NOV 08 2010

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Establishment of Army Campaign Plan for Health Promotion &
Risk Reduction FY 2011 (HP&RR FY11)

1. Attached to this memorandum is the HP&RR FY11 campaign plan, the sequel to the April 2009 Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP). This new campaign plan represents a transformative stage in the Army's health promotion and risk reduction campaign, based upon two years of research and program enhancements. You have all read the Army's *HP/RR/SP Report 2010* (aka the *Army's Red Book*) and understand many of the challenges we are confronting with promoting health and reducing risk across our Force.

2. We must now look ahead to methodically address how we bring the Force home, how we reintegrate a Force that has been at war for a decade and how we improve accountability and quality of life for Soldiers, Civilians and Families. This will require the full dedication of leaders across the Force to ensure compliance with existing policies, programs and processes and to set conditions for the next wave of Army solutions. Execution of this campaign plan is critical to achieving the CSA's imperatives to sustain, prepare, reset and transform the Force.

3. The HP&RR FY11 campaign plan incorporates findings and recommendations from the set of recently issued DoD/Army strategic reports regarding health promotion, risk reduction, suicide prevention, and protection enhancements in the wake of the Fort Hood tragedy. It establishes enduring HQDA-level processes that will set the conditions for rapid change.

4. Changes to existing policy, programs and processes will be facilitated through the HQDA council system by two HQDA-level forums: the Army Health Promotion & Risk Reduction Task Force (AHP&RRTF) and the Army Protection Committee (APC). My intent is to have these forums effect rapid change by implementing this campaign plan in tandem with executing established HQDA requirements and resourcing processes. Program changes will be made based upon ongoing Capabilities Portfolio Review (CPR) efforts and may result in out-of-cycle implementation of identified requirements.

5. The Army Health Promotion & Risk Reduction Council (AHP&RRC) will be co-chaired by flag-level representatives appointed by Senior Army Leadership. The co-chairs of the Council will report the progress of this Campaign directly to Army Senior Leadership. The APC will be chaired by the Provost Marshal General. The APC will coordinate with appropriate stakeholders and progress in this area will be reported directly to Senior Army Leadership.

SUBJECT: Establishment of Army Campaign Plan for Health Promotion & Risk Reduction (HP&RR FY11)

6. Commanders – the Senior Army Leadership (in partnership with you) is committed to ensuring the success of this campaign through the expeditious implementation of report recommendations. This campaign is more than a HQDA-level endeavor and is not "business as usual". I have provided direct guidance to you to improve compliance with existing regulatory requirements. This guidance, provided in Annex D, is intended to assist you in ensuring Soldier accountability, good order and discipline in the Force… both on and off duty.

7. Our Senior Army Leadership and Task Force leaders have been traveling Army-wide to discuss findings and recommendations of the DoD/Army strategic reports. We have found these engagements to be extremely beneficial to both local and Army leadership. It is clearly apparent that the Army (at all levels) continues to move rapidly forward to effect necessary change. If we have not yet visited your command/installation or we can be of service, please contact me or BG Colleen McGuire or COL Christopher Philbrick at (703) 571-5566 and a visit will be scheduled.

8. As a final note, we must all be vigilant of the perils associated with a stressed Force. Leaders at all levels must stress accountability. You must continue to aggressively surveil, detect and intervene to first promote health and well-being and then second to reduce the risk to the individual and others. Our Soldiers, Families and Civilians deserve nothing less.

Encl

PETER W. CHIARELLI
General, U.S. Army
Vice Chief of Staff

DISTRIBUTION:
Principal Officials of Headquarters, Department of the Army
Commander
   U.S. Army Forces Command
   U.S. Army Training and Doctrine Command
   U.S. Army Materiel Command
   U.S. Army Europe
   U.S. Army Central
   U.S. Army North
   U.S. Army South

SUBJECT: Establishment of Army Campaign Plan for Health Promotion & Risk Reduction (HP&RR FY11)

DISTRIBUTION: (CONT)
U.S. Army Pacific
U.S. Army Africa
U.S. Army Special Operations Command
Military Surface Deployment and Distribution Command
U.S. Army Space and Missile Defense Command/Army Strategic Command
Eighth Army
U.S. Army Network Enterprise Technology Command/9th Signal Command (Army)
U.S. Army Medical Command
U.S. Army Intelligence and Security Command
U.S. Army Criminal Investigation Command
U.S. Army Corps of Engineers
U.S. Army Military District of Washington
U.S. Army Test and Evaluation Command
U.S. Army Reserve Command
U.S. Army Installation Management Command
U.S. Army Cyber Command
Superintendent, U.S. Military Academy
Director, U.S. Army Acquisition Support Center
U.S. Army Accessions Command

NOV 08 2010

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Army Campaign Plan for Health Promotion & Risk Reduction FY 2011 (HP&RR FY11)

1. **Situation**: In February 2009, the VCSA was appointed by the Secretary of the Army and the Chief of Staff of the Army to lead efforts and focus attention on the increasing rate of suicides within the Army. In March 2009, the VCSA chartered the Army Suicide Prevention Task Force (ASPTF) and the Army Suicide Prevention Council (ASPC) to implement the Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP). In March 2010, a separate HQDA report team was established to write a holistic report documenting the ASPTF's findings over the initial 13 month period. The report team utilized existing Army data to conduct research and analysis on health promotion and risk reduction, and provided specific recommendations for the way-ahead. In July 2010, the Army published the *Army Health Promotion, Risk Reduction and Suicide Prevention (HP/RR/SP) Report 2010* (the *Red Book*). Based on the *Red Book*'s findings, senior Army leadership directed that the ASPTF and ASPC be reorganized into an interim Army Health Promotion and Risk Reduction Task Force ("HP&RR Task Force") with a permanent Army Health Promotion and Risk Reduction Council ("HP&RR Council"). The HP&RR Task Force and Council were chartered to: (1) implement, as appropriate, the findings and recommendations of the *Red Book*; (2) review, analyze and implement, as appropriate, recommendations from a set of recently issued DoD/Army strategic reports pertaining to health promotion, risk reduction, suicide prevention, and force protection related to the Ft. Hood tragedy; and (3) provide oversight and integration to ensure enterprise implementation of HP&RR policy and programs. All recommendations will be developed by the Task Force in coordination with the Army Protection Committee ("Protection Committee") and incorporated into a global HP&RR Synchronization Matrix ("Sync Matrix") found at Annex B. Finally, the Sync Matrix will be implemented through the HP&RR Council when dealing with HP&RR specific tasks or through the Army Protection Board of Directors ("Protection BOD") when dealing with force protection specific tasks. These two boards will provide enterprise wide coordination, reduce gaps and improve efficiencies.

Mission: HP&RR FY11 is the means by which HQDA and senior leaders will direct implementation of immediate and enduring Policy-DOTMLPF-Resource-Research (P-DOTMLPF-RR) solutions necessary to ensure improvements in health promotion and risk reduction policies, programs and processes (including protection and security).[1]

---

[1] A P-DOTMLPF-RR analysis considers policy, doctrine, organization, training, materiel, leadership and education, personnel, facilities resources and research. DOTMLPF is a recognized DoD term. See JP 1-02, *DoD Dictionary of Military and Associated Terms*, 31 October 2009.

SUBJECT: Army Campaign Plan for Health Promotion and Risk Reduction (HP&RR FY11)

2. Execution:

a. VCSA Intent. The Secretary of the Army and the Chief of Staff of the Army directed me to promote health and reduce risk across the force. My intent is to execute this guidance through this Campaign Plan by expediting staffing and implementing the recommendations provided by DoD/Army strategic reports, including: the *Red Book*; the *DoD Report on Suicide Prevention Efforts Across the Military Services*; and the DoD and Army reports on the Fort Hood tragedy. The HP&RR Task Force will convert the recommendations from these reports into actionable tasks that will rapidly improve health promotion, risk reduction and protection policies, programs and processes. In addition, installation, garrison, MTF and unit Commanders will utilize Annex D of this plan to immediately improve compliance with existing regulatory requirements and traditional processes at installation and unit level.

b. Method. This Campaign Plan contains two parallel lines of operation that address near-, mid- and long-term challenges related to HP&RR and protection. Mid- and long-term changes to policy, programs and processes will be addressed through the HQDA Plan (Section 3.b.(1)). Near-term challenges will be addressed utilizing the Commanders' Plan (Section 3.b.(2)).

(1) HQDA Plan. The HQDA Plan utilizes two distinct yet synergistic lines of effort. To reduce redundancy and ensure proper synchronization, all tasks derived from report recommendations will be developed and monitored by the HP&RR Task Force and synchronization with the Protection Committee. Tasks that relate to HP&RR will be facilitated by the HP&RR Council as described in the HP&RR Line of Effort. Any protection/risk reduction tasks will be facilitated by the Protection BOD as described in the Protection Line of Effort.

(a) HP&RR Line of Effort. All HP&RR tasks will be coordinated by the HP&RR Task Force and sent to the HP&RR Council for review as needed. The HP&RR Council, a senior-level steering committee co-chaired by flag level officers and comprised of colonel level HQDA proponents/officials, will synchronize these tasks to ensure coordinated improvements to HP&RR related programs across the Army.

(b) Protection Line of Effort. Recommendations identified by the HP&RR Task Force that are related to protection will be developed by the Protection Committee and coordinated through the Protection BOD. The Protection Committee is a Colonel level working group comprised of HQDA proponents/officials that will develop and propose solutions for protection related policies, programs and processes. The Protection BOD is the senior-level steering committee, chaired by flag level officers and comprised of HQDA proponents/officials that, in coordination with DCS, G-3/5/7, will validate requirements and changes to policies, programs and processes for Senior Army Leadership approval.

SUBJECT: Army Campaign Plan for Health Promotion and Risk Reduction (HP&RR FY11)

      (2)   Commanders' Plan. This campaign plan provides direct guidance to commanders to assist in reestablishing good order and discipline in the garrison environment and should prevent some of the challenges described in Chapter 3 of the *Red Book*. This guidance will improve compliance with existing regulatory requirements and traditional processes. Commanders, please direct your attention to paragraph 4.b. and Annex D, *Installation, Garrison, MTF, and Unit Commander Critical Actions/Tasks*.

    c. End State. Improvements in Army HP&RR/protection programs and policies result in enhanced ability to surveil and detect at-risk/high-risk Soldiers in order to intervene effectively to promote health and wellbeing while reducing risk to the Force. At the HQDA level, an enduring HP&RR Council supported by an HP/RR office, and the Army Protection Board of Directors supported by the Army Protection Committee, remain continually vigilant to provide programmatic changes that affect health, risk and protection of the force.

3. **Concept of Operations**:

    a. The HQDA Plan. This campaign plan will be executed in two phases. The first phase began with the initial meeting of the HP&RR Council. The second phase will begin once the HP&RR Task Force functions have been transitioned to the permanent HP&RR Office and all protection functions have been transferred to OPMG.

      (1)   Overview of the Plan:

      (a)   Campaign Production – This effort began with the reorganization of the ASPC and the ASPTF to create the new HP&RR Council and HP&RR Task Force. The HP&RR Task Force analyzed the findings and recommendations from the recently issued DoD/Army strategic reports to develop discrete, actionable tasks. These tasks were binned across the P-DOTMLPF-RR domains and coordinated into the attached Sync Matrix. The campaign commenced with the convening of the first HP&RR Council meeting on 28 October 2010, where the Council validated the Sync Matrix.

      (b)   Phase I (Campaign Implementation) – This phase (depicted in Figure 1 below) initiates the operational portion of the campaign plan with the validation of the Sync Matrix by the HP&RR Council. During this phase, the tasks in the Sync Matrix that were derived from the various reports are reviewed and staffed by the relevant proponents/officials. Tasks related to risk reduction which include protection are coordinated by the Protection Committee, actioned through the Protection BOD, and finally approved by Senior Army Leadership. Likewise, tasks related to HP&RR are coordinated by the HP&RR Task Force, actioned through the HP&RR Council and approved by Senior Army Leadership. The HP&RR Task Force will ensure that

SUBJECT: Army Campaign Plan for Health Promotion and Risk Reduction (HP&RR FY11)

approved tasks are integrated with appropriate proponents/officials and the resource community for integration into strategic Army resource & requirements generation processes. It is important to note that the HP&RR Council, HP&RR Task Force, Protection Committee and Protection BOD are forums for the relevant proponents/ officials to coordinate/integrate changes to policies, programs and processes; these bodies do not possess any independent authority. Membership in these forums frequently overlaps. For example, the same proponent/official (e.g., Office of the Surgeon General) may coordinate health promotion tasks through the HP&RR Task Force/ HP&RR Council and risk reduction/protection (such as force health protection) tasks through the Protection Committee/Protection BOD. This is designed to ensure enterprise coordination and synchronization. The purpose of this phase is to embed these collaborative processes into routine HQDA operations and to ensure tasks on the Sync Matrix are completed and approved.
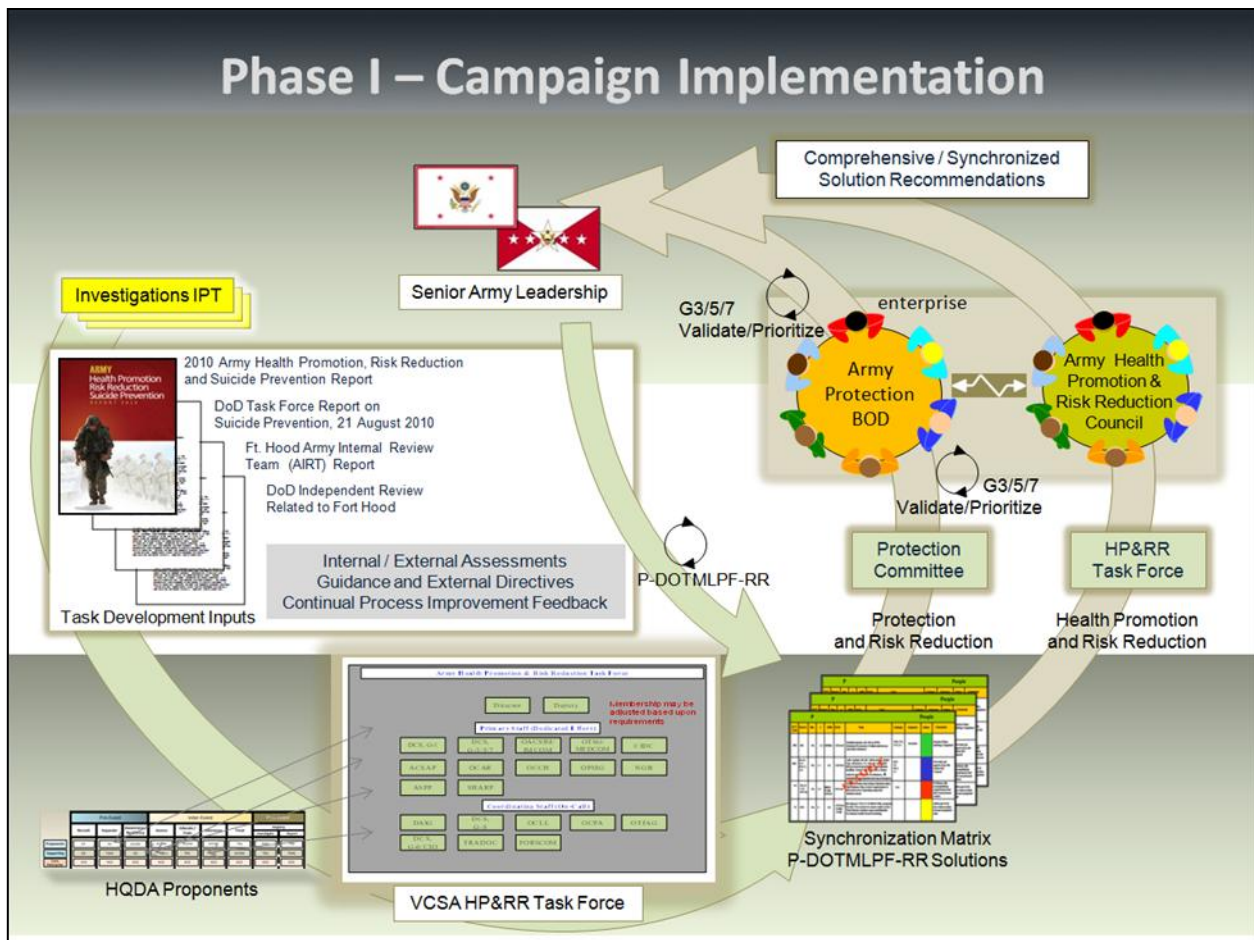

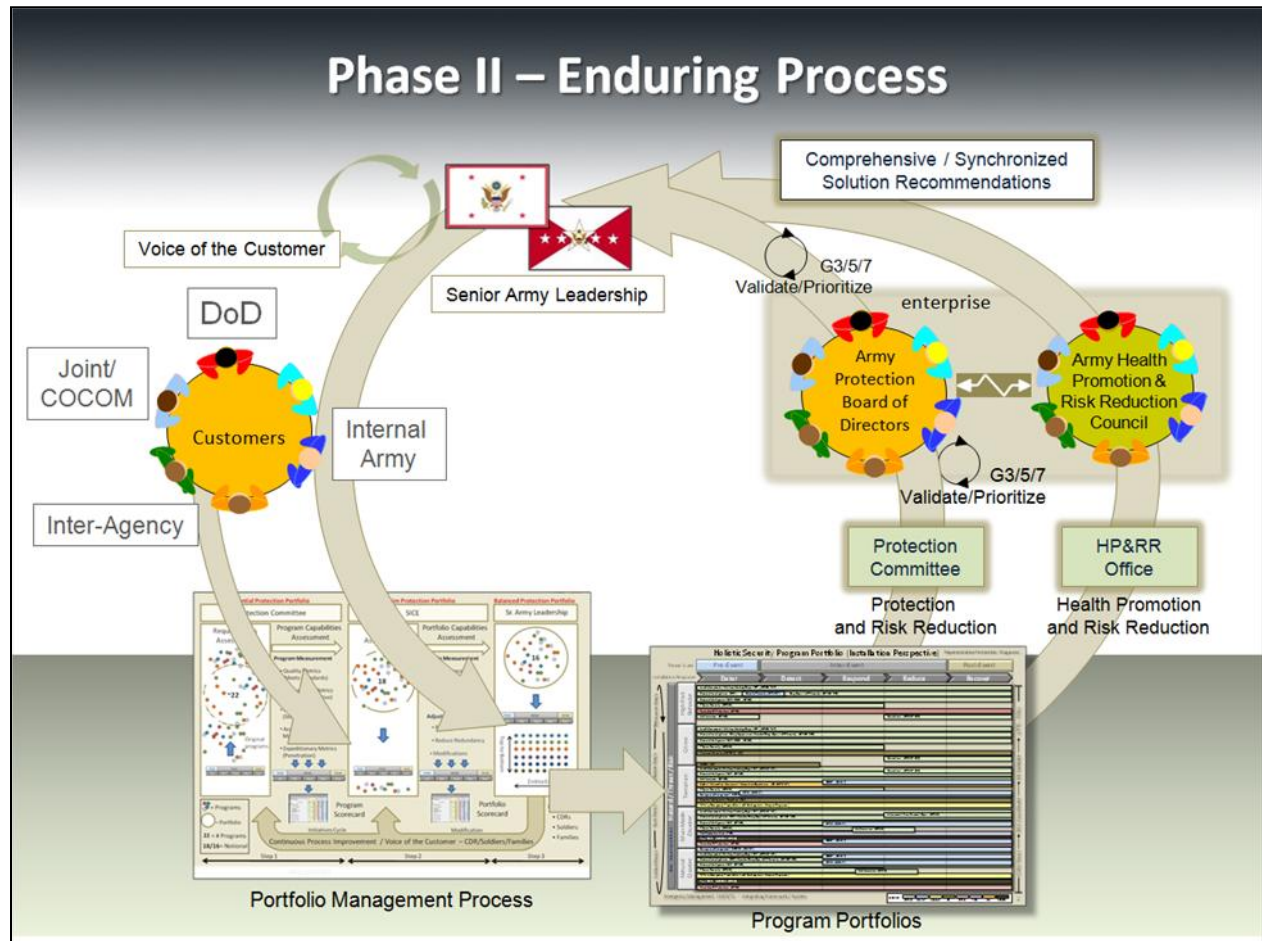Figure 1. HP&RR Campaign Phase I (Campaign Implementation)

Figure 2. HP&RR Campaign Phase II (HQDA Integration)

(c)   Phase II (HQDA Integration) – The HQDA integration phase begins with the activation of a permanent HP&RR office. The HP&RR Task Force will dissolve on order after all functions have been transitioned to the permanent HP&RR office and protection tasks from the Sync Matrix are transferred to OPMG. This phase (depicted in Figure 2 above) institutionalizes the enduring HQDA commitment in support of HP&RR and Protection programs, policy and services.

(2)   Components of the Plan

(a)   Senior Army Leadership. Appoints the co-chairs of the HP&RR Council and retains final approval authority of tasks presented by the HP&RR Council and/or Protection BOD.

(b)   HQDA Proponents/Officials. Provide representatives to the HP&RR Task Force and HP&RR Council as specified in each of the charters. Proponents/officials may designate additional HP&RR TF representatives based on expected workload.

SUBJECT: Army Campaign Plan for Health Promotion and Risk Reduction (HP&RR FY11)

Proponents/officials are also responsible for the preparation, synchronization and execution of the Task Action Plans (TAPs) as discussed in Annex A.

     1.   The HP&RR Task Force. The HP&RR Task Force will support and expedite the transition of the HQDA-level HP&RR functions from the former ASPTF until an enduring ARSTAF HP&RR Office is designated. In addition to the execution of the Sync Matrix, the HP&RR Task Force is responsible for providing operational and administrative support to the HP&RR Task Force Director including: trend analysis, STRATCOM development and briefing materials.

     2.   Composition of the HP&RR Task Force. The HP&RR Task Force will be comprised of both Primary Staff and Coordinating Staff representatives (see Figure 3) who will be responsive to the HP&RR Council and their proponent. Primary Staff will be dedicated full time to the HP&RR Task Force and will be assigned duties by the Director of the HP&RR Task Force. Primary staff will consider the HP&RR Task Force as their primary duty location until the termination of the H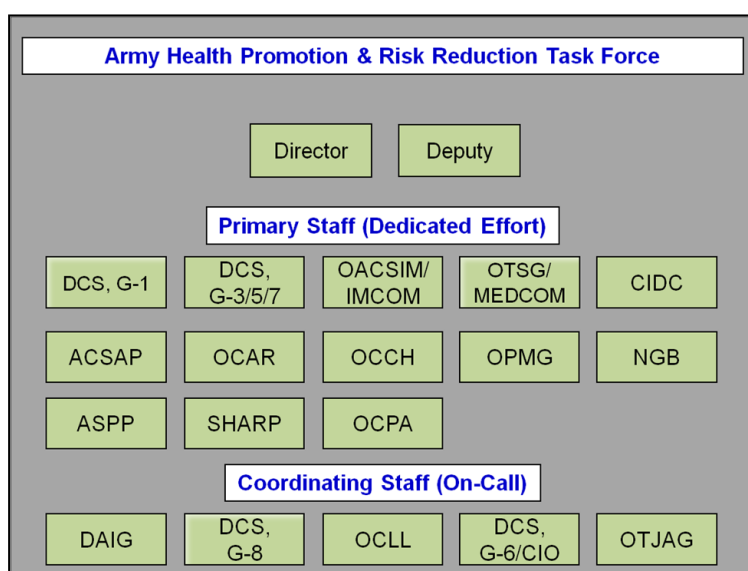P&RR Task Force. They must have unencumbered access to their respective official/principal for immediate decision authority to execute actions. Coordinating staff will be "on-call" with a primary duty to support the HP&RR Task Force Director, but will remain at the location of their proponent.

Figure 3. Army Health Promotion & Risk Reduction Task Force

     (c)   The HP&RR Council. The HP&RR Council is an enduring senior HQDA-level advisory body focused on HP&RR governance, policies, structure, process and programs. This Council will act to rapidly assess, adjust and approve all tasks related to HP&RR.

     1.   The HP&RR Council is a senior working group comprised of representatives from across the Secretariat, ARSTAF and other Army agencies engaged in HP&RR activities. The composition of

the HP&RR Council is illustrated in Figure 4. Council membership may be adjusted to meet requirements as determined by the co-chairs.

2. The HP&RR Council will be co-chaired by two flag level officers, designated by Senior Army Leadership.

3. Members of the HP&RR Council will be nominated by ARSTAF and Secretariat level officials and will be Colonel or civilian equivalent with the authority to speak on behalf of their HQDA principal.
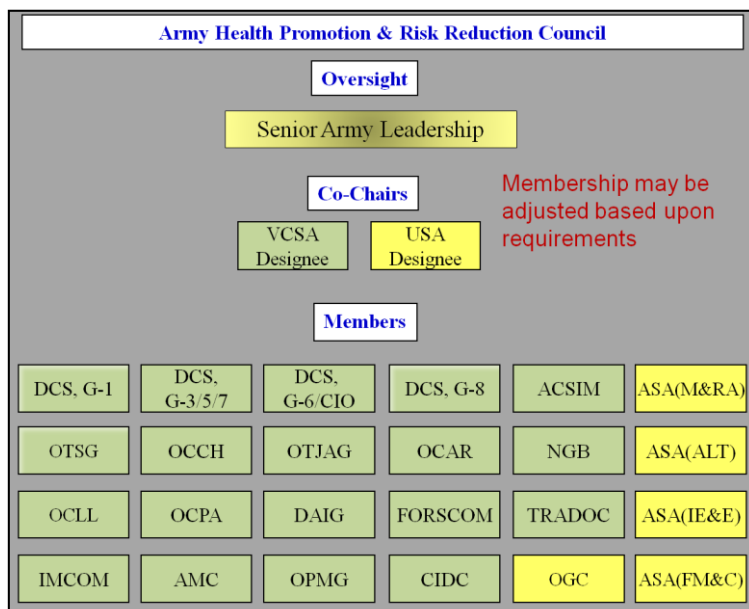

Figure 4. Army Health Promotion & Risk Reduction Council

4. Support to the HP&RR Council. Each of the HP&RR Council members will designate supporting staff member or members who are available to the HP&RR Council and HP&RR Task Force. Some of these members will be considered "primary staff" and will be detailed to the HP&RR Task Force. Other members will be considered "coordinating staff" and will remain within their proponent with primary responsibilities to the HP&RR Task Force and HP&RR Council. Additionally, officials/proponents will direct their prospective staffs to work through their assigned tasks in developing TAPs in support of the HP&RR Council.

(d) The Army Protection Board of Directors (Protection BOD) is an enduring HQDA-level advisory body focused on risk reduction/protection governance, policies, structure, process and programs. This BOD will act to rapidly assess, adjust and approve all tasks related to risk reduction/protection.

1. The Protection BOD (see Figure 5 below) provides a collaborative GO level forum to address issues and concerns related to the Protection Program Portfolio and will be supported by the Protection Committee. The Protection Committee is a Colonel level working group, with G-3/5/7 validation/prioritization, that provides recommendations for task status changes through the Protection BOD for Senior Army Leadership approval.

2. The Protection BOD will be co-chaired by the PMG and a senior representative appointed by the ASA (IE&E).

3.   The Protection BOD works with the Secretariat, ARSTAF, commanders, garrisons, the RC and ASCCs to integrate and synchronize protection solutions across the Army.

(e)   The HP&RR Enduring Office. This is the organization designated by Senior Army Leadership with permanent responsibility for improvements to Army HP&RR programs and services. This office will assume the HP&RR functions of the Task Force during Phase II of this campaign plan.
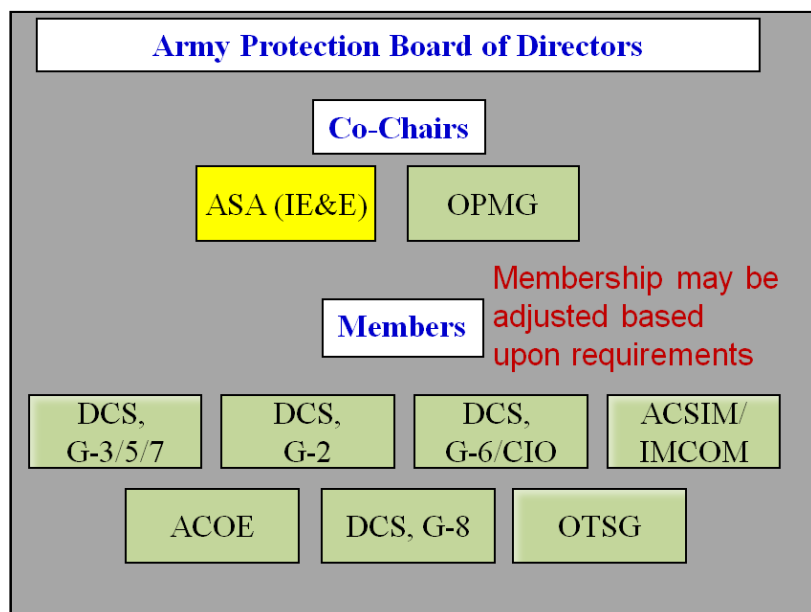
Army Protection Board of Directors

Co-Chairs

ASA (IE&E)   OPMG

Membership may be adjusted based upon requirements

Members

DCS, G-3/5/7   DCS, G-2   DCS, G-6/CIO   ACSIM/IMCOM

ACOE   DCS, G-8   OTSG

Figure 5. Army Protection Board of Directors

(3)   HQDA Council Process

(a)   Orientation Meeting. The orientation meeting on 28 October 2010 initiated Phase I of the campaign. The orientation meeting validated the contents of the Sync Matrix and assigned primary responsibility for tasks.

(b)   Development of Task Action Plans (TAPs). Following the validation of the Sync Matrix, each proponent will develop a TAP for execution of tasks for which they have primary responsibility. TAPs are described in Section 4.a.(3)(c) and Annex A. TAPs are intended to replace the HQDA Form 5 process and accelerate staffing actions.

(c)   Regular Meeting Cycle. Following the initial HP&RR Council orientation meeting, regular HP&RR Council meetings will take place biweekly with Protection Committee/Protection BOD meetings on their designated schedule. These meetings are intended to highlight tasks that are being nominated for inclusion into the Sync Matrix, require HP&RR Council or Senior Leader intervention, or retirement/removal from the Sync Matrix. HP&RR Council meetings will be conducted by a facilitator designated by the Director of the HP&RR Task Force and will include the following:

1.   Roll call of HP&RR Council members present

2.   Review of prior meeting minutes

3. Discussion of prior due-outs to the Co-Chairs

4. Introduction and approval/rejection of new tasks

5. Review and discussion of open tasks and status change requests

(d) Meeting Deliverables. The Director will assign a HP&RR Council recorder as part of the Task Force who is responsible for producing of both Council minutes and an updated Sync Matrix after every HP&RR Council and Protection Committee/APBOD meeting where Sync Matrix tasks are discussed. The minutes will include: a summary of decisions regarding guidance/direction for tasks; approvals for integration of new tasks; retirement of old tasks; and any other pertinent decisions made during the meeting. The HP&RR Task Force will update the Sync Matrix as new tasks are added, task status changes are made, or tasks are retired.

(e) Changes/Additions of Tasks. When a proponent wants to change the status or add a new task, these tasks are brought to the HP&RR Council for vetting by fellow HP&RR Council members and validation by the Co-Chairs. If validated, tasks are then presented to Senior Army Leadership for approval.

(f) Synchronization Matrix (Annex B)

1. Creation of the Sync Matrix. As a critical component of this campaign plan, the HP&RR Task Force translated each of the recommendations from recently issued DoD/Army strategic reports into individual tasks to create a Sync Matrix (see Figure 6 and Annex B). Each recommendation and report finding was converted to an actionable task and outcome. Tasks that are primarily related to health promotion and risk reduction will be managed by the HP&RR Council; tasks that are primarily related to security and protection will be managed by the Protection Committee. Any tasks that remained open as part of the legacy ASPTF Sync Matrix have been incorporated into the new Sync Matrix.

2. Consolidation of Report Recommendations. During the initial development of the Sync Matrix, recommendations from the recently issued series of DoD/Army strategic reports were converted to tasks and outcomes. A number of these tasks overlapped and were consolidated into single tasks that satisfied the recommendations of multiple reports. These tasks are identified under the "Report" column with the appropriate code: AS = the Army Health Promotion, Risk Reduction and Suicide Prevention Report; DS = the DoD Suicide Task Force Report; DH = the DoD Fort Hood Report; and AH = the Army Fort Hood Report.

3. Sync Matrix Structure. The Sync Matrix provides a quick reference and overview of the status of each of task, the anticipated suspense date, linkage to any other task(s) in the matrix, the OPR, any OCR(s), and the specific task and outcome

SUBJECT: Army Campaign Plan for Health Promotion and Risk Reduction (HP&RR FY11)

(see Figure 6). The matrix is primarily divided according to the task outcome and intended impact. Each of the tasks is also binned according to P-DOTMILPF-RR.

4. Composition of the HP&RR Sync Matrix. The primary fields of the Sync Matrix are:

- Task Number (P-DOTMLPF-RR domain + series number)

- Report – Source of the task

- OPR – Office of Primary Responsibility – staff office primarily responsible for preparing and executing the task action plan

- OCR – Office of Coordinating Responsibility – staff office(s) responsible for providing input/support to the OPR as required

- Recommendations/Task/Outcome/Deliverable.

- Suspense date for completion.

- Status – The status of each task is color-coded as shown in Table 1 below:

	Green	Task is on track to achieve deadlines for completion as defined in the task action plan (TAP)
	Amber	Task is in progress but may not meet deadlines for completion as defined in the TAP
	Red	Task is impeded from further progress and will not meet deadlines for completion as defined in the TAP
	Blue	New task to be added to the Sync Matrix
	Black	Task is completed and can be retired from the Sync Matrix

- Linkage – The linkage column lists tasks are related to the subject task and have the potential to affect the status or timeline of other tasks. For example, the first two tasks shown in Figure 6 (below) are linked because they both relate to the same subject (confidentiality of treatment).

Task #	Rpt	OPR	OCR	Recommendations	Task	Outcome	Deliverable	Suspense	Status	Links
Po-045	TF	G-1	ACSAP ARNG IMCOM OCAR OTJAG OTSG	Conduct a pilot to determine the effectiveness of allowing Soldiers to self refer to ASAP education and/or treatment without commander notification.	Conduct a pilot to determine the effectiveness of allowing Soldiers to self refer to ASAP education and/or treatment without commander notification.	Increased willingness of Soldiers to go to ASAP treatment or education.	Decision brief to the VCSA on the future course of action of the Confidential Alcohol Treatment and Education Program (CATEP).	01 Feb 10 01 Apr 10	(red)	ASPTF SM Links: L 5.4.5 AHP&RRC Links: Po-046 Po-066
Po-046	AS	G-1	ACSAP ACSIM ARNG ASA(M&RA) G-2 G-3/5/7 OCAR OPMG OTJAG OTSG	Revise CATEP implementing guidance to specify confidential enrollment eligibility for Soldiers and leaders regardless of duty status or clearance. Ensure revised criteria are inclusive/representative of current Army/DoD policies and statutory criteria. Revise implementing guidance to explain management of individuals in sensitive occupations. Soldiers and leaders who perform duties in PRP programs should not be eligible for CATEP enrollment.	Revise CATEP implementing guidance to specify enrollment eligibility. Soldiers and leaders, regardless of duty status, clearance (e.g. military police, flight status, medical personnel, personnel with TS or above security clearances) etc., will be able to enroll in CATEP with full confidentiality, but require CoC notification for a single incident or if the Soldier does not complete the treatment plan.	(O) All leaders and Soldiers can self-refer into CATEP without notification to CoC; suspended only when critical MOS/duty personnel fail rehabilitation or leave the program.	Revised CATEP implementing guidance to allow all personnel who self-refer to be treated with confidentiality. Critical MOS/duty status personnel will remain under confidential treatment unless they fail rehabilitation / treatment.	13 Sep 10	(green)	Po-045 Po-066
Po-047	AS	OTJAG	ACSIM G-1 G-6 OPMG	[HQDA] Develop and field a central database (compatible with law enforcement databases) for AR 15-6 investigations of disciplinary infractions in support of the recommendation above. (page 50)	Develop and synchronize policy and protocols which designate responsibilities for management, maintenance, data input and retrieval of soldier information in AR 15-6 investigations of disciplinary infractions. Ensure the system and corresponding policy for use is in compliance with all privacy act requirements.	Leaders are provided with a complete picture of a Soldier's high risk behavior before adjudicating.	Revised AR 15-6.	31 Oct 10	(yellow)	Po-032 Po-033 Po-048 O-017 M-004
Po-048	AS	OPMG	ACSIM AMC G-1 G-6	[HQDA] Consolidate criminal and misconduct databases into a single portal providing automatic	Develop and synchronize policy and protocols which designate responsibilities for management,	Leaders are provided with a complete	Revised ARs 600-20, 190-45, 195-2, 15-6, and 600-85.		(green)	Po-032 Po-048 Po-068

Figure 6. Example Synchronization Matrix

5.   Alignment of the Sync Matrix across P-DOTMLPF-RR. Each task on the Sync Matrix will primarily align along a P-DOTMLPF-RR functional area. Each area is described below.

- Policy. Several of the recommendations from all the reviewed reports recognize gaps in policy that need to be addressed in order to improve health promotion or risk reduction/protection. These recommendations will become policy tasks that will change the way policy is executed across the Army.

- Doctrine. Several of the tasks recognize that there is a need to change the way policies are being promulgated and executed rather than changing the policy itself. Doctrine will therefore be addressed through promulgation of implementation guidance that clarifies the intent of policy in order to change doctrine associated with the policy.

- Organization. In order for the Army to successfully implement some of the recommendations, some of the Sync Matrix tasks will deal directly with structural re-organization of programs, personnel and services. This change in organization will help better align program and services to affect improvement of health promotion and risk reduction/protection.

- Training. The Army recognizes that institutional and doctrinal change comes through training at all levels. Several tasks direct the development or

improvement of training activities in order to incorporate recommendations from the various reports and to inform leaders at all levels.

- Materiel. Improved health promotion and risk reduction/protection depend on materiel solutions that provide better visibility through better integration of data, programs and services.

- Leaders. Leader development, education and involvement is essential when recognizing high risk behavior and increasing security of our force. The Council will address leadership issues to improve the targeted delivery of programs and services to those who are in need.

- Personnel. Creating change to health promotion and risk reduction/protection depends upon ensuring that there are sufficient personnel staffed to support programs and services. This means right-sizing programs and services to ensure that personnel are appropriately utilized under the current end-strength constraints.

- Facilities. Facility solutions are focused on providing sufficient physical infrastructure to ensure delivery of services to our Soldiers, Families and DA civilians in a timely and efficient manner.

- Resources. Correctly resourcing programs and services ensures that Soldiers, Families and DA civilians have access to effective programs across the enterprise and that there are enough personnel resources (including contractors) to execute the mission in support of health promotion and risk reduction/protection.

- Research. Consists of primary (basic science), applied (translational), clinical and epidemiological study, as well as surveys and program evaluation, whether conducted by internal or external sources.

(g) Task Action Plans

1. The TAP is the mechanism for monitoring task implementation. The TAP provides a documented, clear path to task completion by specifying specific subtasks with suspense dates, identifying constraints and required follow-up actions. Information needed to understand and execute the task will be incorporated as part of the TAP. Figure 7 below is an example of a TAP generated by the HP&RR Task Force.

2. All proponents will develop a TAP for each task in the Sync Matrix assigned to their organization. The TAP is built from controlled data contained in the Sync Matrix and includes additional data provided by the OPR to report and document progress. Annex A details the preparation and execution of TAPs.

SUBJECT: Army Campaign Plan for Health Promotion and Risk Reduction (HP&RR FY11)

HP&RR TOPIC	TASK	OPR	OCR(s)			SUSPENSE	STATUS	LINKAGES
Expand CATEP Enrollment Options	Po-046	G-1	ACSIM ARNG ASA M&RA	G-2 G-3/5/7 OCPA	OPMG OTJAG OTSG	13 Sep 10		Po-045 Po-066

RECOMMENDATION: Current CATEP implementing guidance does not specifically address confidentiality for sensitive/critical duty personnel. An ACSIM program assessment at Fort Richardson found an existing CATEP policy that precludes critical MOS/duty status personnel (flight status, PRP, Medical, Law Enforcement, TS clearance, etc.) are ineligible for confidential treatment under CATEP enrollment criteria. Although they may receive initial counseling under confidentiality, their CoC must be notified prior to enrollment. The issue, especially for those in sensitive duty positions, is that either a Soldier with a problem does not receive treatment due to lack of confidentiality or a soldier with a problem receives treatment that is confidential; the latter is preferable.

TASK: Revise CATEP implementing guidance to specify enrollment eligibility. Soldiers/leaders regardless of duty status, clearance (TS or above), occupation (e.g. military police, flight status, medical personnel) can enroll in CATEP with full confidentiality, but require CoC notification for a single incident or if the Soldier does not complete the treatment plan. Soldiers/Leaders with duties in PRP programs will not be eligible for CATEP. Ensure revised criteria are inclusive /representative of current Army/DoD policies and statutory criteria. in sensitive occupations.

OUTCOME: All leaders and Soldiers can self-refer into CATEP without notification to CoC; suspended only when critical MOS/duty personnel fail rehabilitation or leave the program

TASK UPDATE			PROPOSED STATUS
SUB-TASK OPRS	**SUSPENSE**	**ITEMS OF INTEREST**	
G-1, ACSIM, HP&RR TF	16 Sep 10	Revised language for the proposed change to the CATEP implementing guidance to ensure full confidential coverage for all personnel under the CATEP staffed and distributed on 10 Sep 10.	
OTJAG		Provide legal review of proposed change to allow personnel in sensitive duty positions (flight status, PRP, Medical, Law Enforcement, TS clearance, etc.), to participate in CATEP without commander notification. Coordinate as appropriate with OGC.	

DELIVERABLE: Revised CATEP implementing guidance to allow all personnel who self-refer be treated with confidentiality. Critical MOS/duty status personnel will remain under confidential treatment unless they fail rehabilitation / treatment. Provide, specific and discrete thresholds for review for command

STRATCOM: ALARACT / Army Portal	**METRICS:** Compare pre-/post- policy change CATEP enrollment by MOS

CONSTRAINTS / RESOURCING: Critical MOS/duty status personnel must have no incidences of relapse (during treatment) and successfully complete the CATEP treatment plan to preserve confidentiality. CATEP is currently resourced at only six installations, which places the burden on CATEP counselors to follow-up treatment for those personnel who may relocate to a non-CATEP installation. DoD policies and statutory requirements may constrain proposed changes.

FOLLOW UP: Complete policy revision of AR 600-85 and audit existing gap for critical MOS/duty status personnel who have no mechanism to ensure stationing stability at a CATEP location; CATEP must conduct follow-up for critical MOS/duty status personnel to ensure successful completion of the program.

AHP&RRC Task Action Plan   Task #Po-046 -- Slide 1 of 2

Figure 7. Example HP&RR Task Action Plan (TAP)

b. **VCSA Message to Installation, Garrison, MTF, and Unit Commanders**

(1)   *Commanders, in the April 2009 ACPHP I asked you to effect change to maximize the effects of HP/RR/SP related programs; optimize existing policy, programs and processes; and set conditions for implementing new programmatic solutions. I appreciate your response in making the necessary changes to enhance HP/RR/SP programs and improve implementation.*

(2)   *I am asking for your help again. The new guidance provided in Annex D of this Campaign Plan is directed towards installation, garrison, medical treatment facility (MTF), and unit commanders at every level. It represents our findings from the ACPHP, publication of the Red Book, analysis of data and feedback from the field. This annex will assist you in educating our young leaders to improve compliance with existing policies/guidance intended to promote health and reduce risk in the Force.*

(3)   *Annex D prescribes actions that ensure/enhance Soldier accountability, Soldier and Family care and readiness of the Force. These mandates can only be accomplished by you, through your compassionate, dedicated mentorship of our young leaders. I firmly believe, if implemented across the Force, we will sharpen our focus on*

command surveillance, detection and intervention; activities that are critical in identifying stress in the Force and linking our Soldiers and Families to our Health Promotion and Risk Reduction Programs. In essence, Annex D will ensure that our young leaders know both their Soldiers and Families and are educated on the processes/resources available to them.

(4)   *Make no mistake – you implement policies and programs that first promote health but also ensure Soldier accountability and good order and discipline. This means we must provide, and you must consider, all pertinent information when holding Soldiers accountable and you must balance rehabilitation with appropriate consequences of their actions*.

(5)   *Many of you have read the Red Book and understand the shift that we must make to improve leadership in the garrison environment. If you have not read it yet, I commend it to your attention and ask that we teach its precepts down to the company level. We now recognize that while deployed, risk is associated with activities on duty but while home, risk is associated with activities off duty. The protocols at Annex D codify the Red Book's message and your candid response to the questions will assist you in focusing your efforts to promote health and reduce risk across the Force. Ensure every leader reads, understands and implements this guidance*.

4. **Shaping Operations**. The strategy for communicating HP&RR FY11 is focused on informing, educating and persuading three critical major audiences; Soldiers and their Families, critical policy and resource decision makers (Congress) and key media providers (who will shape public perception). Our purpose is to be effective, persuasive, compelling and consistent in communicating the circumstance and the content of the plan to our key audiences and stakeholders. Our communication priorities in order of importance are: 1) inform and educate Soldiers and Families as to what has happened and action that is being taken; and 2) as appropriate, provide factual, transparent information to key media to make sure the American public understands that the Army takes the mission of health promotion and risk reduction seriously and solutions are actively being incorporated into policy, procedures and training.

a. Execution. We will accomplish this strategy with an active Congressional Engagement Plan, Command Information Plan and Media/Public Engagement Strategy. See Annex C.

SUBJECT: Army Campaign Plan for Health Promotion and Risk Reduction (HP&RR FY11)

    b. End State. Our desired end-state is a common understanding and appreciation that the Army is taking an active and effective approach to health promotion and risk reduction.

ACKNOWLEDGE:

PETER W. CHIARELLI
General, U.S. Army
Vice Chief of Staff

Annexes:
Annex A – Preparation and Execution of Task Action Plans (TAPs)
Annex B – Synchronization Matrix
Annex C – Strategic Communications Plan
Annex D – Installation, Garrison, MTF, and Unit Commander Critical Actions/Tasks

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

SUBJECT: Army Campaign Plan for Health Promotion and Risk Reduction (HP&RR FY11)

DISTRIBUTION: (CONT)
Superintendent, U.S. Military Academy
Director, U.S. Army Acquisition Support Center
U.S. Army Accessions Command

Installation, Garrison, MTF, and Unit Commander Critical Actions/Tasks

Annex D Table of Contents

1. Recognizing and Planning for Transitions

   - Are commanders educating leaders/front line supervisors on the relationship between transitions (e.g., deployments, PCS, disciplinary actions, marriage, child birth, etc.) and associated stress?

   - Are commanders incorporating unit, Soldier and Family transitions into their planning, operations and administrative battle rhythm? Is this guidance routinely delegated down the chain of command to squad/section/team leaders?

   a. Unit Integration/Reintegration

   - Do garrison-level integration and reintegration programs for Soldiers and Families exist that mitigate the impacts of stress during critical periods of transition? Do these programs interface/synchronize with unit-level integration and reintegration programs?

   - Are leaders conducting initial counseling during integration/reintegration to increase Soldier awareness of unit and community policies, programs and services? This is particularly important but often overlooked during reintegration as an important measure to reset Soldiers in the garrison environment (it may be helpful to view reintegration as "initial integration" to the unit/community).

   - Do commanders have active unit integration programs that ensure immediate accountability for incoming Soldiers, assign sponsors and provide necessary support for stabilization?

   - Do integration programs focus on specific Soldier categories including leaders, career Soldiers, first-term Soldiers and single Soldiers?

   - Do integration programs focus on professional development (promotion status, training records, education, etc.), Soldier readiness (family care plans, MEDPROS, SGLI, etc.) and quality of life (housing, commute, family assistance, etc.)?

   - Are integration programs aligned with barracks utilization plans that promote unit/team cohesion and enable chain of command supervision?

   - Are leaders (battalion and below) inspecting implementation of integration programs?

   - Do units develop reintegration programs in coordination with their rear detachment that focus on activities appropriate for the first 90 days and 90-180 days to ensure continuous surveillance, detection and intervention?

- Do reintegration programs recognize the effects of leader turnover (e.g., changes of command, PCS, PME, TDY, and internal moves) and include appropriate plans to ensure continuity and seamless transition?

- Do reintegration programs leverage integration program protocols to focus on Soldier professional development, readiness and quality of life? For example, reintegrating Soldiers may need to attend PME, transfer to another unit/platoon/squad, locate new housing, or purchase/repair transportation.

- Are commanders identifying returning Soldiers who may be at risk based on behavior/stress indicators and directing them to appropriate services (ensure confidentiality when identifying Soldiers to avoid stigma that may dampen intervention measures or help-seeking behavior)?

- Do reintegration programs emphasize appropriate community program referrals to mitigate deployment related stress/re-socialization including behavioral health/medical conditions, family reintegration, heightened adrenaline (compensation via motorcycle, sport cars, etc.), grief/guilt, team separation/transitions, alcohol binge drinking/tobacco cessation, financial counseling (bonus/combat pay), etc.?

- Do reintegration programs provide requisite transition support for demobilizing Reserve Component/WIAS Soldiers? Ensure a tactical pause to complete reverse SRP, medical screening/treatment, employment legal support…all requisite reintegration programs associated with active duty Service Members as emphasized above.

b. Sponsorship

- Do commanders enforce the mandatory sponsorship requirements in AR 600-8-8, especially those for first-term Soldiers and Family members?

- Do commanders ensure that a trained sponsorship pool exists at the unit or installation level to respond to programmed and un-programmed arrivals?

- Are commanders tracking their sponsorship programs based on their 90 day gains roster as part of their command and staff meetings?

- Are sponsors provided the requisite time, leader emphasis and resources to ensure that unit sponsorship is their primary duty?

- Do commanders ensure that rear detachment sponsorship is provided to Family members during the deployment of the Soldier or civilian employee sponsor?

c. Transition Accountability

- Do commanders maintain accountability of Soldiers while absent from the unit for PME, TDY, WIAS, emergency leave, etc.?

- Are leaders appropriately documenting/verifying all contact information on Soldier leave/pass requests and ensuring appropriate risk assessment/travel preparation?

- Are leaders conducting daily accountability formations to ensure appropriate unit/Soldier status?

d. Deployment Transition Planning (This is not intended as a deployment checklist but emphasizes some programs and measures associated with promoting health and reducing risk identified during the Army Campaign that need additional leader emphasis.)

- Are commanders in coordination with HRC effectively managing transitions of deploying key leaders by slating leadership into deploying units at least 90 days prior to deployment?

- Are commanders in coordination with HRC effectively managing transitions of leaders by retaining them at least 90 days after redeployment?

- Are commanders effectively managing transitions of mobilized Reserve Component, IRR and WIAS Soldiers to actively integrate into the unit and reintegrate back to home station/unit?

- Have Rear Detachment leaders been selected and appropriately task organized to optimize rear detachment cohesion and effectiveness?

- Have Rear Detachment leaders been selected and integrated 90 days prior to deployment and retained 90 days following redeployment (to the extent possible)?

- Are systems in place to transfer responsibility for and ensure continuity of pending disciplinary/administrative actions between deploying and rear detachment commanders?

- Is the Family Readiness Groups (FRG) active and organized to provide optimal support to the Families of Soldiers (in coordination with the Family Readiness Support Assistant [as available], Family Assistance Centers and rear detachment leaders)?

- Are commanders effectively managing transitions of mobilized Reserve Component, IRR and WIAS Soldiers to integrate Families into the unit FRG/plan?

- Does the FRG plan support Families departing the community, geographically isolated Families and Families of single Soldiers?

- Are leaders comprehensively screening Soldiers to ensure deployment readiness? Leaders should not place an over-reliance on SRP readiness but holistically view readiness across composite life cycle events (Soldier and Family transitions/stress such as compassionate reassignment/ill Family member, BH program enrollment, ongoing disciplinary/administrative actions, spouse pregnancy, other risk indicators).

- Are commanders collaborating with medical and behavioral health providers in determining the impact of medical conditions (BH, mTBI, PTSD), the effects of treatment (e.g., medication side effects and multiple medication interactions) and continuity of care on Soldier deployability/employability?

2. Leader-Subordinate Interaction

   a. Surveillance

- Are leaders identifying Soldiers who may be at risk based on behavior/stress indicators and directing them to appropriate services (ensure confidentiality when identifying Soldiers to avoid stigma that may dampen intervention measures or help-seeking behavior)?

- Are leaders employing all available active and passive surveillance measures to detect Soldiers engaging in high risk behavior (urinalysis screening, unit surveys, unit commander's financial report, blotter reports, etc.)?

- Do commanders ensure that leaders to the squad/section/team level know their Soldiers (e.g., family circumstances, living arrangements, interests, financial situation, education, career goals)?

- IAW AR 600-20, do commanders conduct climate surveys within 90 days of assuming command and at least annually thereafter to increase leader awareness of potential unit and individual stress/risk factors?

- Do commanders at the brigade level and higher ensure that the Unit Risk Inventory (URI) is administered to all Soldiers at least 90 days before an operational deployment and returned to ASAP NLT 30 days prior?

- Do commanders ensure that the Reintegration Unit Risk Inventory (R–URI) is administered to all Soldiers between 90 and 180 days after returning from an operational deployment?

- Do senior commanders encourage subordinate commanders (battalion and below) to administer the URI after changes of command to identify trends in high risk behaviors?

- Are commanders conducting 100% urinalysis of all Soldiers assigned rather than 100% of their unit end strength?

- Are leaders at squad/section/team inspecting POVs/motorcycles for appropriate licensing, vehicle operating condition, training and safety/emergency equipment?

- Are commanders designating leader/team oversight for Soldiers under investigation or pending disciplinary/administrative actions?

b. Counseling

- Do commanders ensure that first-line supervisors conduct initial counseling with all Soldiers within the first 30 days of arrival to the unit/assumption of a new duty position?

- Do first-line supervisors provide junior enlisted Soldiers with monthly performance counseling? Are the counseling sessions formally documented on DA Forms 4856?

- Are NCOs and company-grade Officers receiving formal performance counseling within 30 days of the beginning of the rating period and at least quarterly thereafter from raters?

- Are leaders using informal/formal developmental counseling techniques (e.g., crisis/referral counseling) to help Soldiers manage composite life cycle events as appropriate?

- Do leaders monitor the unit/organization counseling program to ensure Soldiers are receiving effective, documented and timely counseling?

- Are leaders counseling officers and NCOs on personal finances, including military programs and benefits (e.g., no pay due, TSP, educational benefits, survivor benefits, etc.)?

c. HP&RR Training

- Do commanders ensure all Soldiers receive required training on HP/RR/SP topics IAW AR 350-1, including:

  – Substance Abuse (in-processing, annually and redeployment)?

  – Suicide Prevention (annually, predeployment and redeployment)?

  – Resilience (predeployment and redeployment)?

  – Sexual Assault Prevention and Response (annually, predeployment and redeployment)?

  – Prevention of Sexual Harassment (semi-annually)?

  – Traffic Safety (in-processing)?

- Do commanders at all levels educate their Soldiers using a standardized program of instruction on the consequences of a domestic violence conviction (*Lautenberg Amendment*) as stated in AR 600-20?

- Do commanders ensure all newly assigned Soldiers are briefed on ASAP policies and services within 30 days of arrival to the unit?

d. Good Order and Discipline

- Do commanders emphasize Soldier good order and discipline in the barracks/garrison by periodically conducting unannounced urinalysis tests; military working dog (MWD) sweeps; health, welfare and morale inspections; recognition ceremonies; safety briefings and accountability formations?

- Do commanders have plans/procedures in place for unit charge of quarters for detecting, intervening and reporting high risk indicators/incidents?

- Do commanders ensure that all Soldiers are treated with dignity and respect if they are experiencing challenges or have been identified with stress/risk indicators?

- Do commanders and behavioral health providers formally collaborate and share information concerning Soldiers at-risk of violence when confiscating/re-issuing weapons?

- Do commanders ensure that Soldiers living in the barracks register their privately owned weapons with the PMO and store their privately owned weapons in the unit arms room?

- Do commanders ensure that Soldiers residing on the installation register their privately owned weapons with the PMO and store them IAW AR 190-11 and local installation policy?

- When notified that a Soldier has a qualifying domestic violence conviction (as defined in AR 600-20) under the *Lautenberg Amendment,* does the commander take immediate action as required by Federal Law?

- Do commanders at all levels appropriately address inappropriate behavior/substandard performance using counseling, extra training, and, if appropriate, flags, bars from reenlistment and other adverse personnel actions?

- Are company commanders reviewing monthly Unit Commander's Finance Reports (UCFR) in order to identify and assist Soldiers with financial issues?

- Do commanders facilitate Soldier attendance/participation at medical appointments? Do commanders take appropriate action when a Soldier misses medical appointments?

e. Accountability

- Do commanders ensure Personnel Asset Inventories (PAI) are conducted at changes of command, before units change duty locations and whenever deemed necessary?

- Are commanders ensuring that Soldier's personal/government property is inventoried and appropriately stored when the Soldier is determined to be AWOL?

f. Administrative Separations

- Do commanders initiate administrative separation of all Soldiers who are involved in two serious incidents of alcohol-related misconduct within 12 months?

- Does the separation authority process the administrative separation of Soldiers who have tested positive for illicit drugs a second time during their career?

- Does the separation authority process the administrative separation of Soldiers who are convicted of driving while intoxicated/driving under the influence a second time during their career?

- Do commanders at all levels initiate administrative separation of Soldiers as appropriate, based upon a pattern of criminal behavior (e.g., multiple felonies)?

3. Reporting of High-Risk Behavior and Referral to Programs/Services

a. Command Reporting

- Do commanders immediately report all drug related offenses (e.g., illegal possession, use, sale, or trafficking in drugs) to installation law enforcement for investigation?

- Do commanders report all positive urinalysis results to installation law enforcement within 72 hours of notification by the ADCO?

- Do commanders report suspected illicit pharmaceutical drug use to installation law enforcement?

- Do commanders immediately report all incidents of sexual assault to CID?

- Do battalion commanders complete DA Forms 4833 (*Commander's Report of Disciplinary and Administrative Action*) with supporting documentation (e.g., copies of Article 15s, court martial orders, reprimands) for all CID investigations and return the completed report within the required 45 days?

- Do company, troop, and battery level commanders complete DA Forms 4833 with supporting documentation (e.g., copies of Article 15s, court martial orders, reprimands) in all cases investigated by military police (MP) investigations, civilian detectives employed by the DA, and the PM/DES and return the completed report within the required 45 days?

- Have commanders submitted all delinquent DA Forms 4833 to the appropriate law enforcement office? Do senior commanders ensure all DA Forms 4833 are returned within the required timeframe?

- Do unit commanders report AWOL Soldiers to the installation personnel office, Provost Marshal Office and the military pay office within 48 hours of the AWOL determination?

- Do commanders change the status of Soldiers to "dropped from rolls" (DFR) after a Soldier has been AWOL for 30 days and submit the DFR separation packet within 30 days of the DFR date?

- Do commanders report suspected spouse and child abuse to installation law enforcement and to the Family Advocacy Program (FAP) point of contact?

b. Program Referrals

- Do leaders evaluate and manage individual Soldier readiness across composite life cycle events by referring Soldiers to appropriate programs and services?

- Do leaders ensure Families are aware of available HP/RR/SP programs and services?

- When commanders recognize indicators of high risk behavior:

   – Do they refer Soldiers to appropriate program/service providers (e.g., ACS for financial issues, Social Work Services for Family issues)?

   – Do they facilitate Soldier attendance/participation at these programs?

   – Do they take appropriate action when a Soldier does not participate in a command referred program?

- When a commander identifies a Soldier as a potential substance abuser, is the Soldier referred to ASAP for evaluation within 5 working days using DA Form 8003, *ASAP Enrollment*?

- Do commanders ensure that Soldiers who have demonstrated non-fatal suicide behaviors (attempts, ideations, self-harm, etc.) receive appropriate medical intervention (e.g., emergency medical services or behavioral health)?

- Following incidents of blast/concussive/overpressure exposure, are Soldiers at risk for mTBI evaluated, treated and tracked as close to the time of injury as possible IAW the Army Campaign Plan for Warrior mTBI?

- Are commanders informing Soldiers and Families of the availability of non-MTF behavioral health programs (e.g., TRIAP, TRICARE Tele-BH, Military OneSource) and encouraging participation as appropriate?

c. Information Sharing

- Are commanders communicating/benching HP & RR policies and processes with other commanders to identify and implement best business practices?

- During a pending investigation of a suspected suicide or equivocal death, do commanders ensure their official interactions with the next of kin (NOK) are coordinated with law enforcement and the casualty assistance officer?

- Do commanders and service providers understand that when safety, readiness, or welfare may be adversely impacted by a medical condition or treatment, Soldiers' f protected health information (PHI) can be accessed, without Soldier consent, pursuant to HIPAA and the Privacy Act?

- Have installation commanders established a forum for commanders to share lessons learned from fatal and non-fatal suicidal behavior and successful interventions?

- Do installation/garrison commanders have a mutual support plan requiring the PM to provide extracts from DA Forms 3997, *Military Police Desk Blotter*, on all incidents involving alcohol and/or drugs on a daily basis to the ADCO?

- Are commanders coordinating with health care providers regarding medical profiles to ensure appropriate compliance, rehabilitation and reintegration (e.g., medical, behavioral health, substance abuse, family advocacy counseling)?

4. Providing Community/Installation Support

a. Installation Law Enforcement (Provost Marshal/Director of Emergency Services / Criminal Investigation Division)

- Does installation law enforcement provide DA Forms 4833 to unit commanders in a timely manner?

- Does installation law enforcement have a formalized system in place to follow up on delinquent DA Forms 4833 from unit commanders?

- Does installation law enforcement provide data to the installation commander regarding unit compliance on the timely return of completed DA Forms 4833?

- Does installation law enforcement provide periodic analysis of information reported on DA Form 4833 (such as trends in offenses and types/levels of adjudication) to the installation commander?

- Do DES and CID routinely coordinate to appropriately staff and resource Drug Suppression Teams (DST) in support of installation drug surveillance, detection and intervention?

- Are Military Working Dog (MWD) teams readily available to support command health and welfare inspections?

- Does installation law enforcement ensure use of appropriate offense/information codes in ACI2 and COPS?

  – Do law enforcement officials correctly classify Family member abuse, alcohol/drug involvement, and other offenses by assigning the appropriate code in their data systems (COPS, ACI2)?

  – Are criminal investigators using appropriate codes when modifying criminal offenses to ensure accurate data entry/query (type-overs will not modify the offense code)?

  – Are military police appropriately referring offenses in COPS, cell 6 "MP action referred to" (ensure referrals are complete to preserve case status and case data)?

- Does the installation DES/PM share information from non-blotter service calls/encounters with other installation stakeholders to ensure situation awareness among community programs? Use of the MP Journal may mask important incidents/trends from other program providers (e.g., CID, FAP, ASAP, ACS, etc.).

- Does law enforcement provide information to Defense Incident Based Reporting System (DIBRS) for input into National Incident Based Reporting System (NIBRS) as required by the Uniform Federal Crime Act?

- Does installation law enforcement routinely work policy, programs and processes with other Services (i.e., DoD base clustering, Joint Basing)?

- Does installation law enforcement have formal memoranda of understanding (MOU) with its civilian counterparts in compliance with AR 190-45 regarding information flow, jurisdiction and investigations of criminal activity?

- Has installation law enforcement established formal forums with local professional civilian counterparts to share emerging threats/risks and law enforcement trends within the surrounding community (e.g., synthetic drug use)?

- Do installation commanders conduct disciplinary control review boards to determine which off-post activities should be placed off limits? Are civilian law enforcement and other local agencies represented as stakeholders on the disciplinary control review board?

b. Army Substance Abuse Program (ASAP) Outreach, Education and Surveillance

- Do Alcohol and Drug Coordination Officers (ADCOs) notify commanders of Soldiers with positive urinalysis results immediately upon verification?

- Do installation/garrison ADCOs monitor and evaluate the ASAP evaluation completion rate? Do the ADCOs provide quarterly reports to the installation commander, battalion commanders and ASAP?

- Do ASAP Coordinators match data collected on high-risk behavior incidents (quarterly risk reduction program report) with data available on the associated response (e.g., DA Forms 4833, 8003) to determine compliance with command referral requirements?

- Do ASAP Coordinators proactively coordinate with unit commanders to schedule Unit Risk Inventories (URI) based on deployment timelines?

c. Community Health Promotion Council (CHPC)

- Does the installation have an active CHPC, appropriately represented by all community stakeholders, that monitors HP/RR/SP policy, structure, process and program execution?

- Does the CHPC collect and analyze feedback from program customers to validate requirements for existing programs and identify/generate new requirements? Are mechanisms in place to report best business practices to HQDA?

- Does the CHPC identify, synchronize and coordinate installation and community support to enhance access to HP/RR/SP services?

- Does the CHPC maintain an inventory of resources available via local community services (e.g., VSO, American Red Cross, universities) to supplement existing HP/RR/SP services?

- Does the CHPC utilize the Army Campaign Plan Health Promotion (ACPHP) checklist (DA Pam 600-24) to ensure compliance with the ACPHP strategy?

d. Installation Emergency Management (IEM)

- Does the installation have a family assistance emergency plan with procedures and protocols for mass casualty and crisis response situations?

- Are installation emergency management programs and plans synchronized and rehearsed to prevent gaps and duplication of effort among agencies?

5. Healthcare Wellness and Risk Reduction

- Have the recommendations of the *Pain Management Task Force Report (May 2010)* been implemented, as appropriate? The following tasks are highlights from the report:

    - Have programs been implemented to manage (e.g., sole provider and limited duration prescriptions) patients identified with substance abuse history or who are receiving chronic pain management?

    - Have complementary and integrative pain treatment approaches been adopted in primary care clinics? Are these options routinely communicated to patients?

    - Are providers allowed to conduct osteopathic manipulation in order to minimize the use of narcotic pain medication?

    - Has the Veteran's Health Administration (VHA) Stepped Care Model been adopted to reduce pain and suffering while improving quality of life for Soldiers and Families?

- Are all redeploying Soldiers (including Reserve Component) being administered the Post Deployment Health Reassessment (PDHRA) no later than 90-180 days after redeployment?

- Are appropriate clinical practice guidelines being used for treating patients with TBI or PTS(D) co morbid conditions (e.g. depression, substance abuse, adjustment disorder, anxiety, etc.)?

- Are medical personnel sharing a Soldier's relevant protected health information (PHI) with the unit commander when safety, readiness or welfare may be adversely impacted by a medical condition or treatment?

- Do MTF commanders have a quality assurance and peer review policy by which "at risk medication" prescriptions are tracked when more than two psychiatric/psychotropic medications are prescribed?

- Do MTF commanders have a system to ensure that DODSERs are submitted by a credentialed BH clinician for all suicide completions/fatalities within 60 days of the date the event was determined by AFME to be a suicide?

- Do MTF commanders have a system to ensure that DODSERs are submitted by a credentialed BH clinician for all suicide behaviors that resulted in hospitalization or theater evacuation within 30 days of the date of hospitalization or evacuation?

- Are MTF commanders providing missed appointment reports to unit commanders in accordance with MEDCOM policies?

- Do MTFs conduct a "warm handoff" of patients who are in/out processing and require ongoing medical/behavioral health care?

- Are PROFIS personnel staying with their unit during "reintegration" periods IAW MEDCOM policy?

- Are unit medical personnel centrally managed in garrison to optimize installation/community medical capabilities?

- Are tele-behavioral capabilities being used to increase access or surge capability for behavioral health during unit deployment cycles and other critical windows (e.g., post deployment screening)?

- Are non-MTF behavioral health programs readily available/offered to Soldiers and Families (e.g., TRIAP, TRICARE Tele-BH, Military OneSource)?

- Are MTF commanders communicating/educating unit commanders on the full range of behavioral health programs offered to Soldiers and Families?

- Do healthcare providers report all allegations and suspected incidents of spouse and child abuse to installation law enforcement?