assignments, or AR 614–100 for officers, and SRU table of distribution allowances (TDA), the SC; CG, HRC; CG al, MEDCOM; Chief, NGB; and CG, USARC, are responsible for resourcing and approving personnel to fill component-specific SRU positions. SRU TDAs are a combination of AC, ARNG, USAR Soldiers and DA Civilians designated to support the population of SRU Soldiers. The Force Providers (FP) will select and the SCs will approve personnel to fill component specific SRU Cadre positions. FPs and SCs will identify, screen, and select best-qualified candidates to fill SRU cadre positions. Thus, commanders will establish and conduct Cadre Selection Panels to select the best qualified candidates. Wounded, ill, or injured Soldiers that are RTD from the SRU are not eligible for selection as a cadre member without at least 1 year in between assignment or attachment to the SRU. Request for ETP will be determined through DCS–ARC to OTSG, MEDCOM approving authority.

b. SRU is inclusive of all size units responsible for the care and leadership of Soldiers. RC refers to ARNG and USAR Soldiers. The responsible FP is defined as the SC; CG, HRC; CG, MEDCOM; CG, USARC; and Chief, National Guard Bureau

c. Soldiers identified for SRU cadre positions must meet the following military education and experience requirements:

(1) *Squad leaders.*

(a) Advanced Leader Course required.

(b) Previously successfully served in grade equivalent leadership position.

(c) At minimum, hold the rank of E–6.

(2) *Platoon sergeants.*

(a) Senior Leader Course required.

(b) Previously successfully served in grade equivalent leadership position.

(c) At minimum, hold the rank of E–7.

(3) *First sergeants.*

(a) Senior Leader Course and Structured Self Development 4 required.

(b) Previously successfully served in grade equivalent leadership position.

(c) At a minimum, hold the grade of E–8.

(4) *Company commander.*

(a) Captains Career Course required.

(b) Previous successful command preferred or demonstrated leadership performance commensurate with grade.

(c) At a minimum, hold the rank of O–3.

(5) *Nurse case manager.*

(a) Captains Career Course preferred.

(b) Clinical experience in past 24 months.

(c) At minimum, hold the rank of O–3.

(6) *Senior nurse case manager.*

(a) Advanced Nurse Leadership Course and Intermediate Level Education is preferred.

(b) Previous nurse case manager experience.

(c) Minimum of 5 years clinical experience.

d. Cadre will meet prescribed grade, educational, and experience requirements for the position.

e. Additionally, Soldiers identified for SRU cadre positions must display strong manner of performance and strong potential for promotion.

f. Soldiers that are RTD from the SRU are not eligible for selection as a cadre member without at least 1 year in between assignment or attachment to the SRU. Requests for ETP will be determined through DCS–ARC to OTSG, MEDCOM approving authority.

g. Soldiers will meet medical readiness criteria 1 or 2 in accordance with AR 40–501, chapter 3; meet dental readiness; pass Army physical fitness training; meet height and weight standards; and possess the required security clearance. Human Immunodeficiency Virus test date must be within 2 years of the tour start date (see AR 600–110). An

unfavorable personnel action properly imposed in accordance with AR 600–8–2 prohibits assignment and/or attachment to a SRU as a cadre member.

h. Soldiers identified for SRU 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. Soldiers will undergo a background check in accordance with DA Assistant Chief of Staff, Personnel (G–1) instructions, prior to assignment or attachment to a SRU.

i. All personnel identified for assignment as SRU cadre will be assigned or attached against an authorized TDA position corresponding to their Service component. COMPO mismatches will only be approved by exception and only for special circumstance detailed in paragraph 7–22.

j. AC enlisted Soldiers identified for SRU cadre positions are selected primarily from the installation of assignment. HRC, Enlisted Personnel Management Directorate (EPMD), Readiness Division in coordination with HR MEDCOM, will build and fill any additional necessary requirements thereafter.

k. RA officers identified for SRU cadre positions are selected primarily from the installation of assignment. Installation G–1 must coordinate with HRC, Office of Personnel Management Directorate (OPMD), and Operations, prior to internally assigning officers as SRU cadre. HRC will coordinate with SRU S–1 POC to build and fill any additional necessary requirements thereafter.

l. On-installation reassignments must be coordinated through the appropriate EPMD or OPMD career branch to ensure personnel are not being considered for their assignments. Soldiers on assignment instructions will not be used for SRU cadre unless coordinated and approved by HRC. Other assignment eligibility and availability codes should not preclude assignment to a SRU for Soldiers identified for cadre assignments on the installation.

m. SRU 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 SRU cadre. Candidate recommendations will then be forwarded to the SC for final approval. SRUs will maintain all interview packets for the duration of assignment or attachment.

n. Upon acceptance, MEDCOM Reserve Augmentation and Mobilization Plans and Operations Division will process RC cadre through DA G–3, Tour of Duty (TOD) for a request for orders under Contingency-active duty for Operational Support (CO–ADOS), 10 USC 12301(d) in a voluntary status in accordance with AR 135–200, policy for management of RC Soldiers on active duty for Operational Support and Full-Time National Guard Duty for Operational Support, consecutive CO–ADOS tour lengths cannot exceed 1095 days.

o. RA selectees must have less than 17 years active Federal service (AFS) and at least 2 years of retention from start of tour. Tour assignment length is 2 years to avoid cadre strain. RA cadre personnel will be stabilized for 24 months upon assignment into the SRU. HRC will reassign AC cadre after 24 months.

p. RC must have less than 17 years AFS at completion of tour. RC cadre orders are for a period not to exceed 730 days.

q. One 12–month extension may be requested for exceptional cadre under extenuating circumstances. Cadre members wishing to continue in the position after their initial TOD must submit an extension request in accordance with AR 614–200 through the chain of command to DCS–ARC for recommendation and submission to OTSG, MEDCOM approving authority. Approved extension requests must be entered into the Department of the Army Mobilization Processing System–Army (DAMPS–A) and TOD no later than 180 days before their initial orders end.

r. To maintain career progression, cadre members will not have concurrent tours at more than one SRU.

s. Assignment and tour lengths for CSMs will be strictly managed by HRC, Sergeants Major Branch.

t. SRUs will initiate replacement and identification of personnel with the responsible FPs no later than 180 days prior to the projected or programmed loss date.

u. SRUs may request personnel through their chain of command MTF and RHC with endorsement from the SC to have HRC backfill COMPO 1 positions vice filling those positions with local assets. Warrior Transition Units will forward requests to MEDCOM HR Soldier Transition Support Branch for coordination with HRC.

7–21. 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.

7–22. Component mismatch assignments

a. All personnel identified for assignment as cadre to a SRU will be assigned or attached against an authorized position corresponding to their service component (as reflected in the TDA and MODS–WT module of the contingency battle roster (CBR)).

b. By exception, component mismatches may be approved when a need for an immediate fill is demonstrated, such as, performance, conduct, illness, or injury that has resulted in the removal of the Soldier currently assigned or attached to the position. Such component mismatches will be for a limited duration until position can be filled with a qualified Soldier of the correct component.

c. RHCs and installation SCs must ensure that Soldiers recommended to fill key billets are properly vetted through component personnel channels (for example, HRC, USARC G-1, ARNG G-1) in advance to ensure availability prior to a mismatch submission. Based on the type of position, this effort could include the generation and staffing of assignment actions for the Accepted List Position in accordance with OTSG/MEDCOM local policy.

d. Requests for component mismatch approval will be sent by the requesting SRU “through” the SC electronically to usarmy.pentagon.medcom-wtc.list.g1-hrab@mail.mil. DCS-ARC will process requests with recommendation to OTSG, MEDCOM approving authority.

e. Upon receipt of requests, DCS-ARC will notify the appropriate FPs of the identified Soldier and the position. Requests for concurrence and non-concurrence will be sent in writing to each FP.

f. Once DCS-ARC receives the concurrence or non-concurrence from the FP, DCS-ARC will send forward to OTSG, MEDCOM approving authority for decision. 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. By name request assignments are not authorized without the written approval of OTSG, MEDCOM approving authority.

7-23. Component mismatch execution

a. The SRU commander will—

(1) Follow guidance and procedures outlined in paragraphs 7-20 through 7-23 when identifying and selecting military personnel to fill component-specific SRU cadre positions.

(2) Coordinate with designated MTF TOL representative, RHC, MEDCOM HR, ARCP Soldier Services Directorate, USARC, ARNG, and SC to ensure unit is fully staffed to ratios applicable to each position.

(3) Ensure military personnel assigned as SRU cadre successfully complete the SRU cadre Orientation Course (distance learning) and appropriate SRU 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. SRU commanders will also use the USA 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 SRU commander assesses the Soldier to have personal stressors that will negatively impact duties and performance, the SRU commander should discuss with the SC or HRC a potential reassignment for the Soldier.

b. Counsel all RC Soldiers and officers on submitting extension requests and the 1095 rule (see para 7-19) and sanctuary. RHCs will—

(1) Monitor and coordinate with SC to ensure that cadre staffing of subordinate SRUs is in accordance with approved and prescribed staffing ratios.

(2) Once a month, report the number of open positions within the region (broken down by unit) to DCS-ARC. Validate that all RC positions are in the TOD System and that TOD positions are eligible to accept applicants.

(3) Train SRUs on the use of the TOD System.

c. SCs will ensure that subordinate SRUs are fully manned in accordance with approved and prescribed staffing ratios. At their discretion, SCs may fill squad leader positions up to 25 percent above required ratio.

7-24. Cadre stability

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. Stability of cadre, both medical and administrative, is critical to the success of the ARCP. Commands must minimize turnover and closely control the movement and transfer of members of the Triad of Care (SL, PSG, and NCM) within SRUs—

a. SRU commanders approve the movement of cadre within the Triad of Care.

b. It is important to note that RC Soldiers are approved and brought on active duty for a specified duty and location. If an RC Soldier is not utilized in accordance with their mobilization orders, SRU commanders must submit a request for amendment of orders or submit for an early REFRAD with a backfill requirement, through DCS-ARC to DCS, G-3/5/7, DA Military Operations.

c. Personnel assigned to a Triad of Care position will remain in their assigned position for the complete tenure of their tour unless one of the following obligations occurs:

- (1) Permanent change of station, professional development, or other official administrative reassignment as directed in AR 614–200 or AR 614–100.
- (2) Relief for Cause, Article 15 or other UCMJ and/or disciplinary actions.
- (3) Command directed and approved move.
- (4) Recall for involuntary mobilization by the RC command.

7–25. Exemption from Professional Filler System

- a.* The SRU cadre personnel and DCS–ARC 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 SRU cadre personnel are assigned to the proper SRU operational Unit Identification Code and are posted in assigned positions in the CBR.
- c.* The MEDCOM major subordinate commands will not assign SRU cadre personnel to PROFIS, PDS, medical augmentee and individual assignments.
- d.* As an exception, COMPO 1 medical corps officers assigned to SRUs who have not deployed may be assigned as PROFIS, but not PDS, medical augmentee, or individual assignments.
- e.* The SRU cadre and DCS–ARC 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.

7–26. Collateral duty exemption

- a.* The SRU 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-SRU commanders at any level will not task SRU 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 CRP.
- c.* SRU commander may utilize SRU Soldiers 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 SRU medical provider). The SRU medical provider 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 SRU Soldiers, or utilizing heavy machinery.

Section III

Career and Education Readiness Worksite Selection

7–27. Definition

The CER program is a disciplined, purposeful approach that prepares Soldiers for success in a career that is personally meaningful, rewarding, and enables the Soldier to achieve self-determination and financial independence. The focus of a Soldier’s CER program is participation in CER activities that are simultaneously therapeutic and beneficial to the Soldier’s rehabilitation.

7–28. Policy

- a.* Prior to participation in a CER activity, Soldiers assigned or attached to a SRU must be determined CER eligible, which will be documented in the ARCS. CER eligibility is based upon two distinct evaluations by the M2 and the SRU commander. Determination can occur as early as in-processing, but no later than the CRP reintegration process.
- b.* Eligibility. CER eligibility is based upon two distinct evaluations by the M2 and the SRU commander, which will be documented in the ARCS.
 - (1) The medical evaluation must conclude that the Soldier is medically, emotionally, and physically ready to participate in a CER activity while continuing medical treatment. The SRU NCM, in collaboration with the IDT, is responsible for coordinating the evaluation of CER eligibility with all members of the M2. The SRU NCM is also responsible for documenting the decision in the CER tab of ARCS.

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

c. Ineligible. Soldiers are deemed ineligible from CER participation on a long term basis if one or more of the following condition exist:

(1) The M2 determines the Soldier has a medical prognosis that will not resolve or allow them to participate in CER activities during the projected length of stay at the SRU. The decision must be approved by the SRU commander and annotated in the ARCS by the SRU NCM.

(2) The SRU commander determines the Soldier cannot participate in CER activities due to administrative actions restricting participation for a minimum of 90 days. The SRU commander must review and update the CER eligibility within 90 days of the CER ineligible determination.

(3) A Soldier who becomes ineligible after being determined eligible due to a change in circumstance (for example, convalescent leave, UCMJ, and so forth). Reasons for ineligibility status will be documented in the ARCS. Procedures for CER eligibility must be resubmitted in order to resume participation in the CER activity.

d. Regardless of component, all Complex Care CER eligible Soldiers will participate in one or more activities aligning with their CRP career track and long term goal(s) at an approved CER worksite. A CER worksite is the physical location where a Soldier participates in a CER activity and is considered their place of duty if they do not have medical or other conflicting appointments.

e. Soldiers who are not CER eligible may participate in CER preparatory activities, such as:

(1) All SRU Soldiers pending separation or REFRAD must complete the SFL-TAP requirements no later than 90 days prior to separation or REFRAD.

(2) Occupational therapy life skill program and work preparation.

(3) Interview skills workshop.

(4) Resume development.

(5) Job and/or career fair.

(6) Dress for success workshop.

(7) Veterans Affairs VR&E or ACES career or educational assessments.

f. Approved CER activities are: internships, education and training, credentialing, apprenticeships, RIAWA, OJT and entrepreneurship. Medical and DES appointment always take priority over CER activities. An internship program develops and/or reinforces skills. A Soldier's need for civilian employment augments transition and supports the Soldier in both the rehabilitation and reintegration process of the CRP.

(1) *Internships.*

(a) Federal internships are coordinated through the TC and Office of the Secretary of Defense OWF Regional Coordinator or the VA Coming Home to Work Program. The approval authority to participate in OWF is the Soldier's SRU commander.

(b) A CER eligible Soldier may also participate in an OWF Federal internship at any point in time, and for any length of time while in the SRU. Soldier may participate in one or more OWF internships that align with their CRP career goal(s).

(c) Non-Federal internships, apprenticeships, and OJT must be approved through the garrison, IMCOM, and HRC in accordance with the Army Career Skills Program guidance.

(d) A CER eligible Soldier must be within 180 days of transition to participate in career skills programs.

(2) *Education and Training Courses.* Education and training courses offered through the ACES will enhance the Soldier's knowledge and support their CRP track and long term career goal(s). Courses may be funded by Army tuition assistance, self-paid, paid by scholarship, VR&E, GI Bill, or offered without a fee. Some examples of education and training programs include, but are not limited to:

(a) College courses (online or classroom).

(b) Functional academic skills training.

(c) Certification course (emergency medical technician, cardiopulmonary resuscitation (CPR), Microsoft, and so forth).

(d) Army Correspondence Courses.

(3) *Credentialing.* Credentialing is the process of meeting specific professional and technical standards for certain occupations. The credential is a license or certification which is usually obtained through completion of exam(s). Army Credentialing Opportunities On-Line is specifically designed to use as a resource in the MOS crosswalk portion of SFL-TAP Goals, Plans and Success, and can aid the Soldier in finding information on certifications and licenses related to their MOS (<https://www.cool.army.mil>). Soldiers interested in obtaining funding for credentialing programs or licensure exams should meet with an Army Education counselor.

(4) *Apprenticeship*. Apprenticeship is a combination of OJT and related classroom instruction under the supervision of a trade official. These programs are sponsored jointly by employer and union groups, individual employers, or employer associations.

(5) *Remain-in-the-Army work assignment*. A RIAWA is a place of duty (in addition to the Soldier's medical routine) that is MOS appropriate and provides a productive work therapy environment aligned with the Soldier's CRP and long-term career goal(s). To qualify, the position must be a military position filled by a Soldier. The training is intended to support Soldiers returning to duty, either in the same MOS or in a new MOS. COMPO 2 & 3 Soldiers may choose to work in an Army Reserve Center or National Guard Armory if REFRAD and returned to their assigned unit. Some examples of RIAWA include, but are not limited to:

(a) MTFs or clinics.

(b) Defense Finance and Accounting Services.

(c) SRU Offices.

(d) Army Warrior Training.

(e) Army Reserve Center or National Guard Armory (Title 10 worksite).

(6) *On-the-job-training*. OJT is employee training and tasks learned at a place of work while performing the actual job. OJT occurs in special work environment where an employee can expect to work on a daily basis.

(7) *Entrepreneurship*. Entrepreneurship is considered as development and/or management of own business. Soldiers may begin to develop their small business while in the SRU, but may not actively run a business for pay during normal duty hours.

g. All CER worksites must be within a 50-mile radius of the SRU installation. If the CER worksite exceeds the 50-mile radius, an ETP request is required. ETP requests will be initiated using a DA Form 4187, signed by the TC and the SRU commander to the respective RHC commander for approval.

h. Travel overseas and across international borders is not authorized to accommodate a CER worksite. Outside Continental United States worksites are not authorized except for Soldiers at SRUs in the Pacific RHC and Europe RHC. These locations must also adhere to the 50-mile radius and may not cross international borders or travel to another overseas location to accommodate a CER worksite.

i. All CER worksites require one JHA using a DD Form 2977 (Deliberate Risk Assessment Worksheet) and all hazards will be mitigated using the risk management tool.

(1) If the organization is a Federal agency and the JHA is completed by the Occupational and Safety Health Administration (OSHA) Agency and the document is on file, this document may be used in lieu of the local DD Form 2977; however, the OSHA JHA must have addressed Soldier's medical issues, to include medication and physical profile limitations and the SRU commander must review and endorse the form by way of a Memorandum of Record, and maintain the form in ARCS.

(2) Additionally, a DD Form 2977 is not required for education facilities that receive Federal funding as they are required to meet OSHA and ADA standards, nor are they required for online classes. However, the OSHA JHA must be reviewed and endorsed with other Federal worksites.

(3) The SRU commander will appoint a cadre or staff member who is certified to conduct the risk management to complete the DD Form 2977 (JHA).

(4) The SRU commander will review, approve, or disapprove the DD Form 2977 (JHA) and forward it to the appropriate command level in accordance with DA Pam 385-30, table 4-1.

(5) Soldiers will not be placed in any worksite that is determined high or extremely high risk and where a DD Form 2977 (JHA) or risk management has not been completed. The DD Form 2977 (JHA) and risk management measures must be completed and implemented prior to a Soldier's initial arrival at any worksite.

(6) For any worksite that is identified moderate to high risk, the SRU commander will ensure the worksite is reassessed within 5 days of the Soldier's arrival to ensure risk mitigation is effectively implemented.

(7) A new DD Form 2977 (JHA) is required if there are physical changes to the worksite and every 2 years at a minimum.

j. An OT must conduct a WSA for each non-Federal worksite to determine if it is conducive to the Soldier's profile and functional status and advise the worksite supervisor on necessary reasonable accommodations prior to the Soldier's participation.

(1) The TC must review the WSA to ensure the job duties do not exceed the Occupational Therapy Evaluation and Work and Education Readiness assessment prior to placing the Soldier in the worksite. The WSA must be completed prior to the Soldier's participation in the CER activity to ensure requirements do not conflict with the Soldier's functional limitation. If concerns arise with the worksite, a follow-on WSA should be completed by the OT, with the Soldier present, to mitigate issues and make appropriate recommendations. This can be documented on the DD Form 2977 (JHA), with annotated plans of action or mitigated issues.

(2) The OT must discuss the worksite conditions and the Soldier's limitations with the worksite supervisor by way of telephone for locations with restricted access (for example, Central Intelligence Agency). The WSA should reflect the position, and not the Soldier. A copy of the WSA will be uploaded into the individual Soldier's attachment tab in ARCS.

k. SRU commanders may release Soldiers from daily unit duties (except medical appointments and DES appointments), unit formations, physical training, and other unit requirements for the period of participation in CER activities. However, daily accountability of Soldiers is required.

l. SRU SLs will contact each Soldier's worksite supervisor monthly and visit the worksite quarterly to ensure the Soldier is accounted for and work conditions are to standards. Squad leaders will document each call and visit. The SL will upload and annotate in ARCS, the completed visit documentation.

m. CER eligibility, participation and activities will be entered and performance metrics monitored using the CER tab in ARCS.

Section IV

Leave and Passes

7–29. Leave and Pass Management Program

a. Leave and passes for Soldiers and cadre will be managed in accordance with AR 600–8–10. SRU commanders will consult with the Soldier's SRU NCM prior to approving any leave or pass, to include convalescent leave, to ensure that the request does not interfere with the Soldier's medical care plan.

b. The SRU 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 DES or IDES are authorized leave and pass; however it should not interfere with completion of DES or IDES.

7–30. Respite Pass Program

a. *Purpose.* The purpose of the Respite Pass Program is to increase resiliency among the staff at the SRUs. SRUs 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 personnel of the IDT as stated in c below assigned and working in a SRU.

c. *Military personnel.* SRU commanders and CSMs will ensure an official respite program is established that will allow the cadre members of the IDT, 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. *SRU commanders, command sergeants major, and first sergeants.* All SRU commanders, CSMs, and 1SGs should identify and adopt best practices for the implementation and execution of this program. SRU commanders will ensure IDT 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.

7–31. Medical care while on leave or pass

Soldiers will be briefed by their SRU 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 SRU NCMs immediately if they seek medical attention at an MTF or local community hospital while on leave or pass. The SRU 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. Soldier must contact the SRU NCM or the TRICARE Nurse Advice Line. The TRICARE Nurse Advice website provide contact information at <https://tricare.mil/contactus/callus/nal.aspx>.

7–32. Convalescent leave

With respect to Soldier recovery, convalescent leave before disposition of the patient is a sick day. It is granted to Soldiers in active duty status and under medical or dental care and prescribed for their recuperation or convalescence. Convalescent leave after disposition of the patient, while the patient is enroute to a new command, and when granted by a line commander after patient discharge from the hospital will be processed in accordance with AR 600–8–10.

Section V

Non-Compliance with the Army Recovery Care Program

7–33. Background

Soldiers assigned or attached to the SRU have a mission to heal and transition. SRUs will continue to provide a compassionate healing environment, while holding Soldiers to the highest standards expected of every Soldier in the U.S. Army. Soldiers are expected to be accountable and actively participate in meeting the goals outlined in their individual CRP (see para 2–22).

7–34. Removal from the Army Recovery Care Program

The approval authority to REFRAD COMPO 2 and 3 or RTD (COMPO 1) Soldier from the SRU for non-compliance is the first O–6 commander in the chain of command, normally designated MTF TOL representative. Areas of special emphasis:

a. Comprehensive recovery plan. Soldiers are accountable for establishing and meeting their goals. They will complete all the requirements related to their CRP 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 ARCS, AHLTA, and Army counseling form (DA Form 4856) will be used to document all Soldiers' progress through their CRP.

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 the 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 an event or performance oriented, will be used to review a Soldier's demonstrated performance and potential. Reception and integration counseling familiarize 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 SRU 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 paragraph 7–34b(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 the 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 follows :

(a) For enlisted Soldiers, except in 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) When Soldiers are under investigation or are charged with an offense under the UCMJ that could result in a punitive discharge .

(b) Soldiers with suspended sentences. Soldiers may not be referred for, or continue in, disability processing if under military sentence of dismissal or punitive discharge unless the sentence is suspended.

(c) Enlisted Soldiers pending administrative separation.

(d) Soldiers AWOL.

(e) Commissioned or warrant officers who are pending administrative elimination.

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 ARCP. 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 SRU medical provider. Additionally, Soldiers will not cancel appointments without approval of their SRU NCM.

e. *Medication use.* Soldiers will use prescription and over the counter medication only as directed and will report any side effects to the SRU medical provider or SRU 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 SRU NCM and SRU medical provider.

(3) SRU medical providers 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 VI

Army Body Composition Program

7–35. General

Army Weight Standards. In accordance with AR 600–9, paragraph 3–3, Soldiers assigned or attached to a SRU 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 who are not in compliance with AR 600–9 will be flagged in accordance with AR 600–8–2 and 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 CRP.

7–36. Exemption

a. The following Soldiers are exempt from the requirements of AR 600–9, chapter 3; 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 on established COAD and/or COAR status. See AR 635–40.

(3) Pregnant and postpartum Soldiers.

(4) Soldiers who have undergone prolonged hospitalization for 30 continuous days or greater.

b. Soldiers found to have a temporary medical condition that directly causes weight gain or prevents weight or body fat loss will have up to 6 months from the initial medical evaluation date to undergo treatment to resolve the

medical condition. The medical specialty physician may extend the time period up to 12 months if it is determined more time is needed to resolve the medical condition. During this time, the Soldier will participate in the ABCP, to include initiation of a DA Form 268 (Report to Suspend Favorable Personnel Actions (FLAG)), nutrition counseling, and monthly body fat assessment, but will not be penalized for failing to show progress. However, if the Soldier meets the body fat standard during this timeframe, he or she will be removed from the ABCP.

c. Soldiers that do not meet the criteria above have the option to request a temporary ETP (see AR 600–9, para 3–17). The exemption paperwork must be endorsed by the SRU medical provider 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 by health care personnel with a medical condition that precludes participation in the Army body fat reduction program 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 or psychological 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 VII

Inspection Programs

7–37. Organizational Inspection Program

a. Inspections are a command and leader responsibility. The OIP is the commander’s program to manage all inspections (internal and external) conducted within the command. The overarching purpose of the OIP is to coordinate inspections and audits into a single, cohesive program focused on command objectives. MEDCOM is responsible to ensure that each SRU is inspected with the appropriate frequency and by a qualified team in order to ensure enterprise-wide effectiveness of the ARCP. Inspections conducted at a SRU are designed to assess its ability to accomplish the mission reliably and consistently for each Soldier in the SRU by determining compliance against established standards, as well as to determine the root cause of non-compliance.

b. The OIP in accordance with AR 1–201 helps to validate SRUs compliance with program standards; facilitate continuous operational improvements; identify innovations and share best practices between SRUs; and compile and communicate SRU trends to senior leadership. Commanders are required to correct critical deficiencies.

c. Additionally, the DFAS Network Audit and Field Compliance Division, in coordination with USAFMCOM and MEDCOM, will also conduct OIP of the SRU’s financial management operations.

7–38. Staff Assistance Visits

a. SAVs provide MEDCOM, SRU, SFAC, and select garrison staff guidance and knowledge on the operations of a SRU. 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 SRU. 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 RHCs, but may be conducted by the office of the DCS–ARC upon request.

b. Each SAV team includes SMEs from MEDCOM RHCs and external participation from DCS, G–1, IMCOM, USAFMCOM, and the DVA, if available. Each team contains active duty, Army Reserve, and ARNG members and will have both Army level and regional representation.

c. Results of SAVs will be disseminated to all activities/locations evaluated.

Chapter 8 Automation Systems Supporting the Army Recovery Care Program

Section I

The Army Recovery Care System

8–1. General

The ARCS will be utilized to document all processes related to the CRP. These include, but are not limited to, self-assessments, risk assessments, goal settings, scrimmages, CER activities and others. Paper-based documenting should be used when ARCS is not available. Any information captured on paper should be entered into ARCS when the system becomes available.

a. Content. Entries will be made into ARCS by the appropriate cadre member who observes or cares for the Soldier during their assignment or attachment to the SRU. No one is permitted to complete the documentation within ARCS on a Soldier unfamiliar to him or her.

b. Signatures. All entries into ARCS are electronically authenticated.

c. Date and time. All entries made within ARCS are electronically dated and timed.

d. Corrections to entries. To correct an entry, the user must submit a help desk ticket through their appropriate CRP 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.

8–2. Upload of documents

a. Required Documents. Non-clinical documents that support all key aspects to document the CRP six processes, in-processing, goal setting, transition review, rehabilitation, reintegration, and post-transition will be uploaded in the ARCS (see chap 3 of this regulation).

b. Additional documents authorized for upload. At the commander's discretion and based on the needs of the Soldier, commanders, cadre and ARCC Center staff are authorized to upload non-clinical documents in ARCS in compliance with the HIPAA, AR 25–22, and AR 40–66. Non-clinical documents such as physical profile, adaptive reconditioning, or other training records, records of counseling, and so forth, to include CCIRs and Serious Incident Reports (SIRs) can be uploaded in ARCS, except as stated in c. below. Retention and disposition requirements of these documents will be in accordance with AR 25–400–2.

c. Documents not authorized for upload. All clinical and PHI documents and non-clinical documents such as CCIRs and SIRs containing sexual assault/harassment, or other sensitive information that can be considered harmful or detrimental to the Soldier's healing or transitioning will not be uploaded in ARCS.

8–3. Control Measures

Documents containing Personally Identifiable Information (PII) will be handled by those with an official need to know that are involved directly in providing assistance for meeting the needs of the SRU Soldier toward healing and transitioning from the ARCP. Commanders will ensure guidance is in place requiring individuals with ARCS access to have the HIPAA and the DOD Cyber Awareness Challenge annual training with current HIPAA certificates uploaded to ARCS user Admin record.

8–4. Army Recovery Care System document upload management

a. The SRU commander will—

(1) Implement policies and procedures that outline ARCS data entries and document upload requirements based on each of the CRP processes in accordance with this regulation.

(2) Ensure the CRP management analysts have a tracking system in place that determines by category of personnel their role-based access to ARCS in each of the cadre categories.

(3) Ensure a tracking mechanism is in place for all individuals to provide their HIPAA certificate prior to receiving access to ARCS and to upload annually during their birth month thereafter. Furthermore, ensure a file record of certificates of each training is maintained.

(4) Ensure only staff members with an official need to know as stated in paragraph 8–3 have access to ARCS and those individuals have HIPAA, and DOD Cyber Awareness Challenge training, and are fully informed of this policy prior to granting ARCS access.

(5) Counsel individuals with access to ARCS on their obligation to maintain the confidentiality and privacy of data, limiting the entering of PII into ARCS, and to report violations in accordance with AR 25–1.

- b. The CRP management analyst will—
 - (1) Serve as the subject matter expert for the SRU ARCS module data and process execution; provide cadre initial in-processing training and conduct sustainment training no less than quarterly.
 - (2) Perform Quality Assurance on Soldiers' data in ARCS, update as required, and provide reports to SRU commander as outlined in paragraph 8–6.
 - (3) Assist SRU staff with Soldier user role assignments, transfers, self-assessment availability, and risk assessment initiation within the SRU ARCS module when required.
 - (4) Provide user role based access to ARCS based on roles in the CRP while ensuring all requests include the completed DD Form 2875 (System Authorization Access Request (SAAR)) with current DOD Cyber Awareness Challenge training and HIPAA certificates. Ensure all supporting documents are uploaded in ARCS and annual HIPAA certificates are uploaded by the user by way of their “My Profile” page in ARCS.
 - (5) Assist users with troubleshooting issues, collecting and submitting requests on ARCS data deficiencies, and processing enhancement requests to the ARCS Help Desk on behalf of the SRU staff.
- c. IDT will—
 - (1) Document as appropriate all required entries into ARCS based on the Soldier's CRP.
 - (2) Ensure and assist Soldiers with completing their information into ARCS.
- d. The RCC and or lead coordinator will document as appropriate all required entries on the Soldier's CRP in the ARCC and SRU ARCS modules.

8–5. Quality assurance and reporting

The CRP Management Analyst will—

- a. Perform quality assurance of data and execution in accordance with policy and guidance stated in this regulation, chapters 2, 3, 4, 12 and paragraphs 8–1 through 8–5, and will report findings to the immediate SRU commander or representative.
- b. Extract and submit in readable format, required metrics and reports as directed by the SRU commander. Required metrics may include but are not limited to the following reports (some of the required data that are currently not entities in ARCS Reports Section must be tracked manually):
 - (1) *In-processing*. Soldiers are entered in ARCS and MODS–WT within 24 hours of their report date to the SRU and in-processing requirements are completed within 30 days as defined in chapter 3.
 - (2) *Self-assessments*. Initial Self-assessment initiated within 24 hours of Soldier's report date to the SRU and completed and validated by SL and SRU NCM within 7 days of the report date to the SRU (see chap 3).
 - (3) *Action plans*. Plans are created within the 7 day self-assessment life cycle, and maintained and completed in a timely manner for all Red and Amber items (see chap 3).
 - (4) *Risk assessments*. Risk assessment completed within 24 hours of the report date to the SRU and in accordance with assigned risk level as defined in this regulation, chapter 4.
 - (5) *Scrimmages*. Initial completed within the first 30 days of SRU Soldier's report date to the SRU and quarterly (at 90 days, 180 days, 270 days, or 360 days, and so forth and thereafter) with SRU commander on each Soldier's transition plan. Location, attendees, and documentation requirements must meet this regulation's, chapter 3 standards.
 - (6) *Focused transition reviews*. Completed within two weeks of MRDP determination or when Soldier reaches 730 days in the SRU. Once a FTR is completed, the scrimmage cycle is reset to occur 90 days after completion of the FTR (see chap 3).
 - (7) *Goal-setting*. Phase I training completed within 21 days. Phase II training, CSF2 with a Master Resilience Trainer-Performance Expert (MRT–PE) within 90 days of the report date to the SRU (see chaps 2, 3, and 12).
 - (8) *Out-processing*. Soldier records are closed in ARCS and MODS–WT within 48 hours of exit from ARCP.
 - (9) *Transition readiness*. Requirements are completed and validated by the commander prior to Soldier's transition from the SRU (such as FTR, CER, SFL–TAP and so forth. (see chap 3)).

Section II

Medical Operational Data System-Warrior Transition

8–6. Medical Operational Data System application management

- a. Commanders, RHC will—
 - (1) Designate a MODS–WT analyst to manage access and to provide analytical support to the Director, Regional RCO.

- (2) Ensure that the Regional MODS–WT analyst recommends access for users based on their roles and validates 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 DCS–ARC management analysts.
- (4) Ensure that the Regional MODS–WT analyst performs weekly reconciliation with affiliated SRU to ensure users’ access is revoked immediately upon departure from units.
 - b. Commander, SRU 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 DCS–ARC, and participate as members of the MEDCOM organizational inspection team.
 - (4) Determine MODS–WT role-based access levels for categories of personnel.
 - (5) Ensure that all applicants are HIPAA compliant prior to registering for access, and that all users maintain a current HIPAA training status.
 - (6) Counsel MODS–WT users regarding their duty to preserve the confidentiality of PHI and to report violations of the same.
 - (7) Designate a MODS–WT lead and ensure that the lead requests access for users in an expeditious manner to support the unit’s mission.
 - (8) Ensure that the unit’s MODS–WT lead utilizes the RHC MODS–WT analyst to address MODS–WT issues as required.
 - (9) Ensure that all users’ access to the MODS–WT module is immediately revoked upon their departure from the SRU.
 - c. The SRU Human Resource Staff will—
 - (1) Create a MODS–WT module record for each Soldier immediately upon the reporting date of the initial SRU in-processing.
 - (2) Review and update MODS–WT data upon Soldier’s report date to the gaining SRU to ensure completeness and accuracy.
 - (3) Manage all demographic and administrative data fields in each assigned or attached SRU Soldier’s record to ensure completeness and accuracy of the data.
 - (4) Synchronize efforts with the affected SRU NCM to facilitate comprehensive management of each SRU Soldier.
 - d. The SRU NCM will—
 - (1) Perform a thorough review of each (assigned or attached) SRU 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 IDT to ensure appropriate data capture in MODS–WT.
 - (4) Ensure that monthly clinical data entries are entered in MODS–WT, to include Soldiers on transitional leave and those who are hospitalized. As an exception, where a Soldier’s condition changes, data entries may be entered as often as warranted.

Chapter 9

Donations

9–1. General

AR 1–100, the JER, and MEDCOM establish policies for accepting, receiving, processing, and reporting gifts offered to MEDCOM from non-Federal entities (NFEs).

9–2. Acceptance of donations

a. *Office of the Deputy Chief of Staff-Army Recovery Care.* The SRU commanders and DCS–ARC 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.* The Secretary of the Army has delegated to the TSG the acceptance authority for all ARCP gifts. See AR 1–100 and (https://securecac.hqda.pentagon.mil/oaacustomer/da_functions.aspx)

c. Regional health commanders. TSG has further delegated acceptance authority to RHCs for gifts valued up to \$50,000 for Army MTFs within their region and gifts for distribution to individuals, including SRU personnel. Therefore, RHC commanders have acceptance authority for all ARCP gifts, and all SRU gifts up to and including \$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 and supplemental DOD policy.

e. Separated and medically retired Soldiers. Army gifts regulations only apply to RA 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 RHC commanders, do not have the authority to accept gifts on behalf of separated or medically retired Soldiers.

f. Recovery Care Coordinators. RCCs may not receive gifts on behalf of wounded, ill, or injured Soldiers.

9–3. Solicitation of gift and donation

The SRU and DCS–ARC personnel will not solicit, fundraise, or otherwise request or encourage a gift from NFEs. However, in response to an inquiry, SRU and DCS–ARC personnel may inform a prospective donor of the needs of the SRU, DCS–ARC, and ARCC Center Programs. For proffered gifts to the SRUs or an individual RHC, personnel will coordinate with the RHC gift manager and supporting command judge advocate. For proffered gifts to the DCS–ARC and ARCC Center Programs, personnel will coordinate with the DCS–ARC Judge Advocate or legal advisor.

Chapter 10 Family Programs

Section I

Family Support Groups

10–1. 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. See AR 608–1 for the duties and responsibilities of Family Support Groups.

10–2. Soldier Recovery Unit Family Readiness Support Assistant

a. The primary function of a SRU FRSA is to know and understand the role of the FRG, and how community agencies can support the Soldiers and their Families (see paragraphs 2–26, 2–28 and 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 a proactive 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, FRSA's are essential in being able to provide continuity and stability. See AR 608–1 for the duties and responsibilities of FRSA's.

Section II

Memorial Ceremonies and Services

10–3. 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 SRU, 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 SRU to provide that service.

10–4. Policy

SRU will ensure their supporting Casualty Assistance Center is notified of the time and place of unit memorial events.

Chapter 11 Benefits and Special Compensation

Section I

Special Compensation for Assistance with Activities of Daily Living

11–1. Background

SCAADL, under the provisions of DODI 1341.12 and DODM1341.12, is a program authorizing compensation for an eligible member of the AC or RC of the military services who has a permanent catastrophic injury or illness that was incurred or aggravated in the line of duty. 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 outlined in AR 600–77.

11–2. Appeal process

The appeal process for Soldiers in the ARCP will be in accordance with AR 600–77. Instructions 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

11–3. Direct billing for non-medical 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. RHC 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 the Joint Travel Regulations (JTR), 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.

11–4. Military escorts for Family members or non-medical attendants traveling on official orders at Soldier Recovery Units only

a. MEDCOM 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. RHC or SRU commanders will ensure a local policy is in place consistent with this regulation.

b. Responsibilities.

(1) The RHC and SRU 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 SRU commander will coordinate with the RHC for assistance.

(2) Commanders will ensure escorts report all problems or concerns to the escort OIC or 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 their escort detail.

(3) The RHCs and SRUs are responsible for developing their own internal escort policy consistent with the guidance in this regulation.

11–5. 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 Service member 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 or aggravated while in a qualifying duty status as defined in AR 600–8–4, and of such severity to render the member medically unfit to perform the duties of their office, grade, rank, or rating. The designated qualified caregiver must be—

- (1) On an invitational travel authorization (ITA) while caring for the Soldier;
- (2) Acting as a NMA caring for the Soldier; or,
- (3) Receiving per diem while caring for the Soldier.

Section III

Non-medical Attendants

11–6. Background

The NMA Program enables physician-designated seriously ill or injured Soldiers to identify an individual that will be placed on ITOs to provide support and assistance to the Soldier as they heal and recover. The attending physician and the designated MTF TOL representative must approve the individual to serve as the NMA. Ordinarily, only one non-medical attendant is allowed. Only in extenuating circumstances and then only through the Secretarial Process may more than one non-medical attendant be authorized or approved. Once the Soldier reaches a level of independence, the NMA is no longer authorized. Authority for this section is governed by 37 USC 481k; the JTR; DOD Financial Management Regulation, Volume 9, chapter 8; and DODI 1341.12.

11–7. Entitlements

a. The non-medical attendant's orientation. All Soldiers and their Families attached or assigned to a SRU will receive an orientation briefing related to NMAs within the first 30 days of the report date to the SRU in an outpatient status.

b. Entitlements.

(1) If the NMA is a uniformed Service member or a Federal 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 SC) 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 predetermined 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 their 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 by way of the DTS. It is normally deposited into the NMA's specified bank account. NMA will submit monthly travel vouchers for reimbursement until the SRU medical provider or 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. The criteria for each is different. The NMA entitlements will be granted upon the criteria established in chapter 11, section I of this regulation.

(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 SRU NCM. If the NMA has insurance and needs care not offered by the MTF, the SRU 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 SRU SL or SRU 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.

11–8. Non-medical attendant administrative management

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 the reporting date 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) Abiding 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 SRU NCM. This training will provide the NMA with valuable tools to help manage stress and increase resiliency.

(5) Access SRU 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 SRU 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 SRU within 30 days of the report date to the SRU. 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 the report date to the SRU 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.

11–9. Non-medical Attendant Program command control

a. RHCs.

- (1) RHCs will maintain a list of all NMAs within their region.
- (2) Ensure SRU cadre are trained in the management of NMAs.
- (3) RHC 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) RHC 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. SRU commanders will—

- (1) Manage the NMA program effectively to ensure NMAs needs are met in a proactive manner.
- (2) Ensure the SRU cadre have a thorough understanding of the NMA Program and understand which Soldiers may be assigned a NMA.

(3) Train cadre on the NMA recommendation process and the process for assigning a NMA.

(4) Appoint a SRU NMA coordinator as an additional duty for a unit personnel. Ensure the designated NMA coordinator—

- (a)* Manages the NMA program.
- (b)* Proactively anticipates and manages NMA needs, ensuring customer service focus is maintained.
- (c)* Remains current on all NMA policies and regulations.
- (d)* Plans and executes NMA support groups based upon the commander's intent.
- (e)* Serves as the NMA support group facilitator.
- (f)* Keeps the chain of command informed of NMA issues and concerns.
- (5) Ensure SRU NCMs receive training on Care of the Caregiver (training occurs at the AMEDDC&S-HRCoE by way of the NCM Course).

(6) Maintain an accurate list of all NMAs with contact information and provides the list to the RHC while ensuring updated information is provided to RHC whenever a NMA is added or deleted from the list. Conducts NMA training. Required training includes the following:

(a) SRU and SFAC orientation within 30 days of the report date to the SRU.

(b) IDES familiarization briefing within 30 days of the report date to the SRU.

(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 SRU NCM.

- (e) Encourage NMAs to participate in unit fire and rescue drills.
 - (7) Provide support to the NMA.
 - (8) Assign and train one SRU 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.
 - (9) Provide resources for NMA who wish to take First Aid and CPR training.
 - (10) 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 SRU 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 SRU 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 IDT, 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) Maintain accurate NMA contact information.
 - (5) Escort the NMA to the SRU 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 IDT and help resolve issues as soon as possible.
 - (7) Ensure the Soldier initiates a CRP goal for developing skills that facilitate independent living and enhanced resiliency.
- e. SRU 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 IDT 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. SRU medical providers will—
- (1) Understand the medical provider training related to assignment process for NMAs within 10 days for assignment as a SRU medical provider.
 - (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) Recommend to the SRU commander to approve the Soldier for a NMA. The SRU medical provider 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 SRU medical provider will complete the required documentation on the SRU medical provider worksheet to extend orders.
- g. The Soldier will—
- (1) Inform the SRU medical provider and command team of the person they would like to serve as their NMA.
 - (2) Inform the chain of command and IDT 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 CRP.

11–10. Non-medical attendant designation

The Soldier's SRU medical provider will recommend to the SRU 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 SRU medical provider will ensure the Soldier has a completed DA Form 2984 (Very Seriously Ill/Seriously Ill/Special Category Patient Report) on record that designates the Soldier as seriously or very seriously ill or injured. The SRU medical provider must counsel with 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 reevaluation will be performed to determine the continued need for the NMA. This counseling must be documented in AHLTA and discussed with the SRU's IDT to ensure all members understand the reason for the NMA and the anticipated length of time for the NMA. This will ensure the IDT delivers consistent messages to the Soldier and the NMA.

11–11. Removal from non-medical attendant status

An individual may lose their NMA status if their presence does not contribute to the recovering Soldier's health and welfare, or if their behavior (for example, substance abuse, breaches of the law or good order that interfere with the mission of the SRU) is such that the contribution to the recovering Soldier's health and welfare is impaired. If NMA status is removed, the NMA will lose the NMA benefits and entitlements. The approval authority for removal of NMA status is the SRU commander in conjunction with the designated MTF TOL representative.

- 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 SRU will report the findings to the MTF's FAP. The SRU will work with FAP to outline a plan to ensure the Soldier has a safe environment. The SRU 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 SRU commander must consult with their servicing Judge Advocate or legal advisor for guidance. Removal of a NMA from the Soldier's immediate location must be approved by the SRU commander (under the advisement of FAP and the Staff Judge Advocate). The SRU commander should also consult appropriate installation personnel for installation level policy and guidance.

11–12. Non-medical attendant training

The SRU will offer NMA training that will aid in providing personal care (as defined) to the Soldier. Recommended training includes:

- a. SRU orientation within 30 days of the report date to the SRU.
- b. IDES familiarization briefing within 30 days of the report date to the SRU.
- 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 SRU, 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.

Chapter 12

Training Requirements

Section I

Soldier Recovery Unit Orientation and Sustainment Training

12–1. Soldier Recovery Unit training requirements

This section establishes guidance, goals, requirements, and objectives and outlines the overall training strategy for SRUs. This section also documents major training events to help commanders prioritize resources and efforts. Units should refer to the annual MEDCOM Command Training Guidance for specific requirements. SRU cadre will comply with AR 350–1 requirements; exemptions for certain training requirements may be established in accordance with

provisions of AR 350–1. Transitioning Soldiers should also comply with AR 350–1, however, SRU commanders in the rank of O–5 or higher may modify AR 350–1 training requirements on an individual basis based on unique circumstances of transitioning individuals. Unique circumstances are defined as circumstances in which the Soldier would be further negatively affected by or is unable to physically do the training.

12–2. Training priorities

SRU commanders will—

a. Develop and execute a unit-level cadre and staff training program on the ARCP. ARCP at the unit level will refresh and sustain training on the CRP, BH issues, resiliency, and those skills necessary for cadre and staff to lead Soldiers.

b. Develop and execute a unit-level Remain-in-the-Army training program for Soldiers in the “Remain-in-the-Army” track. The “Remain-in-the-Army” training program is tailored to each Soldiers’ MOS, rank and abilities.

c. Develop and execute a unit-level 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.

d. Develop and execute a unit-level Army Physical Readiness Training Program in accordance with AR 350–1, Army Training and Leader Development and FM 7–22, Army Physical Readiness Training. Physical fitness is an important component to recovery and an integral part of being a Soldier.

e. Develop and execute a unit-level Army Body Composition Program in accordance with AR 600–9, The Army Body Composition Program.

f. 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. Ensure all personnel are aware that IDES training is available from the U.S. Army Physical Disability Agency at: <https://www.hrc.army.mil/tagd/us%20army%20physical%20disability%20agency>.

g. Ensure RCCs also designated as lead coordinators, are trained and prepared to perform duties as the lead coordinator for all SRU Soldiers.

12–3. Cadre and staff training

a. *Cadre Orientation-Distance Learning.* The Cadre Orientation-Distance Learning is a mandatory prerequisite for all individuals attending one of the resident courses listed in paragraph 12–3b below.

b. *Resident Courses.* There are currently three resident courses which support the ARCP: The SRU Triad Training for Squad Leaders and Platoon Sergeants; SRU Staff Training Course (for 1SGs and SRU commanders; Soldier Recovery Unit Staff Training Course; and the Nurse Case Manager Course). Resident Courses are mandatory as stated below for the following military and DA Civilians assigned to the SRU:

(1) *Soldier Recovery Unit Triad Training for Squad Leaders and Platoon Sergeants Course.* All squad leaders and platoon sergeants must attend this resident course no later than 90 days after assuming duties. TDY enroute is preferred; however, it may not be feasible for COMPO 2/3 leaders. Nevertheless, these leaders must attend this resident course no later than 90 days after assuming duties. Additionally, squad leaders and platoon sergeants may be awarded an additional skill identifier (ASI); refer to DA Pam 611–21 for complete ASI requirements.

(2) *Soldier Recovery Unit Staff Training Course.* Commanders and first sergeants must attend this resident course no later than 90 days after assuming duties. TDY enroute is preferred; however, it may not be feasible for COMPO 2/3 leaders. Nevertheless, leaders must attend the course no later than 90 days after assuming duties. All assigned SRU TCs, OTs, PTs, LCSWs to include SSAs, SRU chaplains and religious affairs specialist, career counselors, and SRU Management Analysts must attend this course no later than 120 days after assuming duties.

(3) *Nurse Case Management Course.* All SRU NCMs must attend this resident course no later than 90 days after assuming their duties. TDY enroute is preferred; however, it may not be feasible for COMPO 2/3 SRU NCMs. Nevertheless, SRU NCMs must attend this course 90 days after assuming duties. After completion of Phase 1 and 2, SRU NCMs may be awarded the ASI M9; refer to DA Pam 611–21 for the ASI requirements.

c. *Cadre Resilience Course.* The Cadre Resilience Course (CRC) provides SRU cadre and staff with resilience skills necessary to supervise and lead Soldiers. The CRC is mandatory for all assigned platoon sergeants and squad leaders. CRC is conducted the week prior to the SRU Triad Training for Squad Leaders and Platoon Sergeants Course. Commanders and first sergeants are encouraged to attend the CRC.

d. *Senior Leader and Clinician Course.* This course provides newly select assigned SRU military and DA Civilians an overview of the ARCP, associated policies, current command issues, and a working knowledge of the ARCS system. The Senior Leader and Civilian Course (SLCC) also provides military and DA Civilians with training for their specific role within the ARCP. This course is mandatory for the following assigned individuals:

(1) All newly assigned SRU command teams (commanders and CSMs), SRU commanders and first sergeants. These leaders must attend SLCC no later than 90 days after assuming duties.

(2) All newly assigned SRU surgeons, SRU medical providers, SRU chaplains, SRU Licensed Clinical Social Workers, TCs, and SRU NCMs must attend this course 120 days after assuming duties.

(3) RHC Recovery Care Office, directors and/or Chiefs are encouraged to attend SLCC.

e. The Army Medical Department Pre-Command Course. The Army Medical Department (AMEDD) Pre-Command Course (PCC) prepares the Command Selection List (CSL) SRU command teams (commanders and CSMs) for their assignments. AMEDD PCC is mandatory for all CSL SRU commanders and their CSMs. These leaders should attend AMEDD PCC at the first opportunity. The AMEDD PCC is the branch-specific portion of a multi-phase program.

12–4. Major training events

a. Army Recovery Care Coordination Training. The ARCC Center conducts a new hire orientation and annual 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. In addition, RCCs must attend monthly Professional Development Training.

b. Army Recovery Care Program Leaders Training Summit. The Leaders Training Summit trains senior leaders assigned to SRUs on all aspects of the ARCP. The Leaders Training Summit is mandatory for all SRU commanders and command sergeants major.

12–5. Training safety

The SRU commanders will utilize the safety training requirements outlined in AR 385–10, DA Pam 385–10, MEDCOM, and local guidance to ensure cadre, Soldiers, and Civilian employees are knowledgeable in the practical application of safety within their workplace.

Section II

Comprehensive Soldier and Family Fitness

12–6. General

In accordance with AR 350–53, Comprehensive Soldier Family Fitness increases the physical and psychological health, resilience, and performance of Soldiers, Families, and Army Civilians. Comprehensive Soldier and Family Fitness Training Center sites support each SRU locally or through mobile training teams (MTTs) and provide training that is focused on performance enhancement and resilience.

12–7. Unit requirement

The SRU 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 SRU must have one trained MRT to manage the unit program and conduct training. The unit's MRT will advise the SRU commander on the completion of the resiliency training requirements.

12–8. Responsibilities

The SRU MRT in coordination with the Comprehensive Soldier and Family Fitness Training Centers and MTT will—

a. Provide Phase II goal setting training to referred Soldiers in the SRU.

(1) Phase II goal setting training consists 16 hours of instruction that includes 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 SRU-organized adaptive reconditioning activities for SRU Soldiers, including all Warrior Games Training Camps and Clinics.

c. Conduct the ARCP Cadre Resilience Course in conjunction with the SRU Cadre Course. The Cadre Resilience Course is a 5–day course focused on providing SRU 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 SRU.

- e.* Conduct performance and resilience training at the SRU cadre courses, specifically for any attendees that did not receive the Cadre Resilience Course.
- f.* Conduct, through coordination with 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 SRU 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 II of this chapter).
- h.* Support the CER Program 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 SRU TC.

Chapter 13

Reserve Components Remote Care

13–1. General

Reserve Component Soldiers who meet the single entry criteria as outlined in chapter 7–2*a* will enter the SRU for complex case management. RC Soldiers who do not meet single entry criteria for complex care criteria, but meet the eligibility criteria in chapter 7–3 will be managed remotely utilizing the Reserve Component Managed Care (RCMC) program (COMPO 2) and the Remote Medical Management (RM2) program (COMPO 3).

13–2. Reserve Component Managed Care

- a.* ARNG (COMPO 2) Soldiers who meet eligibility criteria in chapter 7–3 will be managed remotely utilizing the Reserve Component Managed Care (RCMC) program.
- b.* The RCMC program is managed by the National Guard under the direction of the Chief, NGB.

13–3. Remote Medical Management

- a.* USAR (COMPO 3) Soldiers who meet eligibility criteria in chapter 7–3 will be managed remotely utilizing the Remote Medical Management (RM2) program.
- b.* RM2 Soldiers are attached to the SRU closest to their home of record, and managed by the RM2 section within the SRU HHC.
- c.* USAR human resources personnel of the Soldier's unit of assignment provide input to ARCP and the SRU to determine duty site location and duty site supervisors. The USAR commander of the Soldier's unit of assignment directs specific duties commensurate with the Soldiers rank and MOS and appropriate to the Soldier's profile restrictions.
 - (1) SRUMC (including UCMJ authority) for all assigned RM2 Soldiers
 - (2) SRU provides NCM and SL for all RM2 Soldiers assigned and is responsible for updating and communicating with duty site supervisor and unit of assignment.
- d.* Soldiers in the RM2 program are not eligible to participate in core programs of the ARCP such as CRP, CER, and AR.
- e.* RM2 soldiers are not assigned an Army RCC and are not case managed (unless they meet eligibility in para 2–9), however, should a situation arise where support is requested by the chain of command, information and assistance will be provided on an as-needed basis by an Army RCC aligned with that SRU.
- f.* If the Soldier's medical condition changes and medical needs can no longer be met in the RM2 program, the Soldier's case will be reviewed. If necessary, the Soldier will be processed for entry into the SRU.
- g.* When RC Soldiers are released from the RM2, Soldiers will return to the SRU for out-processing, including receipt of their DD Form 214 (Certificate of Release or Discharge from Active Duty).

Appendix A

References

Section I

Required Publications

AR 1–201

Army Inspection Policy (Cited in para 2–15*b*.)

AR 40–400

Patient Administration (Cited in para 2–21*e*.)

AR 40–502

Medical Readiness (Cited in para 2–20*ah*.)

AR 600–9

The Army Body Composition Program (Cited in para 2–20*k*.)

AR 600–77

Administrative Management of Wounded, Ill, or Injured Soldiers (Cited in para 7–5*b*.)

AR 600–85

The Army Substance Abuse Program (Cited in para 2–20*m*.)

AR 635–40

Disability Evaluation for Retention, Retirement, or Separation (Cited in para 2–25*a*(8).)

AR 635–200

Active Duty Enlisted Administrative Separations (Cited in paras 2–20*m*.)

Army Barracks Management Program (Cited in para 2–34*a*.) (Available at http://www.acsim.army.mil/installationservices/assets/docs/abmp_handbook_final_9_january_2018.pdf)

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 <https://armypubs.army.mil/>. DOD Publications are available at <http://www.dtic.mil/whs/directives/>. USCs are available at <http://uscode.house.gov/> and PLs are available at <https://www.archives.gov/federal-register/laws>.

AR 1–100

The Army Gift Program

AR 11–2

Managers' Internal Control Program

AR 15–6

Procedures for Administrative Investigations and Boards of Officers

AR 25–22

The Army Privacy Program

AR 25–30

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 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 135–200
Active Duty for Missions, Projects, and Training for Reserve Component Soldiers

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 350–1
Army Training and Leader Development

AR 350–53
Comprehensive Soldier and Family Fitness

AR 385–10
The Army Safety Program

AR 420–1
Army Facilities Management

AR 600–8–2
Suspension of Favorable Personnel Actions (Flag)

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 Readiness Processing

AR 600–8–105

Military Orders

AR 600–20

Army Command Policy

AR 600–63

Army Health Promotion

AR 601–280

Army Retention Program

AR 608–1

Army Community Service

AR 611–1

Military Occupational Classification and Structure Development and Implementation

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 638–8

Army Casualty Program

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 2013–01

Guidance on the Acquisition and Use of Service Dogs by Soldiers

ATP 5–19

Risk Management

DA Pam 385–10

Army Safety Program

DA Pam 623–3

Evaluation Reporting System

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Revised

This publication is available from the American Psychiatric Press, Inc., 1400 K Street, N.W., Suite 1101, Washington, DC 20005.

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 (Available at <http://comptroller.defense.gov/fmr>).

DOD 7000.14–R (Volume 12, Chapter 30)

Operation and Use of General Gift Funds

DODD 6010.04

Healthcare for Uniformed Service Members and Beneficiaries

DODI 1241.01

Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements

DODI 1300.18

Department of Defense (DOD) 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 (SCAADL) Program

DODI 1400.25

DOD Civilian Personnel Management System

DODI 6010.24

Interagency Complex Care Coordinator

DODI 6490.04

Mental Health Evaluations of Members of the Military Services

DODM 1341. . 12

Special Compensation for Assistance with Activities of Daily Living (SCAADL) Process

FM 6–22

Leader Development

FM 7–22

Army Physical Readiness Training

Joint Travel Regulation

Joint Travel Regulations (Available at [http://www.defensetravel.dod.mil/.](http://www.defensetravel.dod.mil/))

MCM 2016

Manual for Courts-Martial, 2016 Edition (Available at [https://jsc.defense.gov/.](https://jsc.defense.gov/))

Medical Management Guide, version 3.0 October 2009

DOD TRICARE Management Activity (Available at https://www.qmo.amedd.army.mil/medical_management/mmg_v3_2009.)

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

Health Insurance Portability and Accountability Act of 1996

PL 110–181

National Defense Authorization Act for Fiscal Year 2008

PL 110–181 Title XVI

Wounded Warrior Matters

PL 110–181 Title XVII

Veterans Matters

PL 110–325

ADA Amendments Act of 2008

Soldier and Leader Risk Reduction Tool

Guide for Use of the U.S. Army Soldier and Leader Risk Reduction Tool at http://www.armyg1.army.mil/hr/suicide/spmonth/risk_assessment_tool.asp.

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 Reserve Select Coverage for Members of the Selected Reserve

10 USC 1077

Medical care for dependents: authorized care in facilities of uniformed services

10 USC 1142

Perspiration 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

Regulars and members on active duty for more than 30 days: retirement

10 USC 1202

Regulars and members on active duty for more than 30 days: temporary disability retired list

10 USC 1203

Regulars 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: Non-medical 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 1980A

Traumatic injury protection

38 USC 3675

Approval of accredited courses

38 USC 4113

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) website: <http://armypubs.army.mil> and DD forms are available on the Executive Service Directorate (ESD) website: <http://www.esd.whs.mil/Directives/forms/>.

DA Form 6

Duty Roster

DA Form 11–2

Internal Control Evaluation Certification

DA Form 31

Request and Authority for Leave

DA Form 268

Report to Suspend Favorable Personnel Actions (Flag)

DA Form 1594

Daily Staff Journal or Duty Officer's Log

DA Form 2028

Recommended Changes to Publications and Blank Forms

DA Form 2984

Very Seriously Ill/Seriously Ill/Special Category Patient Report

DA Form 3349

Physical Profile (Available on <https://medpros.mods.army.mil/eprofile/default.aspx?returnurl=%2feprofile%2fadmin%2fusersmanager.aspx>.)

DA Form 4187

Personnel Action

DA Form 4856

Developmental Counseling Form

DA Form 7424

Sensitive Duty Assignment Eligibility Questionnaire

DA Form 7692

Active Duty for Medical Care Application

DA Form 8001

Limits of Confidentiality

DD Form 214

Certificate of Release or Discharge from Active Duty (Available through normal supply channels.)

DD Form 2005

Privacy Act Statement-Health Care Records

DD Form 2648

Service Member Pre-Separation/Transition Counseling and Career Readiness Standards Eform for Service Members Separating, Retiring, Released from Active Duty (REFRAD) (Available through DOD Transitioning Assistance Program.)

DD Form 2796

Post Deployment Health Assessment (PDHA) (This form is completed on-line at <https://rc.mods.army.mil>. You will receive instructions and gain access to the appropriate system at the time of assessment. However, they are still available on the DOD website.)

DD Form 2870

Authorization of Disclosure of Medical or Dental Information

DD Form 2875

System Authorization Access Request (SAAR)

DD Form 2900

Post Deployment Health Re-Assessment (PDHRA) (This form is completed on-line at <https://rc.mods.army.mil>. You will receive instructions and gain access to the appropriate system at the time of assessment. However, they are still available on the DOD website).

DD Form 2977

Deliberate Risk Assessment Worksheet

Appendix B

Internal Control Evaluation

B–1. Function

The function covered by this evaluation is to monitor the major components of the CRP for SRU 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. Is Soldier risk evaluated and documented and risk mitigation implemented within 24 hours of Soldier's report date to the SRU, and as required by risk level thereafter (see para 3–3)?
- b. Is the Soldier's self-assessment completed within the first 7 days of Soldier's report date to the SRU and as assigned by the commander thereafter (see para 3–5)?
- c. Are action plans documented in ARCS for each red and amber self-assessment items as identified by the Soldier? (See paras 3–5)?
- d. Is goal setting Phase I training completed within 21 days (see paras 3–4 and 3–9)?
- e. Are SMART goals established in all 6 domains with 30 days of the report date to the SRU and in all follow-on scrimmages and FTRS (see paras and 3–5)?
- f. Is the Soldier selecting and documenting an appropriate career track with advisement from the OT and career counselor within 30 days of Soldier's report date to the SRU (see paras 2–24 and 3–2)?
- g. Are all in-processing requirements completed within 30 days (see paras 3–3 and 3–9)?
- h. Is goal setting Phase II training with a MRT–PE Specialist completed within 90 days (see paras 3–4 and 3–9)?
- i. Are all completed SFL–TAP requirements documented on a DD Form 2648 (Service Member Pre-Separation/Transition Counseling and Career Readiness Standards Eform for Service Members Separating, Retiring, Release from Active Duty (REFRAD)), signed by the SFL–TAP counselor, Soldier, and commander, no later than 90 days prior to transition (see paras 3–7 and 3–9)?
- j. Are all eligible Soldiers participating in CER activity aligned with their CRP track and career goals (see paras 2–11, 3–6, and 3–9)?
- k. Is a MRDP reached or established within 365 days (see para 3–9)?
- l. Are scrimmages completed by the SRU commander on each Soldier's transition plan (90–day scrimmage) (see paras 3–5 and 3–9)?
- m. Do scrimmages occur by day 30 and every 90 days thereafter (a FTR can count as scrimmage in lieu of the next scheduled scrimmage) (see paras 3–4 and 3–5)?
- n. Are transition readiness requirements completed by the Soldier and staff, and validated by the SRU commander prior to transition from the SRU (see paras 3–6 and 3–9)?
- o. Are all Soldiers participating in an Adaptive Reconditioning Program (see paras 3–6 and 3–9)?
- p. Does the unit Resilience Training Program meet requirement standards (see, chapter 12, sec II)?
- q. Are eligible Soldiers referred to VA (see paras 3–7 and 3–9)?
- r. Is the Soldier's CRP properly documented in ARCS (see chapters 3, 4, 6, 8)?
- s. Has the lead coordinator initiated and completed LCC on all assigned and departed SRU Soldiers and data reflected in ARCS and other required systems of record?
- t. Are TOL entry packet processing timelines met? (14 training days for packets originating at SRU installation; 7 training days for all other packets).

B-5. Supersession

This evaluation replaces the evaluation for the major components of the CRP for SRU Soldiers previously published in AR 40-58, dated 23 March 2015.

B-6. Comments

Help make this a better tool for evaluating management controls. Submit comments to DCS-ARC, Policies and Procedures, Policy Writer, 2530 Crystal drive, Suite 10167, Arlington, VA 22202.

Glossary

Section I

Abbreviations

AAT

Animal assisted therapy

ABA

Architectural Barriers Act

ABCP

Army Body Composition Program

ABMP

Army barracks management program

ACES

Army Continuing Education System

ACOM

Army command

ACOTE

Accreditation Council for Occupational Therapy Education

ACS

Army Community Service

ADA

Americans with Disabilities Act

ADL

Activities of daily living

ADME

Active duty medical extension

AFS

active Federal service

AGR

Active Guard Reserve

AHLTA

Armed Forces Health Longitudinal Technology Application

AMEDD

Army Medical Department

AMEDDC&S

Army Medical Department Center & School

AOC

Area of concentration

AR

Army regulation

ARAP

Adaptive Reconditioning Activity Plan

ARCC

Army Recovery Care Coordination

ARCP

Army Recovery Care Program

ARCS

Army Recovery Care System

ARNG

Army National Guard

ASA (FM&C)

Assistant Secretary of the Army (Financial Management and Comptroller)

ASA (M&RA)

Assistant Secretary of the Army (Manpower and Reserve Affairs)

ASAP

Army Substance Abuse Program

ASCC

Army service component commands

ASI

Additional skill identifier

AWOL

Absent without leave

BH

Behavioral Health

BHI-PHA

Behavioral Health Intake-Psychosocial History Assessment

BLSW

Baccalaureate Level Social Worker

CAR

Chief of Army Reserve

CCIR

Commander's critical information requirements

CER

Career and Education Readiness

CG

Commanding general

CMCW

Case Management Complexity Worksheet

CMO

Chief medical officer

COAD

Continuation on active duty

COAR

Continuation on active Reserve

COTA

Certified Occupational Therapist Assistant

CPR

Cardiopulmonary resuscitation

CRC

Cadre Resilience Course

CRDP

Concurrent Retirement and Disability Pay

CRP
Comprehensive Recovery Plan

CSF2
Comprehensive Soldier and Family Fitness

CSL
Command Selection List

CSM
Command sergeant major

DA
Department of the Army

DCS
Deputy Chief of Staff

DCS-ARC
Deputy Chief of Staff-Army Recovery Care

DD
Department of Defense

DES
Disability Evaluation System

DFAS
Defense Finance and Accounting Service

DOD
Department of Defense

DODD
Department of Defense directive

DODI
Department of Defense instruction

DOL
Department of Labor

DPW
Directorate of Public Works

DRU
direct reporting unit

DTS
Defense Travel System

DVA
Department of Veterans Affairs

ED
emergency department

EFMP
Exceptional Family Member Program

EPMD
Enlisted Personnel Management Directorate

ETP
exception to policy

FAP
Family Advocacy Program

FLIPL
financial liability investigation of property loss

FM
field manual

FP
force providers

FRG
Family Readiness Group

FRSA
Family Readiness Support Assistants

FTR
focused transition review

GI
Government issue

GWOT
Global War on Terrorism

HIPAA
Health Insurance Portability and Accountability Act

HQ
Headquarters

HQDA
Headquarters, Department of the Army

HR
human resources

HRC
Human Resources Command

HRCoE
Health Readiness Center of Excellence

IDES
Integrated Disability Evaluation System

IDT
Interdisciplinary team

IMCOM
Installation Management Command

ISSA
inter-service support agreement

ITA
invitational travel authorization

JER
Joint Ethics Regulation

JHA
Job hazard analysis

JTR
Joint Travel Regulations

LC
lead coordinator

LCC
lead coordinator checklist

LCSW
Licensed clinical social worker

LOD
line of duty

M2
medical management

MAR2
MOS Administrative Retention Review

MC
mission command

MEB
medical evaluation board

MEDCOM
Medical Command

MFGI
Mobilization Force Generation Installation

MODS
Medical Operational Data System

MODS-WT
Medical Operational Data System-Warrior in Transition

MOS
military occupational specialty

MRB
Medical Review Board

MRDP
Medical Retention Determination Point

MRP
Medical retention processing

MRP2
Medical retention processing 2

MRP-E
Medical retention processing-evaluation

MRT
Master resiliency Trainer

MRT-PE
Master resiliency training – performance expert

MTF
Medical treatment facility

MTT
mobile training team

NCM
Nurse case manager

NCO
noncommissioned officer

NCOIC
noncommissioned officer in charge

NCR
National Capital Region

NGB
National Guard Bureau

NMA
Non-medical attendant

OCAR
Office of the Chief, Army Reserve

OIC
officer in charge

OIP
Organizational Inspection Program

OJT
On-the-job training

OPD
officer professional development

OPMD
Office of Personnel Management Directorate

OSHA
Occupational and Safety Health Administration

OT
occupational therapist

OTSG
Office of the Surgeon General

OWF
Operation Warfighter

PAD
Patient Administration

Pam
pamphlet

PBH–TERM
Psychological and Behavioral Health – Tools for Evaluation, Risk, and Management

PCC
Pre-Command Course

PCM
primary care manager

PCS
permanent change of station

PDA
Physical Disability Agency

PDHRA
Post Deployment Health Reassessment

PDS
Professional Filler Deployment System

PEB
physical evaluation board

PEBLO
physical evaluation board liaison officer

PHI
protected health information

PII
Personally Identifiable Information

PL
public law

PMOS
Primary Military Occupational Skills

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

RCC
Recovery Care Coordinator

REFRAD
release from active duty

RHC
regional health command

RIAWA
Remain-in-the-Army work assignment

RM2
Remote Medical Management

RTD
return to duty

S-1
Adjutant

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

SFL–TAP

Soldier for Life-Transition Assistance Program

SGLI

Servicemembers' Group Life Insurance

SIR

Serious Incident Report

SL

squad leader

SLCC

Senior Leader and Civilian Course

SMART

Specific, measurable, actionable, realistic, and time bound

SME

subject matter expert

SOP

standard operating procedure

SRR

Soldier Readiness Review

SRU

Soldier Recovery Unit

SSA

Social Services assistant

STARTC

Soldier Transfer and Regulating Tracking Center

SWRA

Social Work Risk Assessment

SWRA–Q

Social Work Risk Assessment–Questionnaire

TC

transition coordinator

TCM

Transition and Care Management Team

TCS

temporary change of station

TDA

table of distribution

TDY

temporary duty

TOD

tour of duty

TOL

Triad of Leadership

TRANSCOM

United States Transportation Command

TRICARE

Tri-Service Medical Care

TSG

The Surgeon General

TSGLI

Traumatic Servicemember Group Life Insurance

UCMJ

Uniform Code of Military Justice

UH

Unaccompanied Housing

UMT

unit ministry team

USA SLRRT

U.S. Army Soldier and Leader Risk Reduction Tool

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

VCSA

Vice Chief of Staff of the Army

VHA

Veterans Health Administration

VR&E

Vocational Rehabilitation and Employment

WSA

Worksite assessment

1SG

First sergeant

Section II**Terms****Absent sick**

An active duty Service member (Army, Navy, Air Force, and Marine Corps) hospitalized in other than a U.S. MTF and for whom administrative responsibility has been assigned to a U.S. MTF.

a. Absent sick moved to MTF. Patients who have been moved from a non-U.S. military facility to an MTF.

b. Total absent sick. Patients who are absent sick the total time (never moved to an MTF).

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

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.

Adaptive Reconditioning Program

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 SRU PT, PTA, OT, COTA, NCM, TC, LCSW, Surgeon, SRU medical provider and noncommissioned officer in charge (NCOIC), in collaboration with the Triad of Care.

American with Disabilities Act

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

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 Continuing Education System

Programs and services to promote lifelong learning, readiness, and resilience through flexible and quality education programs, services and systems in support of the Total Army.

Army Recovery Care Coordination Center (formerly AW2)

Component of the ARCP under the DCS–ARC assist and advocate for severely wounded, ill, or injured Soldiers, Veterans, and their Families, wherever they are located, regardless of military status. Soldiers in SRUs eligible for the program are provided support throughout their recovery and transition, even into Veterans status. Through the local support of RCCs (DA Civilians or Contractors), they strive 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. The ARCC Center 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.

Career and Education Readiness Program

Disciplined, purposeful approach intended to prepare each SRU Soldier for success in a long-term career that is personally meaningful, rewarding, and enables the Soldier to achieve financial independence.

Career and Education Readiness Worksite

Where a SRU Soldier participates in a work activity that aligns with the Soldier's CRP track and supports the Soldier's long-term career goals.

Caregiver

An individual who renders to an eligible wounded, ill, or injured Soldier services to support activities of daily living and specific services essential to the safe management of the beneficiary's condition.

Certified occupational therapist assistant

Contributes to the Career Domain in the CRP scrimmage in providing goal setting training to Soldiers and their Family.

Clinical social worker

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. Website at <https://www.hrc.army.mil/tagd/crsc>.

Comprehensive Recovery Plan

Supports Soldiers in returning to the force or transitioning to a Veterans' status. The CRP employs six interdisciplinary processes in developing an individual plan that the Soldier builds with the support of the SRU cadre. Although standardized, the CRP allows each Soldier to customize their recovery process, enabling them to set and reach their personal goals. The CRP provides a personal, customized plan created for the Soldier by the Soldier.

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.

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 website <http://myarmybenefits.us.army.mil/>.

Continued on active duty and continued on Reserve duty

Soldiers found not fit for duty by 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.

Dependent

Defined in Title 10 USC 1072 with respect to a member or former member of a uniformed service.

Disability Evaluation System

The DES 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. The PEB makes fitness for duty determinations.

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 Service members 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, SRUs and in American Jobs Centers and coach transitioning Service members and Veterans in the use of online resources to further assist them with their reintegration into the civilian workforce.

Disposition

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.

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.

eProfile

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.

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 Soldiers serving on active duty. 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.

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, their Family, the chain of command, and the IDT. 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 IDT.

Global Assessment Tool

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. It 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 website (<https://armyfit.army.mil/>).

High-risk Soldier

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.

Individualized Adaptive Reconditioning Program

An individualized plan, that consists of adaptive reconditioning activities, and is specific to the CRP needs of the wounded, ill, or injured Soldier.

Integrated Disability Evaluation System

In accordance with AR 635–40, a single set of disability medical examinations that may assist the DES in identifying conditions that may render the Soldier unfit, and a single set of disability ratings provided by VA for use by DOD and the VA. The DES applies these ratings to the conditions it determines to be unfitting and compensable. The Soldier receives preliminary ratings for their VA compensation before the Soldier is separated or retired for disability.

Interdisciplinary team

The following SRU personnel: Triad of Care (SRU medical provider, NCM, SL, or PSG), LCSW, OT/COTA, PT/PTA, chaplain, RCC, TC, SFAC personnel, and/or others as needed to support the needs of the SRU Soldier.

Lead coordinator

Role for an existing member of the IDT who, while fulfilling their responsibilities of their primary role, assumes responsibility for coordinating the development and overseeing execution of the LCC, but the LC is not responsible for the actual delivery of care beyond their scope of practice. The LC facilitates communication and serves as the primary POC to the Soldier and family or caregiver, as well as the rest of the IDT, in order to avoid or reduce confusion. Lead coordinators can be clinical or non-clinical, and are co-located with the recovering Soldier when feasible.

Leisure activities

Leisure activities (events and trips) are those determined by the SRU medical provider, in collaboration with the IDT, not to have a therapeutic purpose as described in paragraph 5–3.

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

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

The primary decision authority regarding diagnosis and treatment of an individual patient. It includes the primary care manager and the nurse case manager.

Medical Operational Data System

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 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 subject matter expert

A physician or midlevel provider, or that person's representative, who is familiar with the goals and objectives of the Soldier's CRP.

Military medical authority

A physician, physician assistant, or a family nurse practitioner trained in the delivery of primary care medicine.

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.

Non-medical attendant

A person selected by an eligible Soldier, recommended by the SRU commander, and approved by the designated MTF TOL representative, who will contribute to the healing and recovery of the Soldier. This individual is placed on orders which provide certain benefits to the individual.

Occupational therapist

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 SRU, 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.

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 WarFighter

Temporary assignment or internship program, developed by the DOD, for Service members who are convalescing at MTFs. The program provides recuperating Service members 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 CRP.

Organic assets

Staff personnel that belong to a unit (that is, SRU cadre or SRU medical provider versus an MTF emergency room contract provider or PCM who belongs to the MTF).

Over hires

Civilian employees, required for more than 1 year, without a valid manpower authorization.

Per diem

The allowance for lodging (if required, excluding taxes), meals and incidental expenses.

Permanent catastrophic injury

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 evaluation board

Sole forum within the Army to determine a Soldier's unfitness for duty as a result of a physical impairment.

Physical evaluation board liaison officer

A PEBLO is an experienced, mature officer, NCO, or Civilian employee designated by the designated MTF TOL representative 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.

Platoon sergeant

The first line supervisor to the Soldier and the link to command.

Primary care manager

Primary care managers are DHA physicians, nurse practitioners, and physician assistants to whom a Soldier is assigned at an MTF or medical clinic which is DHA-funded.

Protected health information

Protected health information individually identifiable health information that is transmitted or maintained by electronic or any other 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.

Recovery Care Coordinator (formerly Army Wounded Warrior advocate)

DA Civilians or contractors located throughout the United States, to include Hawaii, Puerto Rico, and Germany. RCCs are located at SRUs, major MTFs, several Veterans Administration Medical Centers, 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.

Remain-in-the-Army track

"One of the two tracks which the Soldier can select to transition back to the force.

Remote Medical Management

Program provides medical case management for non-complex USAR Soldiers who are authorized evaluation and/or treatment while on active duty orders but who do not meet ARCP entry criteria.

Report Date

Date physically reported and not physical reported (for example, medical TDY, absent sick, inpatient in civilian hospital, incarcerated, and so forth).

Scrimmage

The scrimmage is an informal meeting with the Soldier's IDT that uses the six domains of strength (career, physical, emotional, social, Family, and spiritual) to develop and refine a future oriented transition plan.

Self- assessment

Tool that allows the Soldier to identify issues and concern that the cadre can validate and quickly resolve.

Senior commander

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.

Sister Services

Sister Services are the other branches of Service—Air Force, Navy, Marines, and Coast Guard.

Soldier and Leader Risk Reduction Tool

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.

Soldier Family Assistance Center

A Comprehensive centralized coordinating office that provides a variety of services to Soldiers and their Family members. The SFAC supports the hospitals and Soldier Recovery Units, by developing, coordinating and providing designated services that address complex administrative and personal needs involving SRU Soldiers and their Family members.

Soldier Recovery Unit

Provides critical support to Soldiers who have, or are anticipated to receive, a profile of more than six months duration, with duty limitations that preclude the Soldier from training or contributing to unit mission accomplishment; or the complexity of the Soldier's condition requires either clinical case management or the Soldier's psychological condition is evaluated by a qualified licensed medical or behavioral health (BH) provider as posing a substantial danger to self or others if Soldier remains in the parent unit.

Soldier Recovery Unit cadre

Qualified personnel assigned to occupy a tables of distribution and allowances position at a SRU.

Soldier Recovery Unit medical provider.

The SRU medical provider is a medical provider assigned to the SRU who lays the foundation and direction of the Soldier's recovery care plan for the recovery care team. The SRU medical provider's focus is the full medical recovery plan. The SRU medical provider is separate from the Soldier's PCM. The SRU medical provider oversees Soldier case management but does not deliver health care.

Soldier Recovery Unit surgeon.

The primary lead for all medical management matters in the SRU, serves as the primary liaison with the designated MTF TOL representative and other Health Readiness Platforms, and provides direct oversight to the SRU medical providers.

Soldiers Medical Evaluation Board Counsel

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.

Sole Provider Program

Medication management of Soldiers in SRU from all points of service (MTFs, Mail Order, and Retail Network) and provides analysis of data to identify high-risk individuals based on command policy.

Special Compensation for assistance with Activities of Daily Living

Compensation for 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.

Squad leader

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 SRU process while enforcing military standards.

SRU Nurse Case Manager

A registered nurse who works with the Soldier throughout their time the SRU.

Therapeutic events

One of the many adaptive reconditioning activities used to help Soldiers achieve their short or long-term CRP goals.

Therapeutic trips

Therapeutic events that involve travel away from the Soldier's unit or quarters.

Therapy animals (animals utilized in animal assisted therapies)

Goal directed intervention where an animal is an integral part of a treatment process designed to improve physical, social, emotional, and cognitive function.

Transfer

Each time an inpatient is transported from one MTF (civilian or military) to another MTF, or SRU.

Transition Assistance Program

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

A member of the SRU cadre focused on the career domain of the CRP.

Transition review

Transition review starts during the in-processing and continues through the Soldier's stay in a SRU.

Transition-from-the-Army track

"One of the two tracks which the Soldier can select to transition back to the civilian population or community.

Traumatic Service members Group Life Insurance

Service member's Group Life Insurance (SGLI) provides automatic traumatic injury coverage to all Service members covered full-time or part-time under the Service members' 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 Service members 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 website <https://www.hrc.army.mil/tagd/tsgli>.

Triad meetings

Critical communication mechanism for members of the IDT, the Soldier, and Family in addition to the scrimmage and FTR.

Triad of Care

Refers to the SL, NCM, and SRU medical provider assigned to a SRU.

Triad of Leadership

SRU Commander/Command Sergeant Major (CSM), designated MTF TOL representative/CSM, and the SRU installation's Army Senior Commander/CSM. The MTF TOL representative is determined as follows: When the MTF Director is an Army officer and is dual-hatted to function as the MTF's Army Service Commander, then he or she is the designated as the MTF TOL representative. When the MTF Director is not an Army officer, the respective RHC Commander coordinates with DHA to designate a senior Army medical officer assigned to the MTF as the MTF TOL representative.

Unaccompanied housing

Housing provided to personnel not residing with Family members. Includes: (1) SRU barracks, and (2) Barracks, dormitories, and transient unaccompanied housing. May include privately-leased housing.

Veterans Benefits Administration liaisons

Advisors in SRUs that provide outreach benefits assistance and services to Soldiers their Families, and/or caregivers.

Veterans Health Administration liaisons

VHA liaisons for health care located at major MTFs to support the transfer of wounded, ill, and injured Soldiers to VA health care.

Vocational Rehabilitation and Employment programs

Assist 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 their lives as independently as possible.

Section III**Special Abbreviations and Terms****CBR**

Contingency battle roster

ITP

Individual transition plan

PHA

periodic health assessment

RCO

Recovery Care Office

SPP

Sole Provider Program

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