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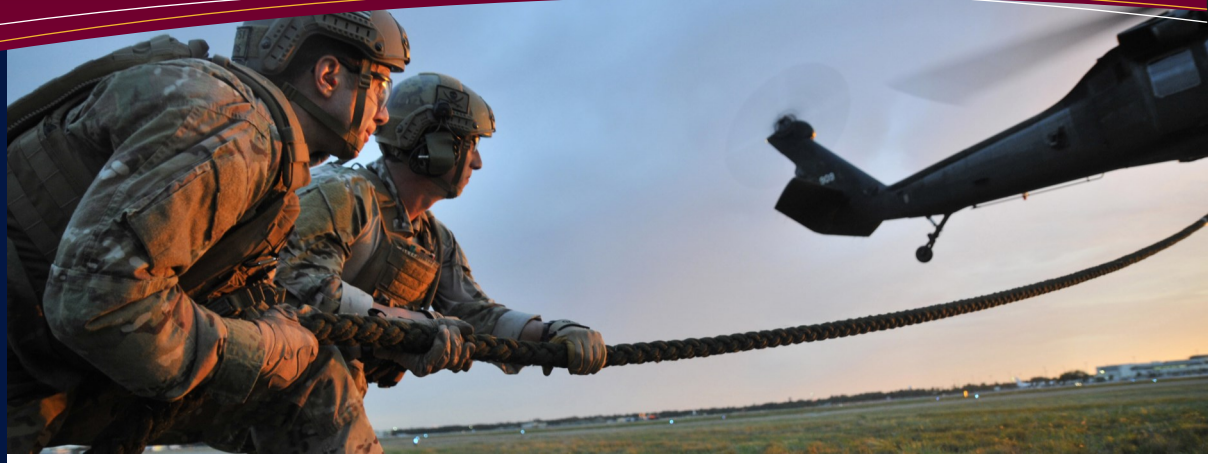
# MEDICAL READINESS READER

Quarterly Newsletter from The US Army G-37 Medical Readiness (MR) Division



## In this issue...



## A Message from the Chief of Medical Readiness

It is with great pride that I send this second Medical Readiness (MR) Reader out to every one of you. Over this past year, we have experienced great partnership from our DA staff colleagues, other MACOMs, our Regional Health Command partners, and teammates within our Military Treatment Facilities. Through this incredible teamwork, we have experienced unprecedented changes in both the technology platform and the policy for MR that will deliver more transparency to both commanders and providers on the readiness of our Soldiers. This transparency supports our number one priority: Readiness.

COL GEORGE GOODWIN, MD
CHIEF, MEDICAL READINESS DIVISION

We are currently finishing the initial training of our command and provider teams on the Personnel and Medical Readiness Transformation (MRT) with the new Commander Portal and enhanced e-Profile system. I truly appreciate the members of the mobile training team that developed the curriculum for training, traveled to 12 different locations to train over 1,000 trainers, and created the online sustainment training that will allow us to ensure our commanders and providers are prepared in the future.

There are still many great things before us. By October, we will see additional enhancements to the MEDPROS platform, and additional portals and features for senior commanders, providers, and medical/administrative support staff. These additions will truly enhance the experience for all MEDPROS users.

As I prepare to hand over the position of Chief of Medical Readiness to COL Michael Pelzner, I want to express my deepest appreciation for the collaboration and support of our partners across the nation and around the world who made this transformation possible. It has been a tremendous effort that could only be accomplished with your active support. Thank you.

As General Allyn has stated:
**Army Ready is Army Strong!**

# MRT: IN CASE YOU MISSED IT

## WHAT EXACTLY IS MEDICAL READINESS TRANSFORMATION?


- To better prepare commanders (CDR) at all levels to make operational and strategic decisions to enhance readiness, the Army is overhauling the personnel and readiness reporting systems. The overhaul will improve the access, visibility, and transparency of medical readiness information to benefit CDRs and providers.
- Army is on track to roll out a complete overhaul of the medical readiness system by 1 Oct 2016, with many changes ready for the O-3 level CDRs (and above) beginning 1 Jun 2016. The roll-out includes training of all command & healthcare teams by 31 May 2016.
- The medical readiness transformation effort ensures balance between optimizing readiness of the unit with the medical needs and well-being of the Soldier.
- G-37 MR Division has coordinated all efforts with FORSCOM, TRADOC, ARNG, USAR, DA G-1, and G-3.

### Why Are We Doing It?

- Ultimately, these changes will save CDRs significant amounts of time, energy, and effort by providing a one-stop, user-friendly shop to view unit and individual medical readiness (IMR) levels to determine which Soldiers are deployable. This heightened visibility will help improve overall readiness.
- Army Senior Leaders are utilizing medical readiness as the strategic lever to change the culture of readiness in the Army. With a heightened focus on deployability balanced with ensuring world-class medical care for injured Soldiers, Army is changing terminology from "availability" to "deployability."
- BACKGROUND: during the Aug 2015 Strategic Readiness Update (SRU), the Vice Chief of Staff (VCSA) of the Army directed the need to:
  - Prevent permanent retention of non-deployable Soldiers; this adversely impacts unit readiness.
  - Ensure the new IT systems and policies are implemented by the end of 2nd quarter FY 16 in order to train the force by 31 May 2016.

### What Is The Way Ahead?

- Revisions of readiness related policies and business processes are driving modernized IT solutions and improving visibility and transparency. An innovative tool called the Commander (CDR) Portal consolidates data from five systems (e-Profile, MEDPROS, NET USR, MRAT and IDES Dashboard) into a one-stop shop that enables CDRs to proactively intervene on individual/unit health readiness issues.
- Initial Operational Capability (IOC) for CDR Portal = 1 Jun 2016 (this date was previously 1 Apr 2016). Key IOC functions include action lists of Soldier medical readiness deficiencies and compliance needs (i.e. medical exams), and a two-way CDR/provider messaging system to improve communication.
- Full Operational Capability (FOC) for CDR Portal = 1 Oct 2016. FOC includes additional IT system functionality for Medical Readiness providers and administrative staff.
- Additional Priorities:
  - Make it easier for Commanders to view medical profiles (single sign-on system = CDR Portal).
  - Redesign the medical profiling system (Single Profile Form).
  - Reclassify the Medical Readiness Classification (MRC) categories by consolidating the MRC 3A and MRC 3B to facilitate CDRs' deployability decisions.

More MRT info is on the Army Training Network: https://atn.army.mil/dsp_template.aspx?dpID=600

# FROM THE VCSA: THE IMPORTANCE OF MR TRANSFORMATION

This past winter, as G-37 Medical Readiness Division coordinated across the Army to spearhead Personnel and Medical Readiness Transformation (MRT), some of Army's most senior leaders also worked to emphasize its importance. They filmed four public service announcements to kick off the MRT training for the Force (*see links at the bottom of this page*). Their words reinforce how MRT will improve readiness to serve our nation, and how MRT will also preserve the health of our Soldiers.

Below, General Daniel B. Allyn, Vice Chief of Staff (VCSA), United States Army, outlines his position.

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*"Leaders, medical professionals, and Soldiers:*

*As worldwide demands for our Army continue to increase, personnel readiness is more critical than ever to accomplish our mission. Individual readiness and deployability are at the core of what our Army provides our nation.*

*To better enable Commanders to effectively manage unit and individual readiness, and to maximize deployability, the Army is transforming its personnel and medical readiness reporting. These improvements fundamentally overhaul current readiness reporting processes.*

*These changes will improve the transparency of information and allow Commanders and healthcare teams to better manage, communicate, and report Soldiers' medical readiness levels.*

*The training you are about to receive is critical for our Army. The training will provide the comprehensive knowledge and skills required to influence accurate readiness and deployability reporting. Additionally, it's paramount you employ this knowledge at home stations to positively impact readiness transparency.*

*Every leader and Soldier makes a difference, and we are counting on your contributions. As always, thank you for your service to your country.* ***Army ready is Army strong.****"*

*– General Daniel B. Allyn, Vice Chief of Staff*





***Click** the names or pictures to hyperlink to the videos. Clockwise from top left: 1. General Daniel B. Allyn, Vice Chief of Staff, US Army. 2. Lieutenant General Nadja Y. West, Surgeon General of the US Army. 3. Daniel A. Dailey, Sergeant Major of the US Army. 4. Gerald C. Ecker, Command Sergeant Major, US Army Medical Command.*

# MRT: STRATEGIC MESSAGING (PART 1)

| Stakeholder to Stakeholder | Personnel & Medical Readiness Transformation (MRT): Key Messages to Communicate |
|---|---|
| CDR to Provider | • Key in on languaging, understand courses of action for Soldier, **build relationships**, enhance force multiplications, and maintain hold on provider changes.<br>• **Hold touch-points** with Chiefs in clinics and build those relationships to help track which providers are caring for Soldiers. Emphasize that **CDRs need to know when providers depart staff** so they know who assumes responsibility of a Soldier's care.<br>• **Help providers understand CDRs' requirements**: not just "what", but "why" it's important. Example: most providers don't know what Tables of Distribution and Allowances (TDA) are. Providers must understand the need to keep Soldiers in the fight. Too much empathy for Soldiers can cause stagnation or frustration for CDRs. |
| Provider to CDR | • **Emphasize the long-term treatment plan** for the sake of the greater health of the SM in the long-run. Example: "Even though you have a strenuous PT regimen for your unit, I'd caution you on pushing too much. This particular **Soldier needs to stay off that ankle if you want him back in the fight."**<br>• Soldier profile and limitations: clarify differences related to specific Service member (SM) needs, treatment response, **be advocate for patient**, and build relationships. |
| Provider to Soldier | • Encourage Soldiers to **take ownership of their experiences.** For instance, encourage Soldiers to **bring family/significant others** to consultations. Providers can accumulate new data points that can greatly enhance the treatment plan. Example: a Soldier may not be aware of what he/she does during sleep, but significant others observe things the Soldier might otherwise miss. So ask the right questions!<br>• Provider clearly communicates that the **treatment plan will be based on the scientific evidence/diagnosis for the injury.** "We're here to help, but I can't just proscribe any Rx you want — that does not assist the Force." Providers can maintain empathy, but must provide a care plan using the most **evidence-based science**. |
| Providers to Clinical Staff | • "We're going to **hold each other accountable as providers**. If we don't, someone else will" (i.e. Congressional inquiries, etc.). Reinforce the point that poor communication or treatment of Soldiers might lead to Soldiers secretly recording the session and making them public. The unfortunate reality is that this happens often.<br>• Opinions and **treatment must be completely unbiased**. Do not disparage any patient in communication with other providers — this will degrade that second provider's ability to have an unbiased opinion of that Soldier if that Soldier ends up seeing him.<br>• We need a **"One Staff"** mentality / **common operating model** of evidence-based care. |

# MRT: STRATEGIC MESSAGING (PART 2)

| Stakeholder to Stakeholder | Personnel & Medical Readiness Transformation (MRT): Key Messages to Communicate |
|---|---|
| CDR to Soldier Designee | Expectation Management: **clear expectations** with Soldier. Any questions that CDRs have can be clarified using the CDR Portal messaging system with Provider.<br>Reinforce that CDR has consistent communication with providers and has a **solid understanding of a Soldier's limitations.** At the same time, emphasize there is a treatment timeline and **Soldier must not violate his/her profile.** |
| Soldier to CDR Designee | Medical status: Soldier builds responsibility for health and readiness. Can have more targeted discussion with Command and assumes responsibility.<br>Must **speak up** about limitations, but also be transparent about what you *can* do as well. Emphasizing **what you *can* do** will make it easier to admit your limitations. |
| CDR Designee to Senior CDR | Must be able to develop actionable SM plans and articulate to Senior CDR. The CDR Designee must be prepared to **explain 'Private Snuffy's medical status at any time** to the Senior CDR.<br>Emphasize that you all have a responsibility to each other to **ensure SM continuity** for the sake of maintaining deployability of the Force. |
| Soldier to Soldier | We will have a **shared responsibility** in supporting each other with a downsized deployable Force. "This treatment is not just for you. It's for us, and your Family."<br>**Communicate DL conditions to other soldiers** as related to job functions. Ex: "If you're on medication that may impair your driving ability, we need to know. For all our sakes'." Again, **focusing on tasks you *can* do will help you admit limitations.** |

*Two-way Communication* → *Better Relationships* → *Healthy Soldiers* → *Maximum Readiness*

# PROTECTING YOUR PRIVACY: ENSURING INFORMATION IS SECURE

In gearing up for the upcoming launches on the new Commander (CDR) Portal system for all Command and healthcare staff (*see page 2*), the Army has been diligently working to ensure patient privacy remains protected.

## Ensuring Proper Terminology and Messaging

To maintain proper Health Insurance Portability and Accountability Act (HIPAA) compliance, patient diagnoses and personnel information must not be released to unauthorized individuals.

As the Force is trained on MR Transformation, emphasis will be placed on consistent communication between healthcare providers and CDRs. Guidance will be provided to CDRs, healthcare providers, and profiling officers to ensure that only Protected Health Information (PHI) deemed necessary "in order to carry out an activity under the authority of the Commander" is entered into MEDPROS.

In addition, CDRs will only have access to information concerning Soldiers under their command; all messages transmitted using the commander/provider messaging function, as well as additional patient data within the CDR Portal, will not be exportable and cannot be disseminated outside of the protected system.

Within the CDR Portal, a disclaimer will be clearly displayed to affirm that PHI will be properly contained within the system and available only to those who are approved to view this information.

## Commander Portal Access

To ensure that all patient data is HIPAA compliant, only authorized healthcare providers and commanders will have access to the messaging application within MEDPROS.

Access to MEDPROS is role-based. Only those validated as CDRs through assumption of command memoranda will receive CDR-level access.

In addition, MEDPROS approval authorities will be responsible for screening new healthcare providers who require system access.

As defined in AR 40-68 Clinical Quality Management (*click for link*), healthcare providers will consist of military and civilian personnel who have been granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimens within the scope of his/her license, certification, or registration. Limiting access to the messaging to only those granted these privileges will protect PHI from being released to unauthorized individuals.

## Summary — CDRs May Access This PHI:

- DoD Drug Testing
- Medical readiness and fitness for deployability
- Medical line of duty investigation determinations
- Changes in duty status due to medical conditions
- Army weight control information.

## Summary — CDRs May NOT Access This PHI:

- Medical information that does not impact readiness or fitness for duty
- The reason for medical appointments, routine medical treatments, clinical service seen, or other information that does not directly affect fitness for duty
- Medical information on Soldier Family members, except for exceptional Family member program (EFMP) assignment limitations.

## Compliance Officer Approval

The above outlined safety measures were reviewed and approved by the MEDCOM HIPAA Compliance Officer and Staff Judge Advocate in an effort to prevent any HIPAA issues endangering the Soldier's welfare.

# MRT: FULL OPERATING CAPABILITY (FOC)

## NEW COMMANDER PORTAL READY, BUT WHAT HAPPENS NEXT?

By now, most Army Command and healthcare staff are intimately aware of the new mandatory Commander (CDR) Portal, its robust features, and its coming Initial Operating Capability (IOC) launch on 1 June, 2016 for approximately 90,000 personnel. However, you may not know about the set of additional CDR Portal features and capabilities currently in the works for Full Operating Capability (FOC) implementation around 1 October 2016. While the precise scope of these new features will not be fully realized until closer to FOC, here is a high-level breakdown of features planned to continue supporting the Personnel and Medical Readiness Transformation (MRT) mission to enhance Army Readiness.

### NEW PORTALS

Addition of Provider, Provider Support Staff, and Administrative Portals in MODS to allow medical personnel and administrative staff to access medical readiness applications using a single sign-on platform.

### INDIVIDUAL MEDICAL READINESS MODULE

Launch of enhanced Individual Medical Readiness (IMR) capture module (currently MEDPROS Web Data Entry) to facilitate workflows and data capture during Solider Readiness Processing (SRP) and other readiness events.

### HIGHER LEVEL COMMANDER PORTAL

And dashboard to allow BN, BDE, and other senior level commanders the ability to view medical readiness summaries of their direct reporting units.

### PHA FUNCTIONALITY

Army implementation of DoD Periodic Health Assessment (PHA) and integration with Sister Services' electronic medical readiness platforms to support completion of Soldiers' DoD PHAs by healthcare providers from other Services.

### ENHANCED REPORTING

Addition of more robust reporting capabilities to support customized data queries, exporting to SCS or Excel, and the ability to manage larger search results faster and more easily.

# MRT TRAINING: INCEPTION TO COMPLETION




**1.** Brigadier General (BG) Raymond Scott Dingle, MEDCOM Deputy Chief of Staff, Operations (G-3/5/7), sets the stage for the initial group of MRT Mobile Training Team (MTT) members including CPT Vanessa Bonner (pictured) during their orientation week at the Defense Health Headquarters (DHHQ) in Falls Church, VA on 18 Nov 2015. **2.** In March 2016, CPT Alysia Franco, medical support operations officer, Staff Sgt. Uriah Low, senior medic, 4th Engineer Battalion, and Staff Sgt. Oscar Ortega, combat medic with 10th Special Forces Group, all from Fort Carson, study to become MRT Train the Trainers (TtT) to further train the Force. **3.** Major General (MG) Wilmot, Deputy Surgeon General for the Army National Guard, completes his command-based MRT training alongside command teams during the National Guard Training Conference at Camp Robinson in Little Rock, AR on 16 May 2016. G-37 MR Division has diligently leveraged such training opportunities before the 1 June 2016 launch of the new Commander Portal.

# SUSTAINMENT TRAINING: LOOKING TOWARD THE FUTURE

**By: Mr. Garfield (Gary) D. Skyers, Enterprise Level Consultant**

One of the key components to measuring the success of the Personnel & Medical Readiness Transformation (MRT) initiative will be how well we do with sustainment training. We have deployed more than 30 Mobile Training Team (MTT) members that trained 1,037 Train-the-Trainer (TtT) personnel across the Army. These teams are essential to getting the force trained by the 1 June Initial Operating Capability (IOC) date.

At some point, those MTT and TtT individuals will transition to units, and in some cases, leave the Army altogether. However, the need to train the force, particularly command teams, healthcare teams, and their support staff, will not end. In other words, the MRT training must be properly sustained.

To continue ensuring that the force is trained, we are executing two lines of efforts (LOE) based on three MR pillars: 1) the Soldiers, 2) their leaders (command team), and 3) their healthcare providers.

To get at the Soldier and command team, we look to LOE 1, which focuses on instituting MRT into applicable Primary Military Education Courses (PME). For this LOE, we are working with TRADOC to identify those courses that are appropriate to incorporate MRT training. Additionally, we understand there is a constant rotation of command teams, so we have updated the MR module in the Company Commander and First Sergeant Course to reflect the new changes. The Army Medical Department will continue to provide course updates as needed.

LOE 2 focuses on the third MR element: the healthcare team. It is important to distinguish the term "healthcare team" instead of "providers" specifically. Most people think of providers in terms of doctors, dentists, or nurses. However, in using the phrase, "healthcare team," our goal is to expand the term "providers" to include healthcare teams comprised of a much larger list of specialties, individuals, and support personnel that require training.

We are also working with the AMEDD Center and School - Health Readiness Center of Excellence and the Defense Health Agency (DHA) to create and post the Healthcare Team sustainment training on the Joint Knowledge Online (JKO) portal with a target date of 1 June. This initial course is intended to serve as a bridge to meet the demands that are expected between 1 June and 30 September 2016. The course will be replaced when the final CDR Portal product is released at Full Operational Capability (FOC) in October 2016.

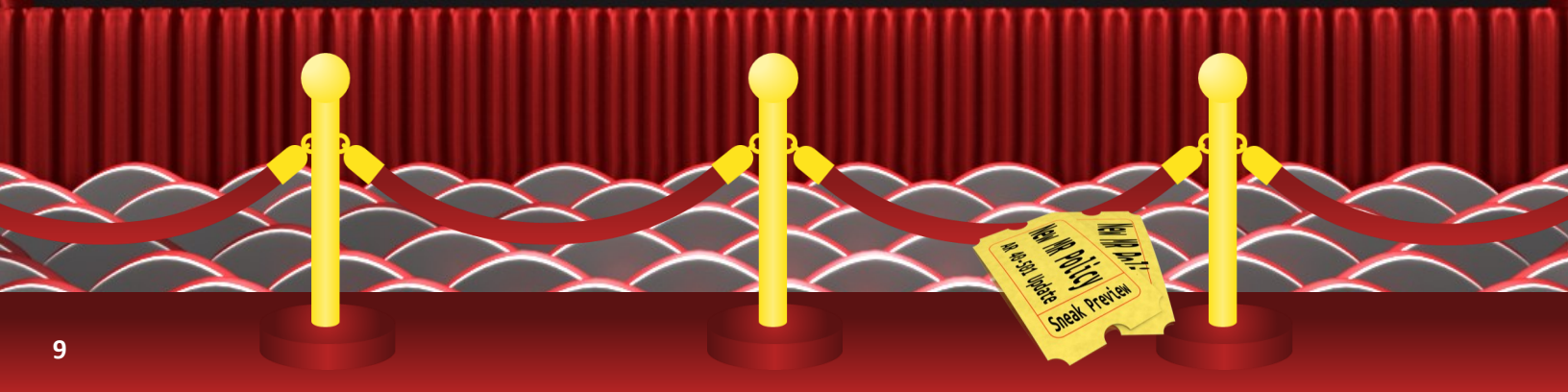
Be sure to check out the Medical Readiness Transformation page on the Army Training Network (ATN) at https://atn.army.mil/dsp_template.aspx?dpID=601 where you can get information on policies, updated MRT course content, points of contact, training schedules, and detailed answers to Frequently Asked Questions.

# Personnel and Medical Readiness Policy: Coming Soon to an Army Near You!

THE FOLLOWING **PREVIEW** HAS BEEN APPROVED FOR
**ALL AUDIENCES**

IN A WORLD where we depend on healthy Soldiers, the US Army is writing new policies to ensure our troops remain ready for anything. Working alongside leaders and subject matter experts throughout the Army, the G-37 Medical Readiness (MR) Division is revising the medical standards for accession, retention, special training and schools contained in Army Regulation (AR) 40-501, Standards of Medical Fitness. It is crucial to note that the update to AR 40-501 will also remove the MR policies from the regulation. Instead, MR policies will be updated and set through a separate, upcoming MR regulation later in 2017, which will also incorporate the 85% or greater standard for MR. Together with an in-depth DA PAM as its companion, the yet-to-be published AR will help more effectively manage, communicate, and report Soldier medical readiness. In other words, the new AR will help keep us **Army Ready and Army Strong.**

Specifically, the new AR and DA PAM will outline information on individual MR elements and deployability determinations. The documents will offer detailed guidance on the new profiling system for communicating individuals' functional abilities, and they will officially establish the new MR reporting system. Last but not least, the new regulation will provide administrative requirements for military exams. Certain key chapters from AR 40-501 are serving as a basis for the emerging personnel and medical readiness policy. These chapters include: Chapter 6 (Aeromedical Administration), Chapter 7 (physical profiles), Chapter 8 (Medical Examinations), and Chapter 11 (Individual Medical Readiness Standards). Meanwhile, the processes and procedures in Chapter 4 (Medical Fitness Standards for Flying Duty) will transition to the new MR policy, while the medical standards will stay in AR 40-501. Stay tuned for the full features of these key policies.



# NEW TOOL: ELECTRONIC PHA FORM

By: Ms. Laurie Fontaine, Health Standards Specialist

After years of collaboration, the Department of Defense (DoD) published the first all-Service DoD Periodic Health Assessment (PHA) tool on 25 April: DD Form 3024. The new DoD PHA completion format will make it easier for clinical staff to conduct PHAs for our Soldiers.

## What is it?

This form contains the DoD question set that each Service's electronic medical readiness platform will customize to the completing Service member (SM), presenting only relevant questions.

Of note, healthcare providers will complete the DoD PHA electronically, regardless of Service.

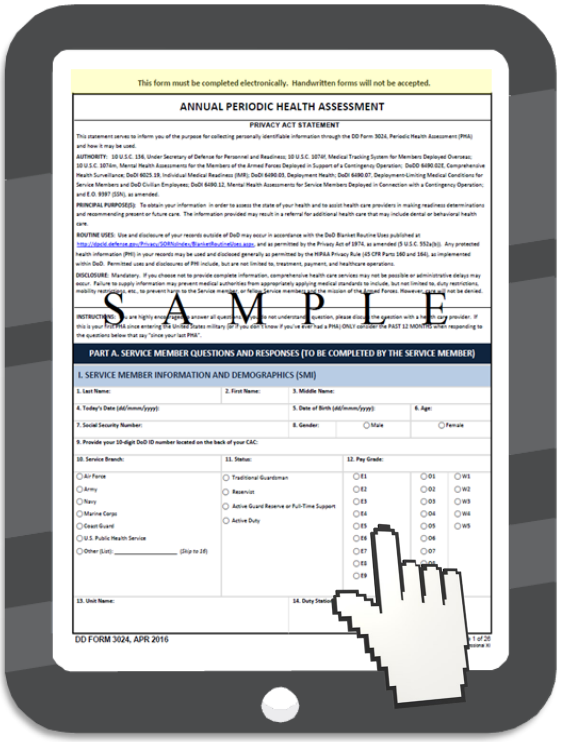
The new DoD PHA contains many of the original PHA questions with some new questions designed to enhance the assessment as a healthcare screening tool (based on USPSTF guidelines) as well as a SM's DoD IMR and deployability elements.

Designated representatives from each Service component's Surgeons General office collaborated to develop the new tool to assess individual medical readiness (IMR) and deployability. The DoD PHA reflects recommendations from the US Preventive Services Task Force (USPSTF), the Mental Health Working Group (WG), the IMR Working Group, and the Deployment Related Health Assessment Working Group.

The DoD PHA structure includes a SM questionnaire, a Record Reviewer Section, as well as a Healthcare Provider Section.

## Advantage: New DoD PHA

Importantly, the DoD PHA will allow Soldiers, Sailors, and Airmen to receive their PHA from a healthcare team from any Service. The change in structure also takes advantage of a having a Service Record Reviewer (e.g. a medic or nurse) to review existing records and summarize SM responses. Utilizing a record reviewer will improve




the quality of the PHA while decreasing the administrative time for the healthcare provider.

An individual healthcare provider may still complete the DoD PHA independently. However, that provider will not reap the full benefit of potential time efficiencies offered by a record reviewer.

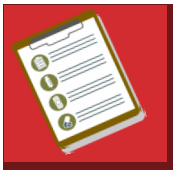
## More to Follow

Additionally, certain screening and lab elements currently mandated in the Army PHA are not in the DoD PHA requirements, but will default to recommendations by the healthcare provider (based on the USPSTF guidelines). Army policy will update to align with this change.

The DoD expects the corresponding DoD PHA DoDI and Procedural Instruction to publish in the very near future. Further guidance regarding Army implementation is emerging to support the 1 October 2016 implementation across the Army via access through the MODS platform.

# SEPARATION HISTORY AND PHYSICAL EXAM (PART 1)

## 1. WHAT IS THE PURPOSE OF SHPE?



The Separation History and Physical Examination (SHPE) provides a single separation examination to support the Department of Veterans Affairs (VA) disability compensation program and the DoD mandatory separation history and physical exam. It is a standardized health assessment with components agreed upon by all three Military Services and the VA. SHPE is used to used to medically clear SMs for separation from active duty service and evaluation of VA disability claims.

Past medical history identified during periods of active duty service, along with the SM's current health status, are documented during this exam. Sometimes, the SHPE may uncover a previously undiagnosed medical condition. DoD may use information captured during SHPEs to recognize and prevent illnesses and injuries arising from military service by mitigating or eliminating occupational exposures or physical hazards in military workplaces, where feasible.

## 2. WHERE IS SHPE COMPLETED?

DoD Military Treatment Facilities (MTF) will conduct the exam for all active duty SMs who do not file a claim for disability compensation or cannot obtain their VA exam results prior to separating from active duty.

The VA will conduct the examination for Soldiers who file a disability claim prior to discharge within the current time frames agreed from 180 to 90 days prior to Date of Separation (DOS).

It is important to note that excessive terminal leave and other issues may prevent the VA from completing the exam and providing the results to DoD prior to the SMs discharge date. In these cases, DoD MTFs will be required to complete the SHPE in order to medically clear the SM prior to final out/separation. A SHPE for eligible Reserve Component (RC) SMs will be completed by DoD MTFs, the VA, or a DoD contracted medical provider.

***IMPORTANT NOTE: PROVIDERS MUST ENSURE ICD CODE "DOD0222" IS ENTERED IN AHLTA FOR EACH SOLDIER'S SHPE COMPLETED IN MODS.***

## 3. WHO IS ELIGIBLE TO OBTAIN SHPEs?

Title 10, Chapter 58 Section 1145 and Directive-type Memorandum (DTM) 14-006, "Separation History and Physical Exam" dated 21 July 2015 requires all SMs preparing for release from active duty to complete a comprehensive SHPE before their scheduled date of release. It includes:

1) Active duty service members who are scheduled to separate after serving 180 days or more.

2) RC SMs who are scheduled to end a period of active duty service after 180 days or more of continuous duty (e.g. Active Guard Reserves, SMs serving on Military Personnel Appropriation tours).

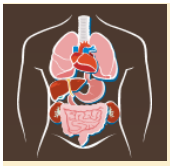
3) RC SMs who are scheduled to end a period of active duty service after more than 30 days of continuous duty in support of a contingency operation (as identified on their orders).

## 4. WHAT IS THE BENEFIT TO SOLDIERS?

The SHPE provides a comprehensive medical evaluation of a SM's current health status at separation and summarizes past medical concerns identified during their active duty service. The exam provides a final review of a SM's health status to identify any potential conditions that may require referral to a Medical Evaluation Board (MEB) or the Disability Evaluation System (DES) prior to separation. For those SMs who wish to file disability claims prior to discharge, exams completed by the VA benefit the SM by initiating the disability claims processing prior to separation, which results in obtaining benefits sooner as well as requiring completion of only one single physical examination for separation from active service, eliminating the need for the military treatment facility (MTF) from having to complete a duplicate separation exam.

# SEPARATION HISTORY AND PHYSICAL EXAM (PART 2)

## 5. WHY WAS SHPE DEVELOPED?



Title 10 law, Chapter 58, Section 1145 codified a requirement for the Services to develop a separation physical for SMs meeting eligibility guidelines. The Joint Executive Council (JEC) initiated a study to conduct a VA-DoD standardized separation exam. Results prompted JEC to approve a standardized exam and led to a DoD/VA Memorandum of Understanding (MOU) signed in Dec 2013 to outline the responsibilities of both organizations. In 2014, the Under Secretary of Defense for Personnel and Readiness published Directive Type Memorandum (DTM) 14-006, "Separation History and Physical Exam" to outline exam requirements and Service responsibilities. This DTM was recently replaced with DOD Instruction (DoDI) 6040.46, "The SHPE for the DoD Separation Health Assessment Program." The DoDI and MOU contain the policy and procedures that allow SMs who plan to file a disability claim to use the exam done by the VA to simultaneously meet separation exam requirements and begin disability claims processing before their release from active duty service.

## 6. WHEN IS SHPE NOT REQUIRED?

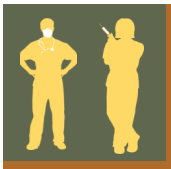
1) If the SM is separating/retiring after being found unfit through the Disability Evaluation System (DES).

2) If the SM has a completed physical exam with audiogram testing documented in their service treatment record (STR) within the last 12 months prior to date of separation and the exam was completed on a DD Form 2807-1/DD Form 2808, and the SM has agreed in writing to waive the exam and complete a DD Form 2697 in place of the full SHPE.

3) If a SM on active duty orders is separating from their current status and starting a new tour with no break in service (e.g. enlisted SM obtaining commission and continuing on active duty; or transitioning from one military branch to another; or active duty changing status to a Reserve Component position and continuing on active duty orders).

4) If an active duty SM has performed less than 180 days of total active duty service. In this case, the original accession physical exam and a DD Form 2697 may be used in place of the full SHPE.

## 7. HOW CAN I OBTAIN A SHPE AT THE VA?



All SMs who plan on filing a disability claim prior to discharge are eligible to complete the SHPE at the VA. But, SMs must meet the submission requirements as agreed upon between the DoD and VA.

Primarily, SMs must file their pre-discharge disability claims and receive VA acknowledgement within the window of 180-90 days prior to their official date of separation. In addition, MTF staff must be cognizant of the SM's terminal leave plans, which may impact review of the VA report prior to the SM's final out.

When a SM has terminal leave, the final out-processing date may be used in lieu of date of separation from active duty for timeline require-ments. This enables SMs to validate their SHPEs as "current" 30 days prior to my date of separation if taking 35 days of terminal leave.

## 8. WHERE CAN I FIND MORE INFO?

In addition to the SHPE User Guide, automated versions of the SHPE forms are on MODS Medical Health Assessment (MHA) module at https://rc.mods.army.mil/MHA/. A blank DD Form 2807-1 for SMs to complete and take to providers for their SHPE appointment can be found at: http://www.dtic.mil/whs/directives/forms/index.htm.

Another great location to obtain general information on services available when preparing to separate is the Tricare Online website and the TRICARE Online (TOL) Secure Web Portal, which is located at: https://www.tricareonline.com/. Through the TOL Portal, SMs can also access electronic medical records using a doorway to "Blue Button" that will allow separating SMs to view and access individual health records from military hospitals and clinics. Info includes: Problem List, Lab Results, Allergy Profile, Medication Profile, and Appointment History.

# DHAP REVEALS OIP PLANS, PUBLISHES NEW LEADER'S GUIDE

By: Mr. Ben Clark, Project Manager, DHAP, G-37 Medical Readiness Division

As you may know, the Deployment Health Assessment Program (DHAP) is a proactive and prevention program that enables the early identification and treatment of physical and behavioral health issues at critical stages within the deployment cycle. The collaborative and combined effort of the personnel and medical communities, as well as unit and installation commanders, is key to successful program execution.

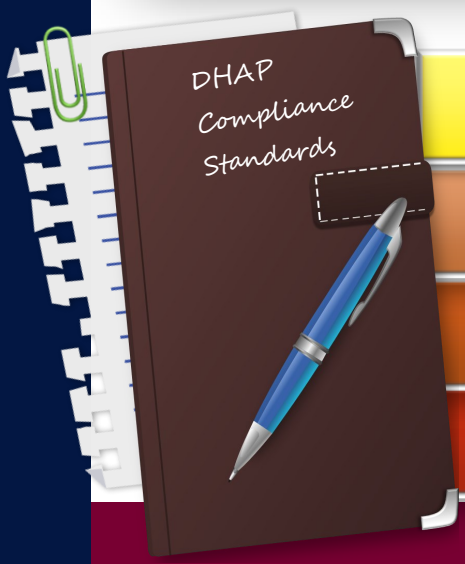
To achieve mission success, the Army established the Organizational Inspection Program (OIP) for DHAP as a management tool that the commanders can use to identify, prevent, or eliminate problem areas.

In Jan 2016, the Office of The Surgeon General (OTSG), DHAP Team kicked off its first successful MEDCOM OIP/Site Assistance Visit (SAV) at Regional Health Command-Pacific (Provisional) RHC-P (P) to ensure command emphasis for completion and compliance in accordance with DOD and Army directives.

The OTSG DHAP is scheduled to visit several RHCs throughout 2016. The OIP/SAV focuses on Execution, Expertise, Access, and Monitoring of the program.

Additionally, the G-37 Medical Readiness Division is also pleased to present the new DHAP Leader's Guide, published on 29 Feb 2016. The DHAP Leader's Guide is a user-friendly resource for Unit and Garrison Commanders, their staff, as well as the medical and personnel communities to implement this important mission to protect the health of our Soldiers.

Ultimately, this guide provides clear, thorough guidance and instructions needed to educate the field on how to properly execute, track, and manage DHAP. This is a major accomplishment, and we expect the Leader's Guide to significantly assist the field in raising awareness and contributing to deployment health assessments completion and compliance requirements necessary to ensure our Soldiers are medically ready for the Army's mission.




**1 DHAP Execution**
Unit DHAP execution meets or exceeds Army standards for Pre-Deployment Health Assessment, Post Deployment Health Assessment (PDHA), and Post Deployment Health Reassessment (PDHRA) real-time compliance.

**2 DHAP Expertise**
Commanders have knowledge of, understand, and have communicated the requirements of the DHAP to the members of their command.

**3 DHAP Access to Internet**
Commanders have ensured that all Soldiers, Department of the Army Civilians (DAC), and Contractors subject to the DHAP have access to health care providers appropriate to meet DHAP requirements

**4 DHAP Monitoring**
Commanders have monitored their Soldiers', DACs' and contractors' progress with PDHRA requirements to ensure compliance.

For more info on DHAP, visit www.dhap.army.mil

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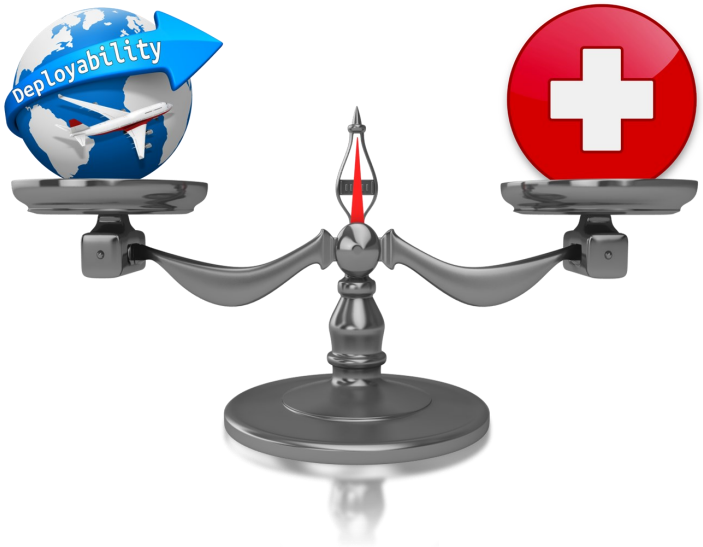


***Equilibrium:*** *the need for Soldiers to deploy, balanced with maintaining world-class medical care.*

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