

NON-DEPLOYABLE SOLDIERS: UNDERSTANDING THE ARMY'S CHALLENGE

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ABSTRACT

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NON-DEPLOYABLE SOLDIERS: UNDERSTANDING THE ARMY'S CHALLENGE

I. Introduction

In the last several years, the Army witnessed a steady increase in the rate of non-deployable Soldiers. This trend concerns Army strategic leaders because Soldiers who are unable to deploy with their units when the Army needs them directly affects the readiness of both operational and institutional forces. Yet, maintaining deployable Soldiers is a complex challenge as several Army organizations and senior staffs have examined how to reduce the rate of non-deployable Soldiers.

Receiving particular focus is the rising rate of non-deployable Soldiers within brigade combat teams (BCT) at latest arrival date (LAD)¹ in a theater of operation. This issue is the subject of an ongoing Army Non-Deployable Campaign Plan addressing numerous factors that contribute to the rising rate of non-deployable Soldiers, and informs this study. In addition, the Army is considering ways to improve the disability evaluation system in order to reduce the number of Soldiers on active duty with disqualifying medical conditions. While the Army appears to be on the right track to identifying and addressing the increase in non-deployable Soldiers, the Army can improve. A special area identified for further research involves identifying and addressing the underlying causes that are driving the increasing incidence of non-deployable Soldiers. By identifying the underlying causes, the Army will be in a better position to effectively target its efforts and resources to reduce the rate of non-deployable Soldiers, particularly those suffering from medical issues.

This paper summarizes the efforts of an Army War College study group to identify ways of reducing the number of non-deployable Soldiers due to concerns by

Army senior leaders about the readiness of the force.² To this end, this study provides information about the Army's rates of non-deployable Soldiers and the impact on operational units. Next, the paper addresses the strategic effect of non-deployable Soldiers on the Army's ability to man deploying units and maintain enough ready Soldiers to support national security requirements. The Study Group then addresses four primary categories of non-deployable Soldiers at LAD – medical, legal, separations, and pre-deployment training – along with several salutary initiatives the Army has taken, or could take, to reduce the number of non-deployable Soldiers in deploying units. The study also examines factors associated with increasing rates of non-deployable Soldiers, including challenges Commanders and units have identifying non-deployable Soldiers and DOD's attempts to reform the physical disability evaluation process (PDES). The Study Group underscores why the Army should determine the underlying causes for non-deployable Soldiers in order to inform remedial efforts.

II. Rates of Non-Deployable Soldiers

On any given day approximately 75,000 Soldiers are categorized as not able to deploy.³ This number represents 13% of the Army's current authorized end strength.⁴ The reasons Soldiers become categorized as non-deployable include administrative, legal, and medical conditions. Most conditions are temporary in nature. However, Soldiers who have long-term or permanent medically disqualifying conditions precluding their ability to deploy, total 31,900, or approximately 5.78% of the Army's end strength.⁵ Considering the Army's engagement in persistent combat operations over the last nine years, high rates of non-deployable Soldiers place stress on the force overall. This is particularly visible at the BCT level.

In fiscal year (FY) 2010, nearly 14.5 percent of Soldiers in BCTs,⁶ the Army's primary operational units, were unable to deploy by the unit's LAD, which is up from 9.9 percent in 2007. Over the last four fiscal years, the average number of Soldiers per BCT unable to deploy at LAD steadily increased as follows: 2007 – 391 (9.9%); 2008 – 467 (12%); 2009 – 502 (13%); and 2010 – 567 (14.5%).⁷ The Army G-1 expects the non-deployable rate to be as high as 16 percent by 2012.⁸ If the current upward trend in the percentage of non-deployable Soldiers is not reversed, it could jeopardize the combat readiness of deploying units. Not surprisingly, General Casey, the Chief of Staff of the Army, set a goal to reduce the BCT non-deployable rate at LAD to no greater than 10%.⁹

Figure 1 depicts this increasing trend by showing the average percentage of non-deployable Soldiers, by category, assigned to a BCT at LAD. Of these categories, medical conditions, theater-specific individual readiness training (TSIRT), separations due to expiration of term of service (ETS) and retirements, and legal processing emerge as offering the best opportunities for the Army to reduce the BCT non-deployable rate at LAD to no greater than 10%.

Most notable was the percentage of medically non-deployable Soldiers which increased from 3.4% in FY 2007 to 4.6% in FY2010 and represented 33% of the non-deployable population at LAD, an average of 198 Soldiers per 3,500-Soldier BCT,¹⁰ constituting the largest category of non-deployable Soldiers.¹¹ On average, 198 Soldiers were classified as non-deployable because of medical reasons.

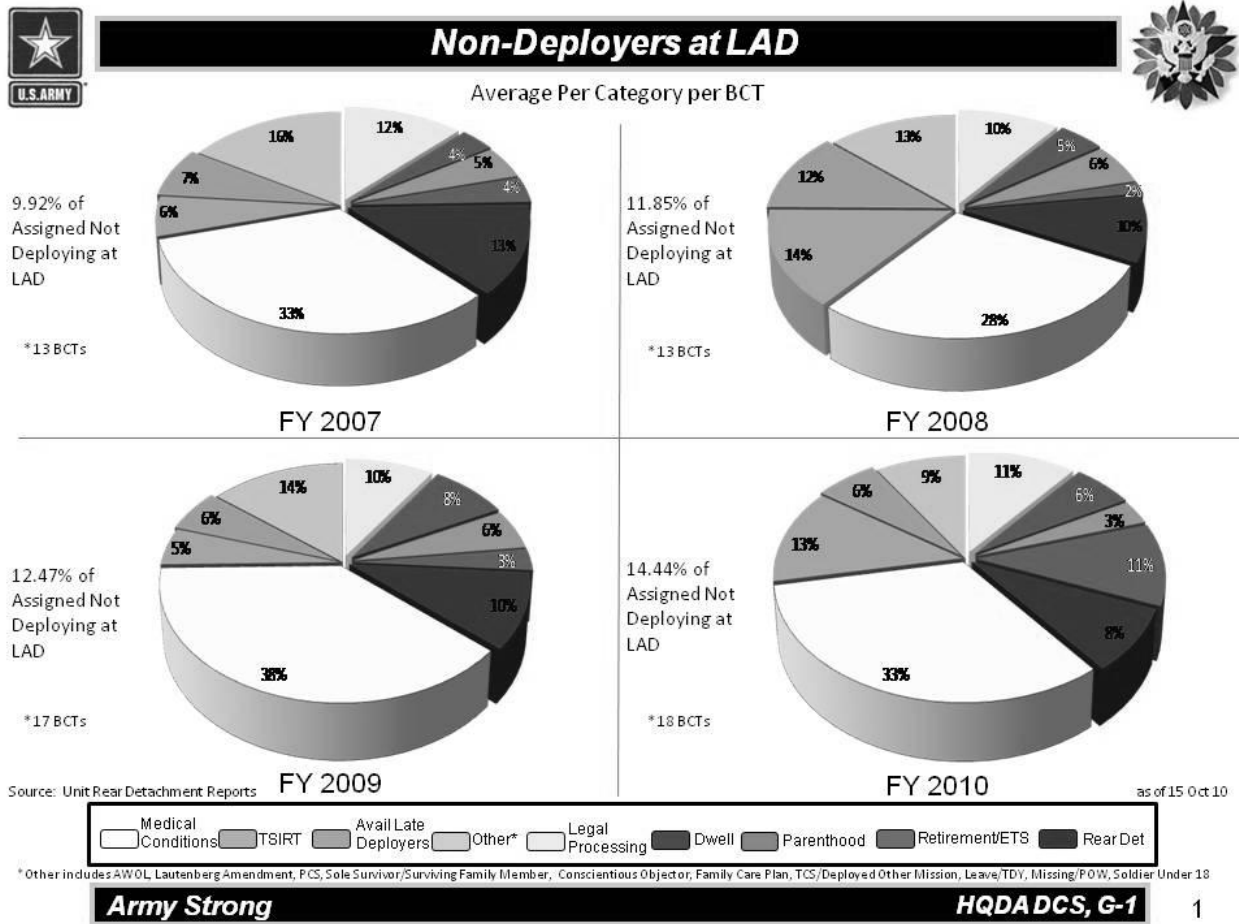


Figure 1. Yearly comparison of Non-Deployers at LAD from Army G-1 Briefing.¹²

Of those, 113 were medical readiness class (MR) 3A which the Army considers to be medically ready for deployment within 30 days. The other 85 Soldiers in this category have conditions that would require more than 30 days to resolve, with many having permanent medical profiles or medical conditions precluding deployment.¹³

The second category failure to complete TSIRT prior to LAD represented 13% of non-deployable Soldiers at LAD, an average of 78 Soldiers per 3,500-Soldier BCT.¹⁴ Soldiers separating due to reaching the expiration of their term of service represented 11% of the non-deployable population at LAD, for an average of 67 Soldiers per 3,500-Soldier BCT.¹⁵ This increase in separations was due in large measure to the elimination

of Stop Loss (i.e., the involuntary extension of Soldiers beyond their contractual obligation to the Army).

Legal issues, including courts-martial and administrative separations, represented 11% of the non-deployable population at LAD, an average of 66 Soldiers per 3,500-Soldier BCT.¹⁶ The remaining non-deployable Soldiers represented a combination of other administrative categories; including deployment dwell time, and available late deploying / not-deploying personnel.¹⁷ Also, Army strategic decisions created earlier-than-expected LADs and deployment dates, contribute to increasing numbers of non-deployable Soldiers. When units must deploy earlier than planned, Soldier dwell times shorten which increases the number of non-deployable Soldiers. This often results in commanders cross-leveling Soldiers with longer dwell times from other units to replace their now, non-deployable Soldiers.

Over the last few years, several studies and reports captured challenges relevant to the issue of non-deployable Soldiers. The Study Group's research included reviewing non-deployable studies from military and academic professionals and compared those studies to the research and engagements the Study Group conducted, including roundtable discussions with U.S. Army War College students in the Class of 2011 as described in Appendix A. The Study Group also reviewed recent reports from Headquarters, Department of the Army (HQDA), U.S. Army Forces Command (FORSCOM) and the US Army War College. In addition to these reports, the Study Group conducted an historical review of the literature published about non-deployable Soldier issues as well as congressional testimonies by senior Army leaders.¹⁸ The Study Group's research, literature review, interviews with Army senior leaders, and

assessment of the impact of non-deployable Soldiers revealed five common themes. In particular, managing Soldiers who become non-deployable remains a significant challenge, and the Army would benefit from clear guidance, expectations, and terms of reference (e.g., non-available, non-deployable). Additionally, Army leaders should focus on continuous individual readiness, which includes confirming Soldier readiness early in reset and movement between installations along with periodic screening in accordance with the Soldier Readiness Program (SRP)¹⁹ throughout the Train/Ready phase of the Army Force Generation (ARFORGEN) cycle.²⁰ Another important theme that emerged is engaged, proactive leaders are essential to reducing the number of non-deployable Soldiers. Leaders who focus on identifying and fixing non-deployable conditions early reduce the number of non-deployable Soldiers at LAD. In addition, the Army should focus on reducing non-deployable Soldiers at every level with improvements in systems, processes and resources to address this issue. The Army continues to improve medical-related policies and streamline medical board processes. The Army remains focused on its desired end-state of manning an expeditionary Army with Soldiers who are medically ready and deployable, while preserving the All Volunteer Force in accordance with the Army's Campaign Plan and DOD's priorities. The Study Group's approach and recommendations reflect many of the recommendations in the studies reviewed.

Personnel manning and readiness is the key component enabling Army units to accomplish their tasks and missions. Army personnel who are non-deployable detract from readiness and encumber their units by failing to perform the required tasks as outlined by regulations, orders, and directives. Unit level commanders are often forced

to seek other resources or individuals to fill vacancies left by non-deployable Soldiers, while also expending time and effort to supervise and process non-deployable Soldiers until they become deployable or are separated. At senior Army levels, non-deployable Soldiers are viewed as a total non-deployable percentage compared to a unit's overall strength. Within a unit, however, the non-deployable percentage is not just an aggregate number but individual Soldiers with particular Military Occupational Specialties, who are needed to perform specific roles and tasks for the unit.

In this era of persistent conflict, the number of non-deployable Soldiers has steadily risen.²¹ Understanding the underlying causes of this steady rise is imperative to improving Army readiness. While the Army has several on-going initiatives addressing how to reduce the number of non-deployable Soldiers, there is no single solution. This study identifies several areas on which the Army should focus, however, an integrated approach across Army general staff principles, major commands and agencies would provide a comprehensive approach to reducing the number of non-deployable Soldiers. Some approaches require leader involvement and training while others require policy changes that could take years to implement.

III. Achieving a Balanced Force

To fully appreciate the gravity of increasing rates of non-deployable Soldiers in the Army's ranks, it is important to understand the dynamics of achieving a balanced force capable of supporting the Army's missions. When examining Army manpower strategically, the Army's personnel system works to strike a balance between requirements and personnel resources. In other words, the Army can only afford so many Soldiers (personnel resources) due to budget constraints and Congressional limitations on its end strength or the number of Soldiers permitted on active duty.

Concurrently, the Army aims to design a force that meets the present and future needs of the nation, while providing the services necessary for Soldiers to perform the duties required of a modern land power force (personnel requirements).

The National Defense Authorization Act (NDAA) for Fiscal Year 2010 and the Ike Skelton NDAA for Fiscal Year 2011 included the Army's active duty end strengths for FYs 2011 and 2012. In summary, Congress authorized the Army permanent end strength of 547,400 Soldiers. Also, Congress authorized temporary end strength for FYs 2011 and 2012 of 569,400 for two specific purposes: (1) "to support operational missions; and (2) to achieve reorganizational objectives, including increased unit manning, force stabilization and shaping, and supporting wounded warriors."²² While the Army works continuously to manage its overall personnel strength with this Congressional authorization in mind, its actual end strength fluctuates over time for many reasons, including recruiting and retention outcomes and discharges of personnel.

Category	Authorization as Legislated 2011	Authorization by Document	On Hand	Percentage of On Hand to Authorization
Operational	--	367,523	397,741	108.2%
Institutional	--	94,685	93,309	98.5%
TTHS	--	76,100	76,117	100.0%
Manning Friction	--	9,092	--	N/A
Permanent Title 10 End Strength	547,400	547,400	--	
Temporary Allowed Strength	22,000	22,000	--	
Total	569,400	560,308	567,167	99.6%

SOURCES:

Authorizations--USAFMSA, Army G-1 and Army G-3

On hand strength as of end of August 2010 (Army G1)

Legislated -- NDAA 2010 and 2011

Table 1. Overview of Army Personnel.²³

Table 1 provides an overall snapshot of Army personnel categories.

“Operational” refers to the Army’s organizations that conduct field operations in support of national objectives such as BCTs and authorizations contained in the Army’s Tables of Organization and Equipment (TOE). “Institutional” organizations contribute to higher level joint headquarters and support activities as well as the part of the Army that produces and supports the Army’s operational units. The Army documents the Institutional Army in its Tables of Distribution and Allowances (TDA). The third part of the force, labeled “TTHS” (Trainees, Transients, Holdees and Students), identifies the Army personnel that are not available to serve in operational or institutional organizations.²⁴ Historically, the Army tries to minimize this category because traditionally, these Soldiers account for approximately 13% of the Army’s manpower.²⁵ The final category “manning friction” accounts for the movement of personnel outside of the other categories.

The percentages on the right of the table show the percentage of on-hand personnel compared to their authorized positions. To support combat operations, the operational force is manned at 108%, which means these units are “over manned” as directed by HQDA Active Component Manning Guidance for FY 2011. The Army’s manning guidance specifies that the approved temporary increase in Army end strength offsets “non-available Soldiers and Army losses in units deploying without Stop Loss.”²⁶ Such offsets allow the Army to “meet the requirements of ARFORGEN process in order to ensure a continued supply of trained and ready units to the Combatant Commanders.”²⁷ Given the above information, it is possible to provide two general risk assessments of the impact of non-deployable Soldiers on the overall Army. The first

risk assessment centers on the temporary over strength increase. Currently, the Army's manning guidance states it plans to achieve ARFORGEN cycle manning aim points in 2012 because the unit rotation schedule will achieve a rotation state of one year deployed and two years at home station, or a ratio of 1:2.²⁸ Using the Army's unit usage rates and manning targets, a simple look at the personnel end strengths highlight the risk. In order to maintain the percentages of manning levels in Table 1, the loss of 22,000 Soldiers would require the Army to reduce the operational force by 14,430, the institutional force by 3,718 and the TTHS accounts by 2,988.²⁹ A reduction in the operational force of 14,430 Soldiers equals slightly more than four light brigade combat teams or three Stryker brigade combat teams.³⁰

Another indicator of risk is found in the permanent non-deployable Soldier population reported to HQDA. As noted earlier, FORSCOM reports that 14% to 16% of Soldiers assigned to combat brigades cannot deploy for a variety of reasons. Many of the reasons are temporary (such as completing training requirements or a temporary injury). However, Soldiers who cannot deploy due to a permanent condition tend to fall into the medical or legal categories. While HQDA-level databases can provide a snapshot of medical non-deployable personnel, they are incapable of trend analysis.³¹ For medical reasons, the Army identifies approximately 19,500 Soldiers as temporarily non-deployable and about 31,900 Soldiers as longer term non-deployable.³² Army manning guidance prohibits assigning the latter group to deploying units and severely restricts assigning those in the temporary group to deploying units.³³ However, these Soldiers remain eligible for assignment to operational and institutional non-deploying units.³⁴

Analysis of these data sources challenges the Army's enlisted personnel system primarily. For example, 31,900 Soldiers classified as long-term non-deployable equates to 5.78% of the Army's total Soldiers. The percentages are significantly higher for Soldiers in the ranks of E-4 (7.67%) and E-5 (6.90%) and drop slightly for the higher ranked enlisted Soldiers but still hover between 6% to 7% up to E-8.³⁵ Since most E-4s and E-5s serve in operational units, the significant number of medically non-deployable Soldiers places additional strain on the Army's personnel management system, because many of these non-deployable Soldiers must be moved out of deploying units under the ARFORGEN system.

As this information highlights, the non-deployable population – especially permanently non-deployable Soldiers – places a “drag” on the manning system. Because these Soldiers are unable to deploy to operational assignments in theater, units require additional manpower to offset non-deployable Soldiers to achieve combat effectiveness.³⁶ Likewise, if assigned to the institutional force or in non-deploying operational units, the Army's overall number of deployable Soldiers shrinks and deployable Soldiers face increased time in the theater of operations. However, even if the Army assigned non-deployable Soldiers to the TTHS account, the Army must seek to adjust, usually increase its overall end strength, to account for fewer deployable Soldiers (or fewer units or smaller, potentially less capable units).

Although multiple Army studies highlighted challenges in managing non-deployable Soldiers and noted solutions which are being implemented, there remains fertile ground for additional research. In particular, the Army should consider conducting a longitudinal study on the impact of non-deployable Soldiers by rank and/or

occupational specialty, especially for first-term Soldiers, to determine the causes for higher rates of non-deployable Soldiers in certain ranks and occupational specialties.

IV. Reducing the Rate of Non-Deployable Soldiers at LAD

A. Medical Readiness Issues

The purpose of the Army Medical department (AMEDD) is to “preserve the fighting strength.” To this end, the goal of the medical readiness system is to provide a healthy, resilient fighting force throughout the ARFOGEN cycle. When Soldiers do not meet medical deployability standards, the AMEDD evaluates, treats, and whenever possible, returns Soldiers to duty. For those Soldiers not meeting medical retention standards the goal is to seamlessly transition them from the Army and into the VA system. Currently, medical readiness issues account for approximately 33% of the non-deployable Soldiers and 25% of the overall increase in non-deployable rates over the last four fiscal years for BCTs at LAD.³⁷ While the Army’s medically not ready (MNR) percentages remained fairly constant over the past few years, MNR Soldiers accounted for 4.6% of a BCT’s assigned strength in FY2010.³⁸ These Soldiers were non-deployable due to MEB/PEB/Medical MOS Retention Board (MMRB) processing, temporary medical conditions, dental readiness, and the need to complete a medical SRP.

The single largest increase in the MNR population was due to temporary profiles, which doubled from 1.54 to 3.5%.³⁹ This increase could be attributable to Soldiers addressing medical conditions related to prior deployments. However, exact accounting for temporary profiles is difficult because Soldiers’ medical conditions are not routinely updated in Medical Protection System (MEDPROS) and are often not discovered until an SRP. As a result, medical reasons represent the largest category of non-deployable

Soldiers with temporary medical issues or those in the MEB/PEB process representing about one third of the total non-deployable population.⁴⁰

The following section addresses medical-related challenges the Study Group identified impacting the Army's number of non-deployable Soldiers. Specifically, to reduce the number of Soldiers categorized as non-deployable, the Army could improve how it manages temporary medical deficiencies and the medical automation systems supporting MNR processes. In addition, this research suggests the Army improve medical personnel and leader training in Soldier deployment standards. An assessment of the Physical Disability Evaluation Process (PDES) is addressed in Section VI.

1. *Temporary Medical Deficiencies*

The Study Group found that earlier identification of and intervention in Soldiers medical conditions reduce the number of non-deployable Soldiers at LAD. Early identification relies on engaged unit leaders and thorough medical screening and documentation, including medical screening for theater-specific medical readiness criteria.

Identifying medical issues early enables Soldiers and units to rectify many medical issues before LAD, whereas the late identification of medical issues adversely impact medical readiness of deploying units. For example, the FORSCOM Surgeon's review of medical issues that contributed to Soldiers not deploying found that of the 1577 Soldiers in the rear-detachment non-deployable population, 52% were MNR.⁴¹ Significantly, 51% of MNR Soldiers had medical deficiencies that required relatively simple interventions such as completing a periodic health assessment (PHA), vision screening, HIV testing, hearing screening, dental readiness, and immunizations as

shown in Figure 2.⁴²

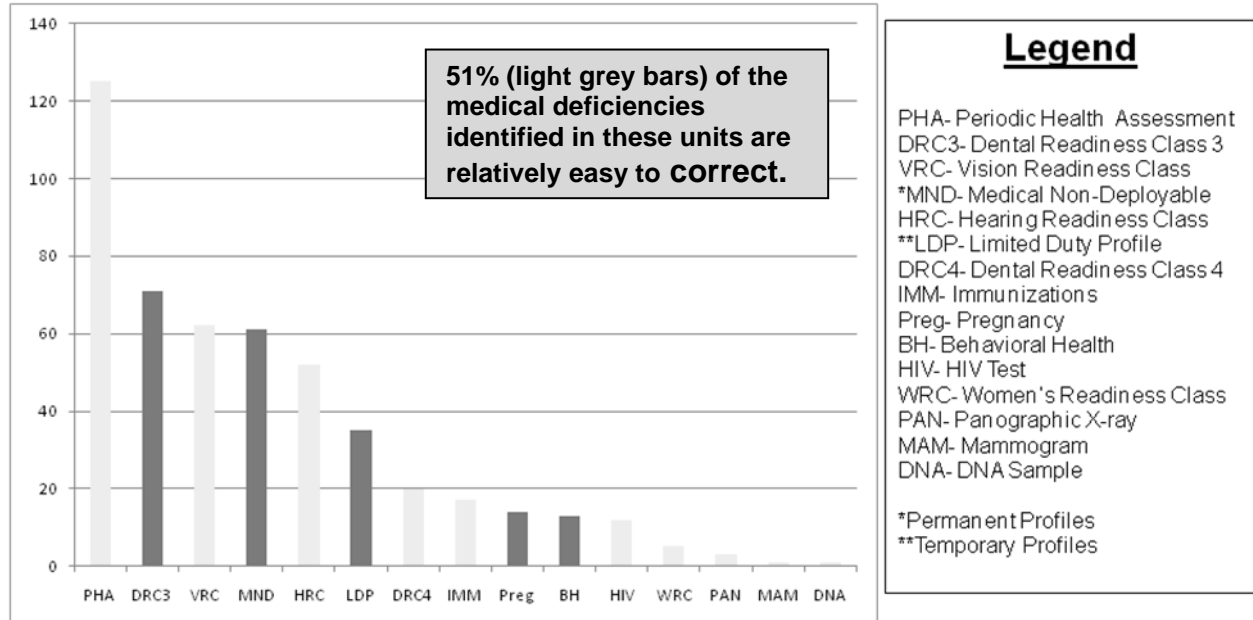


Figure 2. Medical deficiencies resulting in medically not ready for deployment.⁴³

In addition, data from Army Human Resources Command (HRC) showed that the majority of Soldiers in Medical Readiness Class 4 (MR4) moved into other categories over the 14-month period analyzed, with only 5% being classified as MR3B.⁴⁴

Specifically, the data revealed:

- 61% (42,758) who were MR4 became MR1 or 2
- 13% (9,025) who were MR4 remained MR4
- 19% (13,513) who were MR4 separated
- 7% (4,746) who were MR4 became MR3A or 3B

The HRC data supported the FORSCOM Surgeon's findings that most MR4 issues were easily rectified, with only 7% becoming either MR3A or 3B.⁴⁵ A majority of MR3As were able to deploy at a later date once Soldiers resolved the identified deficiencies.

This suggests an issue with late discovery of non-deployable conditions, the profiling process, or both.

There are several reasons medical profiles are not written for medical conditions limiting deployment. First, many specific medically non-deployable conditions stipulated in the Personnel Policy Guidance (PPG) and theater-specific guidance (e.g., CENTCOM Modification 10) are not medically disqualifying conditions for remaining in the Army.⁴⁶ Unless deploying, Soldiers are not routinely screened for medical conditions in the PPG or theater-specific criteria. Thus, commanders may not identify a Soldier's non-deployable medical condition until the unit conducts a pre-deployment SRP using the PPG or theater-specific screening requirements within 60 days of deployment date. Additionally, there is no mechanism in MEDPROS to identify Soldiers who do not meet PPG or theater-specific medical screening criteria. This often results in Soldiers being assigned to deploying units and later finding out they have a non-deployable medical condition when the unit conducts a pre-deployment SRP. Second, MEDPROS errors occur because medical treatment facility (MTF) medical providers must enter temporary profiles manually. Therefore, units may be unaware when the MTF issues a Soldier a medical profile. For similar reasons, Soldiers may not be properly coded as MR3B when reaching their Medical Retention Decision Point (MRDP) and starting the MEB/PEB process.⁴⁷ Also, the outcomes of Soldiers' MMRB/MEB/PEBs are not reliably entered into MEDPROS.⁴⁸ Other contributory factors include improper medical in-/out-processing and failing to use MEDPROS as the sole means for determining medical readiness.⁴⁹

To increase medical readiness in support of the ARFORGEN cycle, the Army's Office of The Surgeon General (OTSG) is developing a Soldier Medical Readiness Campaign Plan (SMRCP). The Surgeon General's goal is to ensure the Army deploys healthy, resilient, and fit Soldiers, improve the Army's medical readiness, and to return the maximum number of MNR Soldiers to available/deployable status.⁵⁰ Current OTSG and US Army Medical Command (MEDCOM) initiatives include five lines of effort (LOE).

The LOEs focus on (1) standardizing the MNR Soldier Identification Process by ensuring the medical readiness database (MEDPROS) is accurate; (2) synchronizing MNR management programs to reduce the number of MNR Soldiers and ensure Soldiers' access to care; (3) synchronizing health promotion, injury prevention and human performance optimization programs, by focusing on prevention to reduce injury rates and improve the physical readiness of the force; (4) assessing the SMRCP continuously to improve MNR management processes; and (5) communicating the MNR Campaign Plan within the Army.⁵¹

While the OTSG expected to publish the SMRCP by April 2011, the Army is currently implementing many initiatives. For example, the Army directed MTF to implement the electronic profile (eProfile) system in January 2011 to provide commanders visibility of Soldiers' medical conditions.⁵² MEDCOM is also focusing on validating Soldiers' MEDPROS data, identifying MEDPROS Readiness Coordinators for each MTF to assist supported units, automating MR3B (e.g., temporary profile or MEB/PEB status) requiring entry of medical "profiles" using only eProfile, and expanding the Medical Management Center (MMC) pilot program to other posts.⁵³

Additionally, to develop resiliency within the force, the Army is implementing a Comprehensive Soldier Fitness (CSF) program which is designed to give Soldiers and their family members the knowledge, thinking skills, and behaviors to help them thrive and cope with life's challenges.⁵⁴ Though CSF is not a MEDCOM program, it supports the OTSG SMRCP LOE of health promotion, injury prevention and human performance optimization programs.

When the FORSCOM Surgeon examined the increase of non-deployable Soldiers in FORSCOM units, he concluded Army commanders could better manage and most likely reduce the number of MNR Soldiers by complying with current policies.⁵⁵ For example, if MEDPROS were the sole source for Soldier Medical Readiness data, commanders would have one source of medical information to more effectively manage their Soldiers' medical readiness. Assigning MEDPROS Readiness Coordinators to MTFs to assist unit commanders would improve compliance with Periodic Health Assessment (PHA) requirements and medical in- and out-processing procedures and reduce the number of MNR Soldiers. MEDCOM initiatives such as eProfile, Medical Management Centers, and Health Promotion programs would provide commanders timely assessments of a Soldier's medical status and improve the coordination and relationships between commanders and local MTFs to reduce the MNR Soldiers.

Therefore, based on a review of current temporary medical conditions that make Soldiers MNR for deployment and current solutions the Army is working on, the Study Group makes the following seven recommendations:

- a. Use MEDPROS as the sole source of Soldiers' medical readiness status at the point of service and sustain connectivity between MEDPROS and the Net Centric Unit

Status Report (NetUSR) while prohibiting commander's override of Soldiers' medical status in NetUSR;⁵⁶

b. Require Soldiers to complete medical in- and out-processing IAW AR 600-8-101, Personnel Processing (In-, Out-, Soldiers, Readiness, Mobilization, and Deployment Processing);

c. Expand the Medical Management Centers (MMC) model across the Army to improve Soldier access to care;

d. Use the PPG and theater-specific medical criteria and conduct continuous SRPs and Periodic Health Assessments (PHAs) throughout the ARFORGEN cycle, especially when units first receive notice of pending deployment, to identify MNR conditions early;

e. Develop a way to flag Soldiers' records in eMILPO and MEDPROS to reflect non-compliance with PPG and other theater-specific medical conditions that do not constitute potentially unfitting conditions under AR 40-501 Standards of Medical Fitness;

f. Enforce the Army's PHA process to assist in preventing and reducing injuries and improve Soldiers' overall health and physical readiness; and

g. Educate commanders and leaders on medical readiness processing such as identified in the Medical Readiness Leader Guide

2. *Improve Medical Information Systems*

Automation technologies can increase efficiencies and decrease errors in processing medical information. AMEDD is advancing the use of information technologies, including the implementation of an electronic medical record (EMR),

Armed Forces Health Longitudinal Technology Application (AHLTA), MEDPROS, eProfile, and testing for an automated MEB/PEB process.⁵⁷

Unfortunately, the lack of an interface between AHLTA and MEDPROS, the two primary electronic medical systems military healthcare providers use to update Soldiers' medical information, requires duplicate data entries which increases the chance for errors. To improve the efficiency and accuracy of Soldiers' medical information for providers, leaders and Soldiers, AHLTA updates and changes should flow seamlessly into MEDPROS.

Continued upgrades to AHLTA have brought limited improvements but are slow. These challenges gained national attention when Congress stepped in to push DOD to improve AHLTA. For example, the Army's Surgeon General acknowledged problems and provider dissatisfaction with AHLTA while speaking before a House joint subcommittee hearing in 2009.⁵⁸ The OTSG has long recognized this disconnect and added it to the SMRCP as an issue to be worked.

In addition, Army MTFs are currently implementing eProfile so medical providers and commanders have an automated physical profiling system. Historically, Soldiers' physical profiles were generated by one of three mechanisms: the AHLTA profiling function, the WEB AMEDD Electronic Forms Support System (WEB-AEFSS), and hand-written DA Form 3349s (Physical Profile). These separate profile mechanisms often resulted in incomplete or inaccurate PULHES and medical readiness data in MEDPROS, varying functional limitations and PULHES profiles, and sub-optimal communication between commanders and profiling officers.⁵⁹ At times, commanders were unaware of Soldiers' medical conditions or profiles prohibiting their performance of

their normal military duties until the unit completed an SRP prior to deployment. Because eProfile generates, approves and routes Soldiers' physical profiles electronically and automatically updates MEDPROS, it should improve commanders' visibility of Soldiers medical conditions and provide consistency in Soldiers' PULHES profiles.

In addition, MEDCOM is testing an automated system to improve the speed and efficiency of the MEB process.⁶⁰ This system will use existing databases to capture common information, allow for the real-time transfer of digital information to a PEB, and provide 100% accountability for cases throughout the Physical Disability Evaluation System (PDES). The United States Army Physical Disability Agency (USAPDA) is also automating the PEB using the same technology and software to replace the Physical Disability Computer Assisted Processing System (PDCAPS), which has been in use for the past 18 years.⁶¹

The automated eProfile and MEB/PEB systems should increase accuracy and decrease errors inherent in multi-mechanism, paper systems. Therefore, the Study Group recommends the Army continue to develop an interface between AHLTA and MEDPROS to further capitalize on these systems. In addition, DOD should develop an EMR that seamlessly integrates medical data systems into one comprehensive medical record. While system improvements may not decrease the rate at which Soldiers become MNR, automation can identify and process MNR Soldiers faster to address their non-deployable conditions and speed their return to units.

3. Education and Training for Commanders

Leaders face numerous challenges in managing Soldiers undergoing medical treatment and disposition throughout the ARFORGEN cycle. Likewise, the Study Group identified that unit leaders and medical providers often are unaware of Army policies, guidance, and criteria for identifying, validating, and resolving the status of MNR and non-deployable Soldiers. Contributing to this situation, the Study Group found a lack of education and training resources for leaders and medical providers.⁶²

One of the most challenging administrative processes for Army leaders, medical providers, Soldiers, and Families to understand is the MEB/PEB process. Education and training is important to ensure a basic understanding of the MEB/PEB process. The Study Group concurs with General (Retired) Franks' assessment that the Army should improve leaders' understanding of the MEB/PEB process to enhance the efficiency of case processing.⁶³ The report emphasized education and training as a way to improve transparency, understanding and trust by providing information about the complete MEB/PEB process to Wounded, Ill, and Injured (WII) Soldiers, Families, and NCO/officer chains of command.⁶⁴ While it may be unrealistic to require Soldiers and Families to understand the MEB/PEB and other medical processes, the Army should emphasize conducting assessments and continuing refresher training for case managers and Physical Evaluation Board Liaison Officers (PEBLOs).⁶⁵

General (Retired) Franks made four recommendations to improve understanding of the MEB/PEB processes. First, US Army Training and Doctrine Command (TRADOC) should collect, analyze, and distribute lessons learned concerning the overall healing and rehabilitation process for WII Soldiers, which could rapidly improve

information sharing among Soldiers, Families and commanders.⁶⁶ Second, TRADOC, US Army National Guard (ARNG), and United States Army Reserve (USAR) should establish MEB/PEB instruction within pre-command (battalion and brigade) and leader courses for officers and NCOs (e.g., Basic Officer Leader Course and Advanced Leader Course) to provide leaders a basic understanding so they are able to supervise the progress of WII Soldiers undergoing MEB/PEB processes. Third, the Army should implement web-based and digital Soldier education and training programs encouraging Soldiers and Families to use the MyMEB/PEB website DVDs explaining the PDES process from a Soldier's perspective, and a streaming video link on Army Knowledge Online (AKO).⁶⁷ Fourth, General (Retired) Franks recognized gaps in training WTU medical personnel and cadre and recommended MEDCOM develop WTU Cadre Certification Training, expand training for Nurse Case Managers, and PEBLOs including an Adjudicator's Course, and provide medical narrative summary (NARSUM) training for physicians. Indications are that implementing General (Retired) Franks' recommendations should improve the Army's management of non-deployable and WII Soldiers.

B. Legal Processing

Soldiers undergoing legal processing constitute the third largest category of BCT non-deployable Soldiers at LAD.⁶⁸ This category includes Soldiers facing courts-martial and administrative separations under the provisions of AR 635-200, Active Duty Enlisted Administrative Separations. According to Army G-1 data, the average number of Soldiers at LAD per BCT who were non-deployable because of legal issues increased from 47 to 66, or 40 percent, from FY 2009 to FY 2010.⁶⁹ However, the data

do not provide reasons for the increase. Nor does it provide sufficient fidelity, such as the specific types of legal actions, to determine whether there were changes in any particular type of action, such as an increase in Chapter 14 actions or courts-martial for AWOL/desertion. Nonetheless, experience indicates the vast majority of legal actions are administrative separations, with the greatest number of those falling under Chapter 14 of AR 635-200.⁷⁰

The Study Group concluded commanders have sufficient tools to address Soldiers whose conduct, behavior or situation renders them unsuitable for continued service in the Army. The Study Group also found, however, the Army could improve the processing of administrative separations by improving the processing times for administrative separation cases. While making the changes discussed below should improve processing of administrative separation cases and would likely decrease the number of non-deployable Soldiers at LAD, active leader engagement is essential to early identification and expeditious disposition of Soldiers who warrant separation from the Army. To this end, the Study Group recommends tactical leaders such as company commanders conduct thorough legal reviews of their unit's Soldiers to determine those who warrant separation or are at risk for separation, and take appropriate action. Company-level leaders should conduct these reviews throughout the ARFORGEN cycle, but especially no later than 120 days before LAD, to allow time before deploying to disposition separating Soldiers and integrate replacement Soldiers.

1. Administrative Separation Processing Times

AR 635-200, paragraph 1-7 establishes processing goals for administrative separation actions. In cases in which the notification procedure is used, the action

should normally not exceed 15 workdays.⁷¹ For cases involving an administrative separation board, the processing goal is 50 working days. Processing time is measured from the date a Soldier acknowledges receipt of the proposed separation to the date the separation authority directs separation. However, since the Army does not track the processing times for administrative separation actions, no data is available to determine whether the Army's processing goals are being met. Determining whether processing goals are being met, and more importantly the reasons they are not, could inform whether resourcing, policy or other changes are needed to achieve the most efficient processing of administrative separation actions without compromising Soldiers' due process rights or the interests of the Army. The Study Group recommends studying processing times for administrative separation actions.

2. Physical and Mental Examinations

Based on Study Group member experience and discussions with commanders, Soldiers and Commanders frequently encounter delays in obtaining the requisite physical and mental health examinations for administrative separations. AR635-200 directs commanders to ensure Soldiers "obtain a physical examination per 10 USC 1145."⁷² However, because physical and mental health examinations must comply with medical regulations and other policy guidance from OTSG and MEDCOM, delays are often a function of access to appointments with the appropriate healthcare provider. As a result, the Army should consider establishing specific time frames, such as 72 hours, or give priority for administrative separation-required examinations. Also, the Study Group recommends determination by the Army whether a separation health

assessment or PHA will meet the statutory requirement for a physical examination as set forth in United States Code, Title 10, Section 1145.

3. Chapter 14 Administrative Separation Processing for Misconduct

Currently, separating Soldiers for misconduct under Other Than Honorable (OTH) conditions requires the approval of a general officer under the administrative board procedure, which lengthens separation processing times.⁷³ This most frequently arises under Chapter 14 for misconduct where only a general officer separation authority may convene a board and may not delegate their authority. In all other administrative separation actions, the separation authority, depending on the basis for separation, is a special court-martial convening authority (SPCMCA), usually a brigade-level commander (Colonel /O-6), or an O-5-level (Lieutenant Colonel) commander. In order to streamline the processing of Chapter 14 cases while maintaining a respondent-Soldier's due process rights, the Army could expand the authority of the SPCMCA to take action in cases initiated under the administrative board procedures.

First, authorize an SPCMCA separation authority to separate Soldiers with a general discharge when the chapter initiating authority, usually a Soldier's company-level commander, recommends an OTH separation (which requires use of the administrative board procedure). Since an SPCMCA may already separate Soldiers with a general discharge when using the notice procedures, this change would allow the SPCMCA to exercise the same level of separation authority when an initiating authority recommends an OTH separation. To ensure Soldiers have an opportunity to submit matters, the Army could require SPCMCA's to allow Soldiers an opportunity to submit written matters before taking action. Under current policy, the OTH recommendation by

an initiating authority limits an SPCMCA's exercise of independent judgment by foreclosing the SPCMCA's ability to separate Soldiers with a general discharge. Adopting the recommended change would ensure consistency in an SPCMCA's authority and correct the anomaly that exists under the current policy.

Second, authorize the SPCMCA separation authority to convene boards authorized to recommend discharge under OTH conditions. If the board recommends an honorable or OTH character of service, the action could still be forwarded to the general officer separation authority for action. If the board recommends a general character of service, then the SPCMCA could act as separation authority, obviating the need to forward the action to a general officer separation authority.

While DOD would have to approve these two changes, they would reduce the number of separation cases and separation boards that require action by a general officer, and thus decrease processing times. Shortening the processing time of Chapter 14 cases would reduce the number of "legal" non-deployable Soldiers at LAD.

4. Transition Unit

Another way to potentially reduce the number of legal non-deployable Soldiers at LAD could be establishing at Army installations transition units responsible for handling administrative separation actions. (This would not include Soldiers pending courts-martial out of concern for claims of unlawful command influence and illegal pretrial punishment.) This approach worked successfully at Fort Riley in 2007-2008.⁷⁴ By transferring Soldiers undergoing legal processing from a deploying unit approaching its LAD, deploying commanders could focus their attention on preparing deployable Soldiers for operational missions while installation commanders could provide non-

deployable Soldiers focused support. The primary challenges would be (1) ensuring dedicated cadre oversee the demands of this cohort of Soldiers and (2) developing transfer requirements that do not exceed the Army's ability to resource these elements. (See Appendix B which discusses the resource challenge in the context of Warrior Transition Units) Nevertheless, the Study Group believes this approach merits further study and consideration.

5. *Dual Administrative Separation – Medical Evaluation Board (MEB) Cases*

Current Army regulations require Soldiers facing administrative separation and not meeting medical retention standards to be evaluated by an MEB, after which the separation authority determines whether the Soldier will continue with the administrative separation or the PDES. This process is inefficient and time consuming because Soldiers' medical processing takes precedence over their legal separation processing and does not meet the Army's intent to process Soldiers in a timely manner.

Currently, when an enlisted Soldier is pending administrative separation under AR 635-200, chapters 7, 14, or 15,⁷⁵ and a medical authority determines they do not meet medical fitness retention standards, the Soldier's commander must refer them to an MEB.⁷⁶ Pending the MEB's outcome and a decision by the general court-martial convening authority (GCMCA), if necessary, the Soldier may not be separated. Should the MEB recommend referral to a Physical Evaluation Board (PEB), the GCMCA must review the MEB results and determine whether the Soldier continues with the administrative separation action or the PDES. The GCMCA may suspend the administrative separation action and allow referral to the PEB if they determine one of the Soldier's medical conditions is a direct or substantial contributing cause for the

misconduct that led to the administrative separation action, or circumstances of the Soldier's case warrant disability processing instead of administrative separation.

Many Soldiers facing administrative separation are also physically and medically unfit for further service and are referred to the PDES by the separation authority. Also, many Soldiers continue to demonstrate indiscipline and misconduct throughout the PDES process, undermining the good order and discipline of their units. Since the average time to complete an MEB under the current PDES⁷⁷ is 130 days, and total processing time from referral to separation is over 277 days,⁷⁸ Soldiers with a history of indiscipline and misconduct are remaining in the Army pending disposition of their PDES cases. These PDES processing timelines are challenging for commanders who expect to separate Soldiers for misconduct but learn these Soldiers will remain in the Army for up to another year.

Once Soldiers begin either administrative separation or PDES processing, the Army considers them non-deployable and they detract from the unit's personnel readiness and deployment preparation. In addition, commanders attempt to reassign these Soldiers to other non-deploying units to reduce the challenges of processing administrative separations while their higher commands work to obtain deployable Soldiers to fill the vacated positions.

Based on discussions and comments from the Army War College Class of 2011 student survey, the Study Group recommends the Army implement three actions to mitigate the effects of dual cases on deploying units.

a. Assign separating Soldiers to a WTU. The Army currently prevents assigning Soldiers facing administrative separation to a WTU.⁷⁹ Once the GCMCA suspends an

administrative separation, we recommend the Army reassign Soldiers to a WTU. This would provide Soldiers care by those who understand the PDES, provide Soldiers oversight and counseling by trained WTU cadre, and would enable commanders to focus attention on deployment preparation. Most of the USAWC officers from our roundtable survey recommended reassigning Soldiers whose administrative separations are suspended for medical reasons because they are concerned about commanders having deployable Soldiers in units to support readiness at LAD.

b. In cases where it is infeasible to assign Soldiers to a WTU, installations should give them the same access and priority to care as Soldiers assigned to a WTU.

We also recommend MTFs establish forums where commanders can offer feedback and prioritize which Soldiers should receive priority to meet their separation or PDES requirements. This would enable commanders to take action to minimize processing times, and opens a dialog with the MTF to ensure quality care and due process for Soldiers. During the USAWC survey, officers stationed where the MTF's commander and staff assisted unit commanders with non-deployable Soldier issues indicated they had lower rates of non-deployable Soldiers within their units.

c. Identify a medically acceptable decision point short of completing the full MEB process, so Soldiers pending administrative separation and PDES processing are presented sooner to an GCMCA for decision with the VA handling necessary post-separation follow-on medical care for a service-connected illness or injury.

C. Theater-Specific Individual Readiness Training (TSIRT)

Because all Soldiers must complete TSIRT prior to deploying, a lack of training is another category for which Soldiers are classified as non-deployable prior to LAD.

According to Army G-1 data, Soldiers without TSIRT accounted for 13 percent of BCT

non-deployable Soldiers at LAD in FY 2010. The two-week-long TSIRT course for Operation Enduring Freedom and Operation New Dawn incorporates training required by CENTCOM about nuclear/biological/chemical agents, first aid, searching people and vehicles, convoy procedures, improvised explosive devices, and medical evacuation procedures.⁸⁰ Lack of TSIRT becomes an issue for deploying units when Soldiers arrive too late in the ARFORGEN cycle to conduct TSIRT before LAD. Soldiers arriving within 60 to 90 days of LAD seldom receive TSIRT before the unit departs for theater and then become late deploying or non-deployable Soldiers pending TSIRT completion.

Improving current policy, procedures, funding, and management oversight for TSIRT would reduce the number of Soldiers who deploy late. Because TSIRT is decentralized and unsynchronized in the Army, major commands and local field activities such as garrisons and non-deploying BCTs spend much effort to manage and support TSIRT for late deploying Soldiers. While there are many stakeholders, no single Army organization provides oversight for planning, programming, budgeting or executing TSIRT training and support. This approach results in major command-specific projects and duplicative efforts rather than a deliberate Army program for deploying and deployed Army forces. As a result, the Army should prioritize and schedule training, reduce training requirements from CENTCOM, and increase training resources to augment deploying forces.

D. Retaining Deployable Soldiers with the Deployment Extension Incentive Program (DEIP)

Another category of non-deployable Soldiers impacting unit readiness are Soldiers scheduled to separate from the Army during their unit's deployment. These Soldiers are proven performers whose contractual enlistment obligation will expire

during their deployment. From FY 2009 to FY 2010, the rate of BCT Soldiers at LAD who were non-deployable because of pending separation from the Army due to retirement or expiration of term of service (ETS) increased from 3% to 11% as a result of eliminating the Stop Loss program. In response, the Army established the Deployment Extension Incentive Program (DEIP) as a monetary incentive to encourage active duty enlisted Soldiers scheduled to ETS during a deployment to remain in the service.⁸¹ DEIP provides two different monthly payment amounts depending on when an eligible Soldier extended. As figure 3 shows, the earlier a Soldier committed to DEIP, the greater the monthly payment, which begins upon the extending Soldier reaching his original ETS date.⁸²

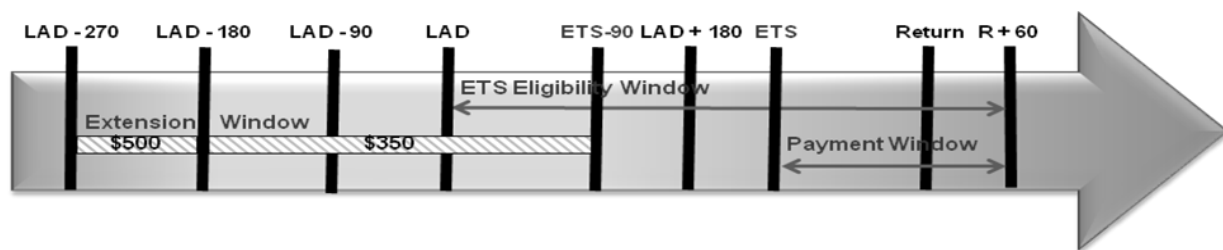


Figure 3: DEIP Timeline⁸³

Because of DEIP, the active Army succeeded in encouraging Soldiers to extend beyond their original ETS. As of 29 December 2010, 11,086 Soldiers accepted DEIP at a cost of \$37.6 million to the Army. Units within 180 days of LAD, labeled as “Current” in table 2, experienced 18.3% of eligible Soldiers opting for the DEIP payment. The Army’s goal was to achieve an acceptance, or “take”, rate of 30% prior to LAD –180 days, but the actual overall acceptance rate was 25.9%.⁸⁴

	Eligible	Takers	% Takers	Total Cost
Current	23,644	4,319	18.3%	\$15,729,594
To Date	42,742	11,086	25.9%	\$37,366,950

Table 2: DEIP Take Rate and Cost⁸⁵

The majority of eligible Soldiers were assigned to BCTs and as a result these Soldiers accounted for the greater part of the takers. Soldiers in career fields of Operational Support and Force Sustainment (OF/FS) showed lower take rates compared to the Maneuver, Fires, and Effects (MFE) specialties. As reflected in table 3, most Soldiers opted for DEIP within 90 days of LAD or after deployment.⁸⁶

Unit Type	from LAD	Eligible	Takers	Take %
BCTs	≤90 / Dep	14935	5163	34.6%
	91-180	6663	1246	18.7%
	181+	841	89	10.6%
	Total	22439	6498	29.0%
MFE	≤90 / Dep	8352	2232	26.7%
	91-180	501	145	28.9%
	181+			
	Total	8853	2377	26.8%
OS/FS	≤90 / Dep	9168	1623	17.7%
	91-180	47		
	181+	276	31	11.2%
	Total	9491	1654	17.4%
HQ/Others	≤90 / Dep	1792	535	29.9%
	91-180	167	22	13.2%
	181+			
	Total	1959	557	28.4%

Table 3: DEIP Take Rate by Time⁸⁷

Because the DEIP improved readiness and provided units continuity and certainty about deployable Soldiers, the Army should continue the DEIP program. For example, the Army stabilized 6498 Soldiers in deploying BCTs as of 29 December 2010. Also, the Army should further study the best ways to offer incentives to increase the number of Soldiers extending their service, which enables the Army to fill deploying units by reducing the number of Soldiers considered non-deployable because of ETS. Changing the mix of money and time it offers Soldiers to extend their ETS could lead to more Soldiers enrolling. In turn, deploying units would benefit from greater personnel stability. Three recommendations warrant further study.

a. Increase money and timeframe. Most Soldiers within 90 days of LAD enrolled for the monetary incentive. Since the Army wants to decrease personnel turbulence by enticing Soldiers to take the incentive earlier, it could offer higher incentives for agreements made 6-9 months prior to LAD, and lower amounts for accepting the incentive later.

b. Offer a higher monetary incentive for Soldiers extending 9 months or more prior to LAD. This would afford the unit the greatest personnel stability.

c. Start paying the incentive at LAD rather than the original ETS date, because Soldiers may not otherwise deploy without voluntarily extending.

V. Issues in Evaluating and Identifying Non-Deployable Soldiers

Administratively, the Army could improve the guidance it provides commanders for evaluating and identifying non-deployable Soldiers. Specifically, the Army lacks guidance regarding evaluation and identification of non-Available Soldiers. Because Army units use AR 220-1, Unit Status Reporting, for monthly Army Strategic Readiness

Update (ASRU) /Unit Status Reporting (USR) to identify Soldiers not available for personnel readiness, this guidance has become the de facto accounting standard for non-deployable Soldiers as well. In addition, AR 600-8, Military Personnel Management, AR 600-8-6, Personnel Accounting and Strength Reporting, and AR 600-8-111, Wartime Replacement Operations, are dated, redundant, and conflicting because they do not support the current operational environment of Army units. In order to support rapid policy changes, the Army now uses automated “living documents” such as the Deployment Cycle Support Checklist, Personnel Policy Guidance (PPG), Manning Guidance, and All Army Activity messages (ALARACTs), rather than published regulations. This practice allows for continuous updates based on approved policy guidance/revisions (i.e., ALARACT, MILPER (Military Personnel) messages, DOD instructions, ARs, etc.). While the Active Component Manning Guidance for FY 2011 contains specific guidance on how the Army assigns non-available Soldiers, it does not provide guidance for assigning Soldiers with temporary medical conditions. In addition, the consolidated PPG provides theater and HQDA guidance in one document to supports contingency operations. A primary issue with the PPG is that the Army does not have one clearing house to staff changes in policy across the Army staff and Army agencies.⁸⁸ This lack of integration creates conflicting policies and guidance and leads to unintended 2nd and 3rd order effects for Soldiers and units. For example, a Soldier with sleep apnea requiring the use of a continuous positive airway pressure (CPAP) machine may be assigned to a deploying unit under current Army manning guidance because he is not coded as MR3B. However, current CENTCOM MOD 10 medical guidance in the PPG categorizes a Soldier with sleep apnea as non-deployable, leaving

the deploying unit with a non-deployable Soldier. The Army should clarify and revise medical readiness policies to better support the Army's manning effort.

VI. Physical Disability Evaluation System and MEB/PEB Process

On any given day over 31,000 Active Component Soldiers are classified as MR3B⁸⁹—who many of are undergoing or will undergo processing in the Physical Disability Evaluation System (PDES),⁹⁰ leading to their separation from the Army. Any Soldier who is MR3B is not deployable. Therefore, decreasing the length of time a Soldier's status is MR3B should result in a decrease in the number of MR3B Soldiers. An examination of the PDES and its impact on the number of the Army's non-deployable Soldiers shows that by eliminating or modifying the MEB the Army could reduce the processing time of Soldiers with unfitting medical conditions.

Current combat operations impacts the medical readiness of today's Army. Soldiers with temporary medical conditions (MR3A) or long-term medical conditions (MR3B) that may result in referral to the PDES have increased. According to the USAPDA its caseload increased by 56% from 2001 to 2010 (Figure 4). Specifically, there was a 27% increase in active component, 317% increase in reserve component and a 51% increase in Temporary Disabled Retirement List (TDRL) cases.⁹¹ In addition, USAPDA's FY 2009 caseload was the highest since the current database was created in the late 1980s.⁹²

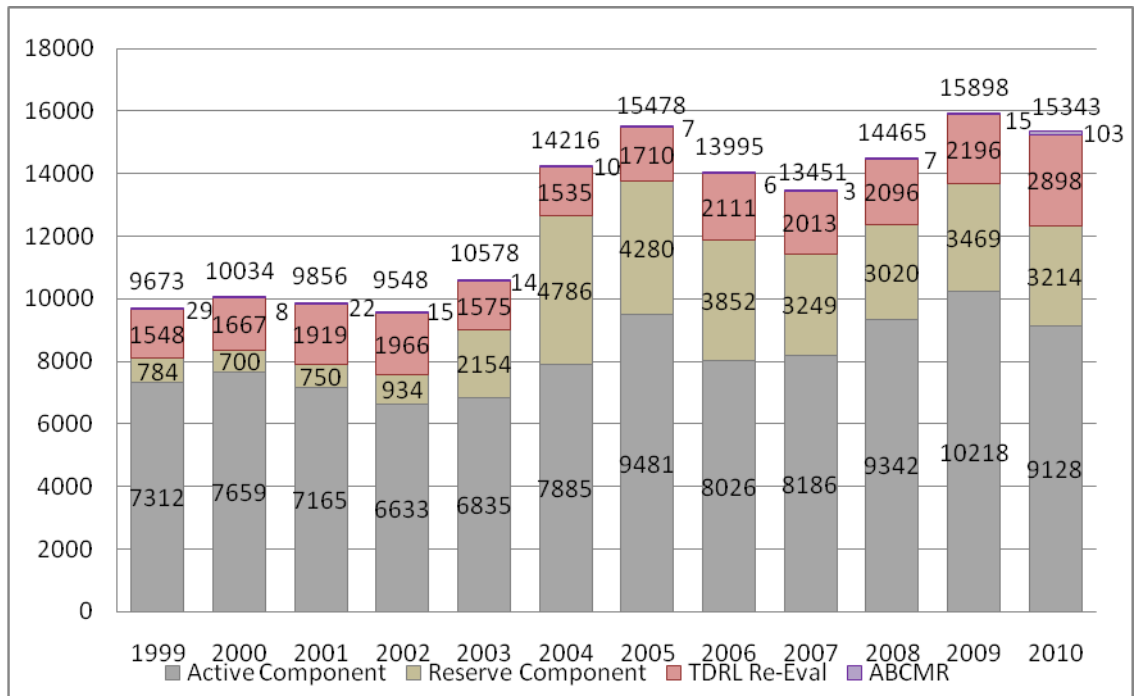


Figure 4. USAPDA Caseload FY 1999 – FY 2010⁹³

Table 4 reflects the percentage of Soldiers with an unfitting medical condition in a particular body system. Some Soldiers have disqualifying conditions in more than one body system, hence the percentages total more than 100%. From 2002 to 2009, significant increases were seen in the Mental Disorders and Neurological conditions categories, increasing from 7% to 39% and 10% to 22%, respectively.⁹⁴ Given the nature of current military operations and the Army's emphasis on Traumatic Brain Injury, Post Traumatic Stress Disorder, and other mental health issues,⁹⁵ these increases are understandable. Nevertheless, the increasing caseload of Mental Health Disorders in the Army may cause delays in the MEB/PEB process.

System	FY 2002	FY 2010
Musculoskeletal system (orthopedics)	73%	70%
Mental Disorders	7%	39%
Neurological conditions and convulsive disorders	10%	22%
Respiratory System	8%	5%
Skin Disorders	1%	2%
Organs of special sense (eye, ear, taste, smell)	1%	2%
Digestive System	2%	2%
Cardiovascular System	2%	2%
Endocrine System	1%	1%
Genitourinary System	1%	1%
Hematological and Lymphatic System	1%	0%
Gynecological Conditions and Conditions Breast	1%	0%

Table 4. Unfitting Conditions by Body System.⁹⁶

DOD and other government studies examined the current PDES and its impact on medical readiness of the force. The 2010 Quadrennial Defense Review emphasized DoD's commitment to improving care, management, and benefit delivery as well as standardizing services among the Military Departments and federal agencies to WII service members. The QDR recommended improving support to WII service members by “[e]stablishing a single Disability Evaluation System (DES) that creates a simpler, faster, and more consistent process for determining whether wounded, ill, or injured service members may continue their military service or should transition to veteran status.”⁹⁷

However, a challenge to a single DES is that DoD and the Department of Veterans Affairs (VA) evaluate medical conditions by different criteria: DoD evaluates service members based on their ability to perform military service, while the VA evaluates them based on their ability to perform civilian jobs. The purpose of the MEB⁹⁸ process, whether in the current Disability Evaluation System or the recently

implemented Integrated Disability Evaluation System (IDES), is to determine Soldiers' medical retention for continued Army service. Based on an MEB's findings, a PEB⁹⁹ investigates the nature, cause and severity of the Soldier's condition; evaluates the Soldier's condition against physical requirements; provides a full and fair hearing as required under Title 10¹⁰⁰; and recommends whether the Soldier is eligible for separation or retirement because of an unfitting condition.¹⁰¹

WII Soldiers face many challenges such as dealing with their injury or illness and the uncertainty that comes with a potentially military career ending condition. In its review of the military's PDES in 2007, the Dole-Shalala presidential commission recommended the military disability determination and compensation system be updated and simplified. Specifically, the commission suggested eliminating the parallel activities between the DOD and VA, reducing inequities between DOD and VA, and providing services to return injured veterans to productive lives.¹⁰²

Similarly, General (Retired) Franks highlighted the real challenge was not for Soldiers who recover from their wounds, illness, or injuries and return to service, but rather rested on Soldiers referred to the PDES with the uncertainty that comes from working through separate DOD and VA disability programs.¹⁰³ The Franks study recommended streamlining the MEB process to eliminate "dual" disability ratings which the Army and the VA determine independently. Historically, the Army's ratings often resulted in lower ratings than the VA and created mistrust and confusion.¹⁰⁴ Additionally, General (Retired) Franks insisted there must be a paradigm shift in the military's disability system from a disability system to a process focused on rehabilitating Soldiers to remain on active duty or transitioning them to civilian life. The report said

the disability system must promote resilience, self-reliance, re-education and employment, while ensuring enduring benefits for the Soldier and Family. Implementing these recommendations, would increase trust and transparency and enable Soldiers and Family members to focus on healing, recovery, rehabilitation, and transition, rather than compensation and entitlements.¹⁰⁵

To improve disability processing, DOD tested the IDES pilot program in November 2007 with the goal of combining the VA and DOD disability systems so WII service members – those who return to duty as well as those who must return to civilian life because of an unfitting condition – have a simpler, faster, and fairer experience.¹⁰⁶ The IDES integrate DOD and VA disability systems to run concurrently instead of sequentially and uses a single-sourced disability rating based on the VA's medical examination protocol. The Army directed commands to transition from using the DES to the DOD/VA IDES in January 2011.¹⁰⁷

According to the USAPDA, the DoD-VA pilot successfully reduced the overall time it took service members to complete the physical evaluation process by 53%.¹⁰⁸ Even though the cumulative time to complete separate DoD and VA physical disability evaluations was longer than using IDES, the IDES has resulted in service members remaining on active duty longer which the Army should consider as it implements IDES.¹⁰⁹ Unless processing times improve to where they at least equal those under the DES system, the Army should not expect IDES itself to decrease the number of non-deployable Soldiers. In fact, it has the potential to initially increase the number of Soldiers remaining in the Army pending completion of their cases.

One means to shorten processing times for Soldiers not meeting retention fitness standards is to redefine the MEB start point. Acknowledging the rationale behind reaching optimal therapeutic benefit – i.e., to determine a physical “steady state” before adjudicating the case by a PEB – General (Retired) Franks argued that military physicians should be allowed to exercise their prognostic abilities. He contends that in many cases physicians know the likely outcome of a Soldier’s condition and their ability to continue on active duty in the future. In these cases waiting to achieve maximum therapeutic benefit delays the inevitable. Therefore, physicians could initiate an MEB while a Soldier continues treatment and stipulate the process could be delayed if a physician determines it is clearly in the Soldier’s best interest.¹¹⁰ Recent USAPDA data supported this concept by revealing that only 4 to 5% of the PEB population was found fit for duty and retained on active duty.¹¹¹ To support this concept, the MEDCOM MMC pilot program is studying best practices for determining the MRDP for Soldiers not likely to continue in military service.

As Army MTFs began implementing IDES in February 2011, it may be possible to shorten the MEB evaluation process for Soldiers remaining in home units by using nurse case managers in the MMCs. Regardless of the systems used, the Army’s behavioral health backlog will likely continue to negatively impact evaluation timelines. Regardless, the IDES is important for Soldiers and their Families because it eliminates the dual adjudication of disability ratings completed independently by the services and the VA.

Creating efficiencies in the PDES requires assessing the entire process. In rethinking the MEB process, General (Retired) Franks referenced a concept, promoted

by BG Keith Gallagher, MEDCOM, to categorize MEBs in two ways: Expedited, or “MEB-EZ,” and Standard MEB. The MEB-EZ would be for relatively straightforward cases involving only one or two disqualifying conditions.¹¹² By employing an automated MEB system, PEB members could adjudicate MEB-EZ cases within 72 hours and return the case to the PEBLO for signature and follow-on transition processing of the Soldier. Soldiers with multiple medical problems requiring extensive documentation could use the current standard MEB process except the PEB would receive the case earlier outlining the medical care and services already rendered. As the Soldier proceeds through the MEB process, the PEB could receive updates which culminate in a final summary the Soldier reviewed, endorsed and submitted to the PEB. By involving the PEB from the beginning, BG Gallagher contends the process would be more transparent and efficient.¹¹³ The Study Group believes this proposal merits further development.

COL James Andrews also recently examined the DES and concluded that today’s PDES was not designed to support an Army engaged in persistent conflict. He proposed changing the current disability system by having the services determine medical fitness for active duty and the VA determine Soldier disability ratings as part of their transition from active military service.¹¹⁴ To accomplish this, Colonel Andrews advocated eliminating the MEB, arguing that when a Soldier has an unfitting medical condition, the service’s PEB could coordinate directly with the VA to determine an appropriate disability rating and compensation.¹¹⁵

Specifically, Colonel Andrews recommended near- and long-term solutions. For example, in the near term the Army could eliminate the MEB once a Soldier reached the

MRDP since a PEB must determine a Soldier's fitness for continued military service. As a result, the VA could then provide a single disability rating for service-connected conditions and the Army's PEB could use the VA's disability rating of the Soldier's service-connected conditions to make its final decision. In the long term, Colonel Andrews acknowledged DOD would have to pursue legislative changes to reform the PDES for the four services.¹¹⁶

Offering another recommendation to meet the Army's operational needs, COL Brian Lein suggests the Army implement a "presumptive MEB" based on Soldiers' primary medical condition that made them unfit for active service.¹¹⁷ Though the concept was not fully developed, the Army could provide a Soldier a presumptive MEB with a PEB rating based on their disqualifying condition. The Soldier would then transition to the VA for a medical evaluation and adjudication of their medical conditions and the Army would accept the VA's final rating.¹¹⁸ At the end of this process, the PEB would confirm the VA's rating as the basis for determining whether the Soldier would separate with disability severance pay or transition to medical retirement. The Army's determination would remain separate from the VA Rating Board's combined disability award which would still provide the basis for disability compensation payments and benefits administered by the VA.

Transparency and fairness with a focus on healing and rehabilitation – while supporting the Army's medical readiness needs – is the challenge facing the Army in changing the PDES. In most cases, meaningful change to the PDES would likely require statutory and/or regulatory changes. Nevertheless, the goal of any change must include preservation of the Soldier's Title 10 right to a fair physical disability evaluation

and subsequent adjudication while allowing Army leaders to replace medically unfit Soldiers to meet operational needs. The Study Group supports COL Andrews' and COL Lein's recommendations to eliminate or modify the MEB portion of the PDES.

Based on the foregoing, the Study Group recommends the Army take the following actions regarding the physical disability processing of Soldiers.

a. Study whether the one-year period to achieve maximum therapeutic benefit can be shortened without prejudicing Soldiers. Similarly, develop maximum medical therapeutic benefit guidelines to assist healthcare providers in making medical decisions about the likelihood of Soldiers meeting medical retention standards before reaching the medical retention decision point (MRDP) for their condition.

b. Test eliminating the MEB or adopting a "presumptive MEB," to allow for streamlined processing of cases and earlier adjudication by the PEB and the VA.

c. Consider allowing commanders to transfer Soldiers undergoing MEB/PEB processing to a WTU to enable commanders to focus on training their units for operational missions. Also consider permitting commanders to requisition a replacement after referring a Soldier to the MEB/PEB process.

d. Partner with the VA and the other services to find efficiencies in the IDES to reduce processing times of cases.

e. Recommend DOD complete a comprehensive review of the military PDES.

VII. Further Study Areas

This paper addressed many aspects of the Army's non-deployable challenge, and provided observations and recommendations. Some apply to the unit level; others address Army-wide processes and or DOD and interagency level ideas such as the

IDES. In the end, though, these recommendations could positively impact the Army in several ways: (1) transferring more Soldiers from a temporary non-deployable status to an available status, (2) moving non-deployable Soldiers from one organization to another for management and processing, or (3) transitioning non-deployable Soldiers from the Army and recruiting replacements.

As seen throughout the paper, much of the Army's effort has focused on Soldiers after they become non-deployable. However, one area not addressed involves prevention. In other words, the initiatives fail to address why Soldiers are incurring non-deployable conditions and how these conditions may be prevented or mitigated.

For example, the increase in behavioral health conditions could be the result of Soldiers being ill-prepared for the emotional and mental stressors of combat. If so, programs such as Comprehensive Soldier Fitness could help develop Soldier resiliency in dealing with combat-related stress. Similarly, the increased incidence of Soldier misconduct and indiscipline could be the result of lax leadership and limited controls in garrison. If so, the Army's focus on the art of leadership in garrison may help to reduce unacceptable behavior. Studying the underlying causes of non-deployable conditions makes it possible to prevent their occurrence and reduce the incidence at which Soldiers become non-deployable, rather than contending with Soldiers once they become non-deployable.

The Army should consider studying the underlying causes for the increased incidence of non-deployable Soldiers, especially those with either medical or legal issues. In doing so, the Army will be in a better position to marshal resources to address the underlying causes and thereby decrease the incidence of non-deployable

conditions across the Army. This produces more deployable Soldiers “up-front” and enables commanders to focus on mission essential tasks.

VIII. Conclusion

The problem of rising rates of non-deployable Soldiers is well studied by the Army. The implications to force readiness and well-being are also appreciated by Army senior leaders. Since the start of the Army War College study, the Study Group saw the Army move forward on plans, programs, policies and practices that should decrease the number of non-deployable Soldiers at LAD. As this report identifies, the Army can take further steps to attack this challenge. Chief among these is promoting active leader engagement throughout the ARFORGEN cycle to detect and address Soldier deployment readiness issues. The Study Group found that early, active, sustained leader involvement can result in units with significantly lower non-deployable rates. This finding is reflected in the recent FORSCOM Commander’s directive to his subordinate commanders to, among other things, assess Soldier deployment readiness, including by use of earlier SRPs, throughout the ARFORGEN cycle.

In addition, the Army must ensure leaders have the tools, training and guidance, along with enabling policies and programs, to carry out their responsibilities. For example, full implementation of eProfile should provide commanders better awareness of Soldiers with potentially deployment-limiting conditions. However, if Soldiers are not being screened for theater-specific deployment-limiting conditions until a final pre-deployment SRP, fully implementing eProfile may have a limited impact on identifying Soldiers earlier with such conditions. Therefore, establishing a policy screening for PPG and theater-specific deployable standards throughout the ARFORGEN cycle, as

well as across the entire Army, would support commanders' efforts to identify and address Soldiers with deployment-limiting conditions as soon as possible. Similarly, changing the policy on administrative separation approval authority could help commanders in expeditiously separating unsuitable Soldiers from their formations.

The disposition of WII Soldiers is a particularly complex problem. There is a palpable tension between taking care of our Soldiers and reducing the number of non-deployable Soldiers. The recommendations offered in this paper recognize this tension. From a readiness perspective, rapidly separating permanently non-deployable Soldiers ensures a force with the highest percentage of deployable personnel. However, there are implications at the strategic level. First, end strength management will require intense supervision when the Army's end strength is reduced (as planned in FY2012), making additional manning of deploying units more problematic. Next, placing permanently non-deployable Soldiers in non-deploying organizations carries direct and indirect costs; in the case of the Wounded Warrior Program that cost will be steep. Third and most important, separating non-deployable Soldiers does not necessarily ensure the Army fulfills its commitment to the men and women who took an oath to serve our Nation. At the end of the day in an All-Volunteer Force, the Army must support its Soldiers, even if it means keeping WII Soldiers on active duty longer than it might otherwise.

In the final analysis, the Study Group believes achieving a decrease in the number of non-deployable Soldiers across the Army depends upon a reduction in the incidence at which Soldiers become non-deployable. To that end, the Army should determine the underlying causes for non-deployable conditions. Once these underlying

causes are understood, the Army will then be in a position to develop programs, policies and procedures, and apply resources to address those causes.

This study was reviewed in accordance with federal regulations governing human subjects research including 32CFR 219 and DOD Directive 3216.2 where applicable.¹¹⁹

APPENDIX A: USAWC Roundtable Survey

The Study Group conducted a roundtable survey of AWC officer students who dealt with personnel deployment readiness issues. No data gathered during the roundtable survey was attributable to any student or organization. The sole purpose of the roundtable survey was to gather additional data on the subject of non-deployable Soldiers in deployable units. Forty-four students participated in roundtable discussions. Experience levels included former brigade and battalion commanders, deputy commanding officers/executive officers, and various staff officers. The conduct of the roundtable centered around five (5) questions:

1. How long before deployment did your unit begin looking at overall personnel readiness rates? Why?
2. What were the top 3 reasons for non-deployables?
3. What resources were available to assist you to resolve non-deployables?
4. What systems did you use to track non-deployables? How effective was that process/system?
5. What was the impact of non-deployables at LAD? What populations were most affected? (i.e. E-1 – E-4 or NCOs or Officers)
6. Best practices

Question 1: How long before deployment did your unit begin looking at overall personnel readiness rates? Why?

Over half of the respondents report their units started looking at personnel readiness rates at 12 months prior to LAD. And while there is no regulatory guidance for these efforts they reported it was driven by the deploying commander. Many report units cross-leveling Soldiers within the same brigade or battalions to meet required deployment strength. Respondents were clearly frustrated by the ARFORGEN cycle of replacing Soldiers late in the deployment cycle. Reports of receiving Soldiers at LAD - 90 were prevalent, specifically after the completion of National Training Center rotations

and other mandatory training requirements. Soldiers reporting late were also more likely to have deployment issues than those who had been in the unit for longer periods. A consensus amongst the group was that readiness should be a continual process even when units are not on a deployment schedule. At large installations priority at SRP sites remains the issue. Respondents reported a lack of installation focus on unit deployment dates; in fact, units competed for time at the SRP sites for several reasons notwithstanding lack of priority, but also including multiple units deploying at the same time. Leaders participating in the discussion applauded the SRP concept however felt that civilian physicians were more likely to contribute to the issue of non-deployable Soldiers than assisting commanders in maintaining their deployment status. A majority of respondents said they believed civilian providers over-emphasized non-deployable conditions without any requirement for Soldiers to provide existing medical documentation. In summary, these senior leaders felt they were beginning the process early enough, however the ARFORGEN cycle of new Soldiers to the unit prior to deployment acted as an inhibitor to those efforts.

Question 2: What were the top 3 reasons for non-deployables?

Every respondent in the roundtable listed medical issues as their top reason Soldiers were categorized as non-deployable. However, the medical issues were varied; they included theater-specific medical qualifications, psychotropic drug policies, immunizations, pregnancies, TBI, and Soldiers being prescribed medications as a result of statements made at SRP. Several leaders acknowledged the Soldier contributions in multiple deployments. Senior leaders believe that Soldiers who are medically non-deployable and want to deploy work very hard to change their status, while those who

do not wish to deploy will use their medical issue to avoid deployment. The earlier medical issues were identified, the greater the likelihood of the Soldier deploying; conversely those issues that were only identified at the SRP were less likely to be resolved prior to the unit's scheduled deployment date. Senior leaders became personally involved in tracking individual Soldiers with medical issues at approximately 120 days prior to deployment. The second largest response to this question surrounded legal and/or chapter actions. Senior leaders did not deploy with Soldiers who they were expecting to be chaptered out of the Army. In some cases, commanders used their judgments in not taking Soldiers who were facing UCMJ actions because they were not conducive to good order and discipline to the unit. All the senior leaders understood these decisions were of their own discretion and not governed by any army regulation or policy. A majority of respondents appointed their rear detachment commanders well in advance of the deployment. The two headquarters units operated together until the deploying unit left; leaving a seamless transition. The third most prevalent answer to this question was lack of sustainable family care plans. While most senior leaders stated Soldiers had established family care plans in accordance with regulatory guidelines, once units got closer to departure date family circumstances and dynamics changed. Some of the reasons were not and could not have been foreseen and for those instances Soldiers were given additional time to get a family care plan in order. If after that time they could not deploy due to family reasons, then separation actions were initiated. Several senior leaders recalled finding positions on the rear detachment staff in some circumstances.

Question 3: What resources were available to assist you to resolve non-deployables?

Most respondents were not aware of any available resources to help them resolve their deployment issues. Most felt the issue of deployability was a commander's responsibility. They cited individual initiative as the number one resource in dealing with this issue. Senior leaders used their influence and personal relationship with the military treatment facility (MTF) commanders and dental clinic commander as leverage to get short notice and no notice appointments for their Soldiers. In some instances the brigade level staffs were augmented with legal professionals from the SJA office to handle legal matters, such as wills, power of attorneys and paperwork for separation chapters. This augmentation happened early enough in the deployment cycle that commanders were able to get non-deployable Soldiers off their books and receive replacements, in most instances. Medical augmentation to the brigade level staff was mentioned as a resource that assisted these senior leaders in their deployment efforts. These professional, when augmented to the staff, were very proactive in addressing medical issues and keeping the senior leaders informed. In fact, senior leaders preferred this augmentation more than they did having Soldiers medically screened at the SRP sites. In summary, senior leaders felt that leaders who were personally involved had fewer deployment issues at LAD.

Question 4: What systems did you use to track non-deployables? How effective was that process/system?

Overwhelming senior leaders acknowledged the use of the monthly USR data to track non-deployable Soldiers. Between submissions of the USR units developed

excel spreadsheets to track individual Soldier status. Some leaders reported to their higher headquarters monthly when they were 120 days from deployments. As the timeframe decreased reporting cycles increased. At 30 days prior to deployment, many senior leaders report they were reporting/tracking non-deployable Soldiers with their higher headquarters almost on a daily basis. Some senior leaders felt micromanaged by their higher headquarters. Some expressed concern about officers doing “NCO business.” During this discussion, senior leaders insisted that a combination of effort in both the NCO and Officer channels was indeed warranted. The timing of the handover to the rear detachment was also discussed in this forum. A majority of the senior leaders interviewed recalled “working” the non-deployable roster until and sometimes well into their block leave. All believed that MEDPROS was not a reliable system and found themselves constantly pushing corrected information to the system. Units that did not have their own physician’s assistants were significantly hampered in getting information updated in MEDPROS and relied instead on data reported directly from the chain of command. In these instances Soldiers were often required to “prove” their deployment at the SRP site because of conflicting data in MEDPROS.

Question 5: What was the impact of non-deployables at LAD? What populations were most affected? (i.e. E-1 – E-4 or NCOs or Officers)

In the instances where the majority of non-deployables were noncommissioned officers, senior leaders report a significant impact to overall readiness. However, the majority of the respondents report that the population with the highest non-deployable rate was private through specialist ranks. The impact was substantial in units for low-density personnel in these ranks. For instances, when a unit is only

authorized three (3) generator mechanics and two (2) of them are non-deployable, this has a significant impact on the unit. So the unit is not just looking for a specialist E4 to fill its deployment strength, but especially for an E4 generator mechanic. The impacts as reported by the senior leaders also included incomplete fire teams and maneuver squads. There was minimal impact to morale. In stark contrast was in the event of the non-deployable noncommissioned officer. While the number of non-deployable noncommissioned was not significant, it definitely had a major impact in the deploying unit. In many instances, those key NCOs were team leaders, squad leaders and in two instances, platoon sergeants. When NCOs were absent from deploying formations the impacts to cohesion were noticeable. Even when the positions were filled prior to deployment, the effectiveness of the unit at that level is diminished. In many instances junior NCOs were recognized for their demonstrated potential to perform at the next higher level. In summary, impact of non-deployable ranks was significant based on unit type. The combat support and combat service support respondents felt greater impact of Soldiers in the ranks of private through specialist on mission accomplishment; specifically those personnel with low density military occupational specialties (MOS). Our combat arms brethren felt a substantial impact to mission accomplishment when noncommissioned officers were categorized as non-deployable for both mission accomplishment and overall morale and cohesion to the unit.

Question 6: Best Practices

There were several suggestions and recommendations for best practices and implementation across the Army. A large number of the recommendations stayed

consistent with the themes in the answers provided above. This section will briefly outline those recommendations.

1. Contract medical and dental services. In many instances the military treatment and dental facilities become overwhelmed with the number of Soldiers requiring short notice or no notice appointments. Provide both facilities with the authorization to refer deploying Soldiers to civilian providers to avoid the backlog. Or provide the authorization for non-deploying Soldiers to use civilian providers with the same goal.

2. A comprehensive understanding of the MOS Medical Retention Board (MEB)/Physical Evaluation Board (PEB) processes and the tools for execution of both systems. Overall, senior leaders lacked a thorough understanding of the MMRB/PEB processes. They believe the system is too cumbersome and has several layers where individual Soldiers may become “stuck” in the system.

Overwhelmingly senior leaders believe that Soldiers in the MMRB/PEB process use this system to remain in the Army and avoid deployment. They recommend training for junior leaders and some type of electronic means to communicate with MEDCOM to ask specific questions.

3. Several senior leaders reiterated the importance of standing up the rear detachment as early as possible as a best practice. Those leaders who activated a rear detachment 6 – 8 months prior to deployment were able to take advantage of training offered to rear detachment leaderships and were able to transition much more seamlessly. One installation has developed a Rear Detachment University that requires certification of its rear detachment commanders and noncommissioned officers. Also mentioned in this section of the discussion was the importance of

bringing in key players like the Chaplain and the FRSA to get a feeling for the issues surfaced by Family members and Soldiers in deploying units.

4. Augmentation of medical and legal professionals early in the deployment cycle.

Having these personnel embedded in the brigade staff proved invaluable in preparing units for deployment. Senior leaders were better able to track individual deployment status when they had either dedicated medical contacts in the military treatment facilities or medical personnel augmenting their staffs. All agreed that beginning to track medical readiness based on information provided through MEDPROS or at the SRP site were inadequate and most times inaccurate. With regard to the legal staff augmentation, senior leaders stated that having additional legal support would enable commanders to discharge Soldiers and receive replacements early enough to incorporate them into mandatory pre-deployment training requirements.

APPENDIX B - Impact of Changes to the Non-Deployable Population on the Warrior Transition Program and the Warrior Transition Units

Issues:

1. Evaluate the criteria for admittance into the Warrior Transition Program and Warrior Transition Units.
2. Evaluate potential impacts on policies affecting the length of stay of Soldiers in the Warrior Transition program to the Warrior Transition Units.

Discussion:

In 2007, the Army transformed the way it provides care, services and support to wounded, ill, or injured (WII) Soldiers while serving on active duty (Code of Federal Regulations (CFR) Title 10 status). The Army transitioned the Army Medical Action Plan team into the Warrior Care and Transition Office (WCTO). Concurrently, Army installations improved services and dedicated additional staff to providing medical treatment to increasing numbers of WII Soldiers. On 15 June 2007, WCTO established Warrior Transition Units (WTUs) to bring military-style structure to the recovery process and consolidate wounded Soldiers into units where Soldiers main mission is to heal. Soldiers assigned to the WTU were labeled Warriors in Transition.

The WTUs and associated new concept of Warriors in Transition remain the centerpiece of the system. The Army created WTUs to replace the medical-hold/medical-holdover model used throughout the Army's history. Instead of being assigned to a holding unit of the local garrison while receiving treatment in a MEDCOM facility, active duty and reserve component Soldier outpatients are now assigned to a WTU under one MEDCOM chain of command. Warriors in Transition have the following duties: (1) Work as hard to heal as they work on defending freedom and (2) Follow the

instructions of their “Triad of Care”: physician, nurse case manager, and squad leader of the Warrior Transition Unit.

To manage the Warrior Care and Transition Program, the Army established the Warrior Care and Transition Office (WCTO), now the Warrior Transition Command. WCTO’s mission is to support the Army’s Warrior Ethos tenet: “I will never leave a fallen comrade.”

Historically, combat wounded do not contribute greatly to the overall Wounded Warrior population. From 2007 to 2009, the Center for Army Analysis calculated

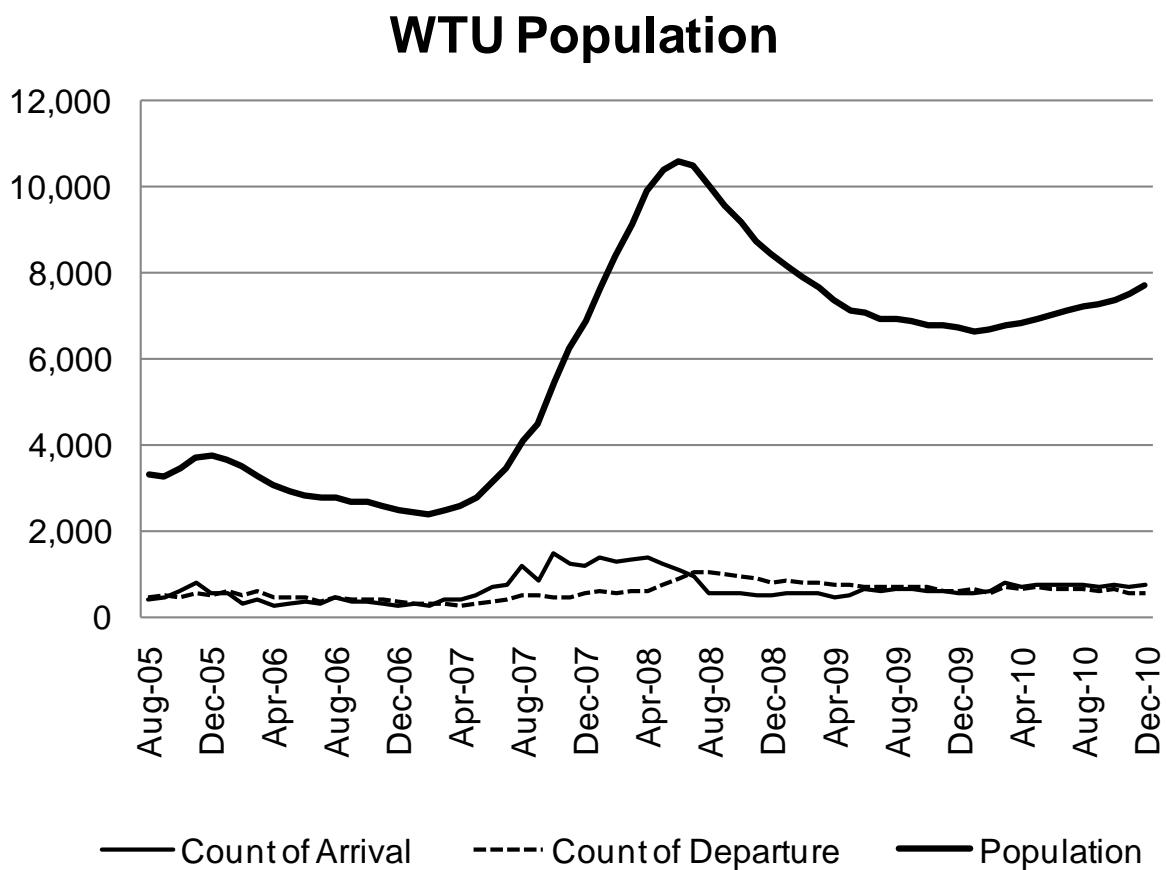


Figure 1. Overall CONUS Medical Hold/WTU Population (August 2005 to December 2010).

that approximately 15% of the WTU population consisted of wounded Soldiers.¹²⁰

Figure 1 on the previous page highlights the overall population of Warrior Transition Units (WTU) in the continental United States over a four year period. Note the increase in 2007 and 2008, the decline from 2008 to about 8000 Soldiers by the middle of 2009, and then the gradual increase through 2010. The primary reason for the increase centers on Soldier arrivals and the changing criteria for entering the Warrior in Transition program.

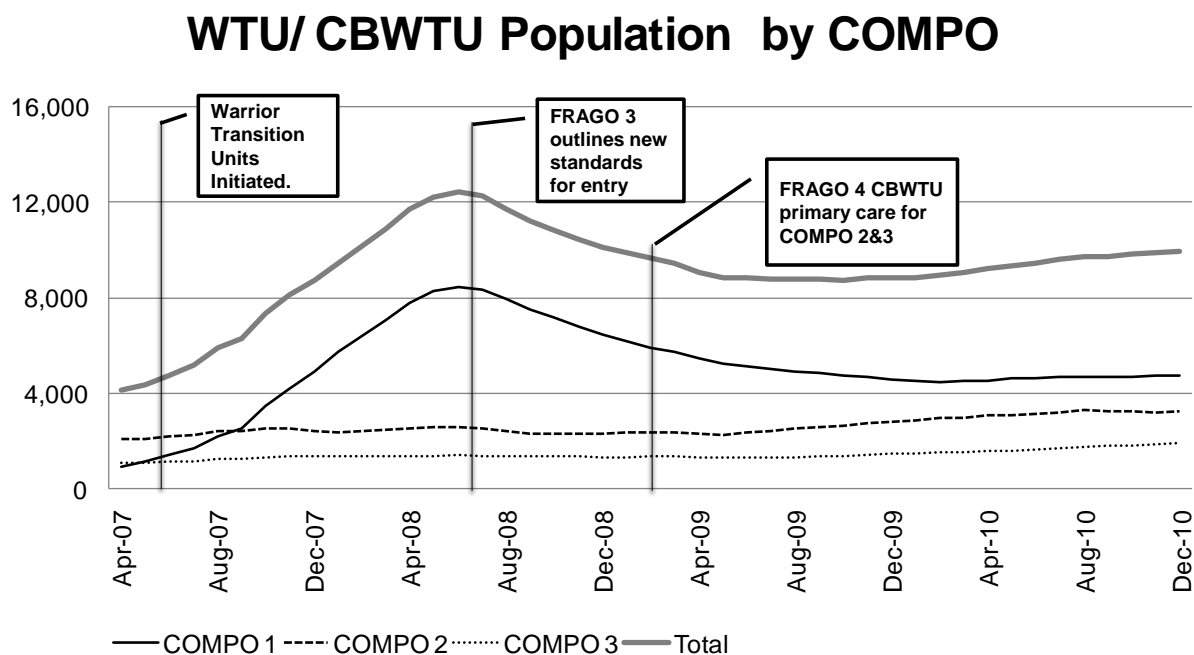


Figure 2. Overall WTU Populations by COMPO (April 2007 to August 2009).

Figure 2 identifies when the major changes in the WTU populations occurred and why. Data prior to the establishment of the WTU correspond to the medical hold populations in various locations across CONUS, to include ones that were community based. Initially, criteria for entry into the program allowed many Soldiers to go to the WTU even though their medical situation did not require major medical treatment or

rehabilitation. Given the high ratio of WT to caregivers, this situation placed a strain on the overall Warrior in Transition program.

Once the Army enacted FRAGO 3 (requiring “complex medical condition” criteria be met),¹²¹ the arrivals dropped significantly. FRAGO 4 adjusted the entry criteria and encouraged reserve component Soldiers to opt for the community-based WTU program. As seen in Figure 1, the arrival and departure rates did not change significantly but Figure 2 indicates a steady increase in the WTU populations for COMPO 2 and COMPO 3 categories.¹²² Since the scope of the overall non-deployable study focuses on COMPO 1, this annex will provide a detailed examination of this population in the next few paragraphs.

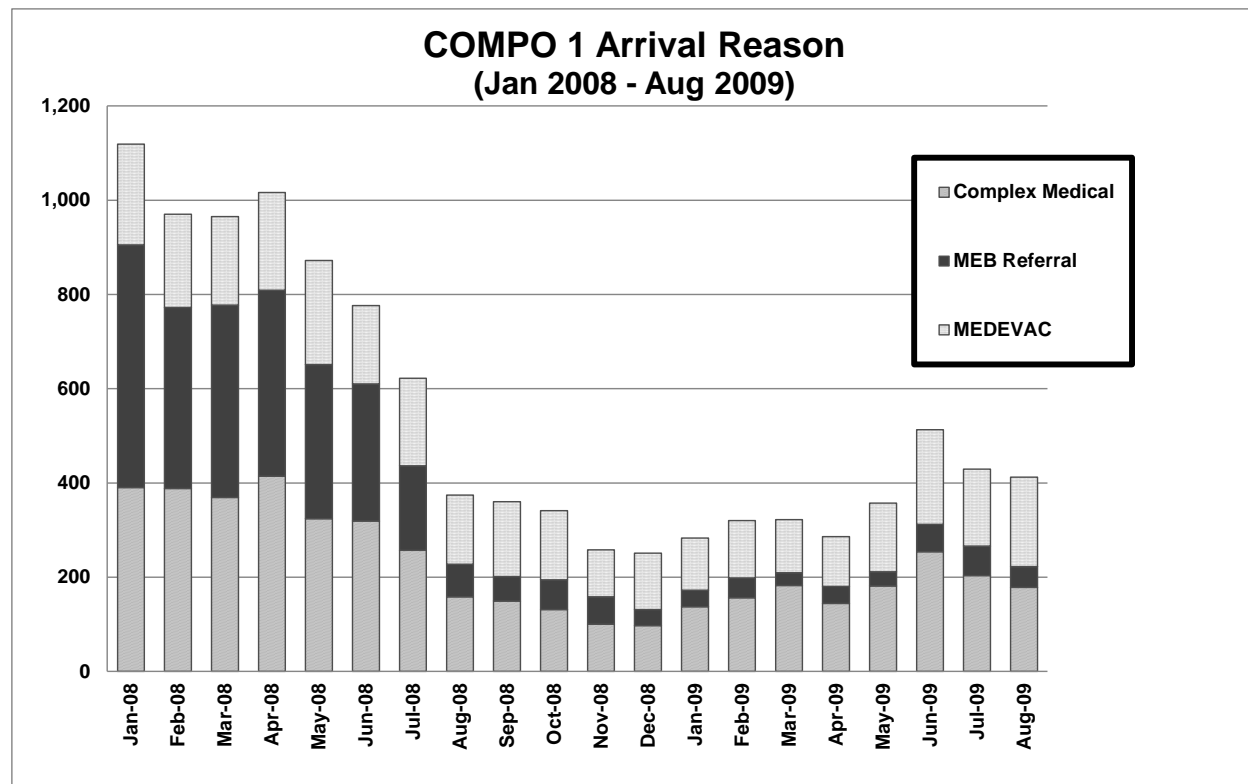


Figure 3. COMPO 1 Arrival Categories.

Figure 3 highlights the various categories by which Soldiers were assigned to the WTU. CAA analysis noted that the Medical Evaluation Board (MEB) referrals demonstrated a major increase from the summer of 2007 through the middle of 2008. According to the study report, this was due to an effort to bring to WTUs old MEB cases that would be handled more efficiently by that process. The drop in MEB referrals beginning in July 2008 corresponds to FRAGO 3 implementation. If FRAGO 3 criteria were rescinded, then a probable outcome would be a return to MEB arrival rates observed in the first half of 2008. Reviews of more recent data indicate that the mix seen in 2009 has continued into 2010. Figure 4 below shows that the overall population of arrivals has not changed in that time period. Figure 4 also shows the same impacts of FRAGO 3 seen in the earlier charts.

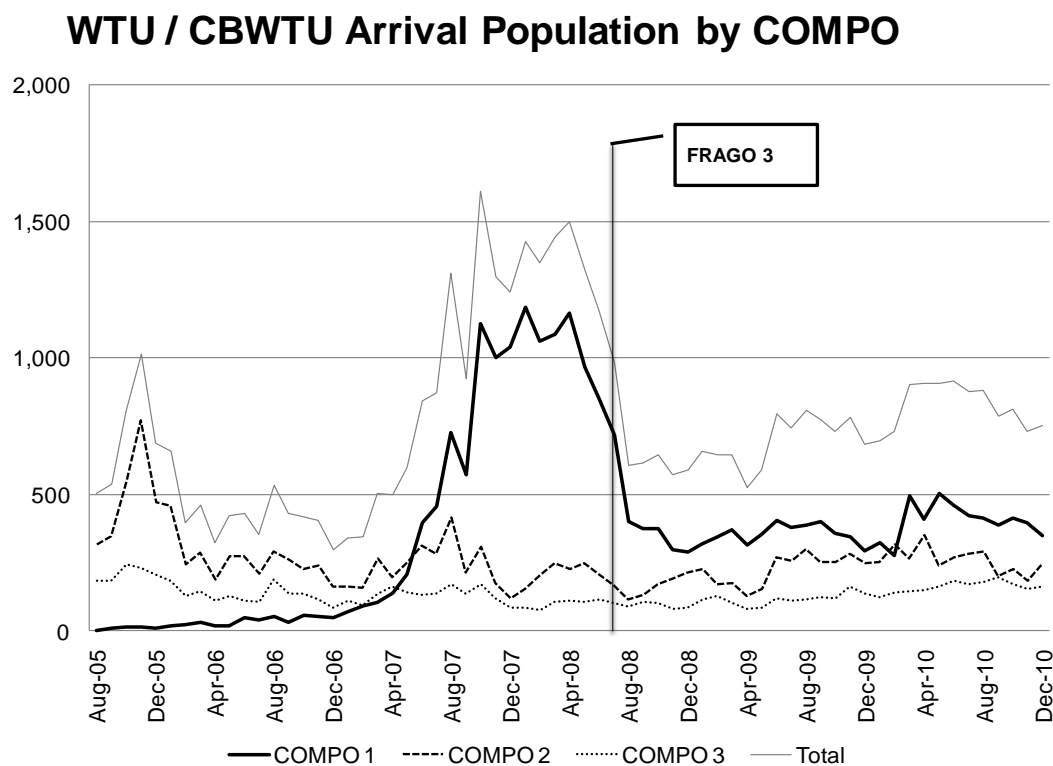


Figure 4. Arrival Population by COMPO.

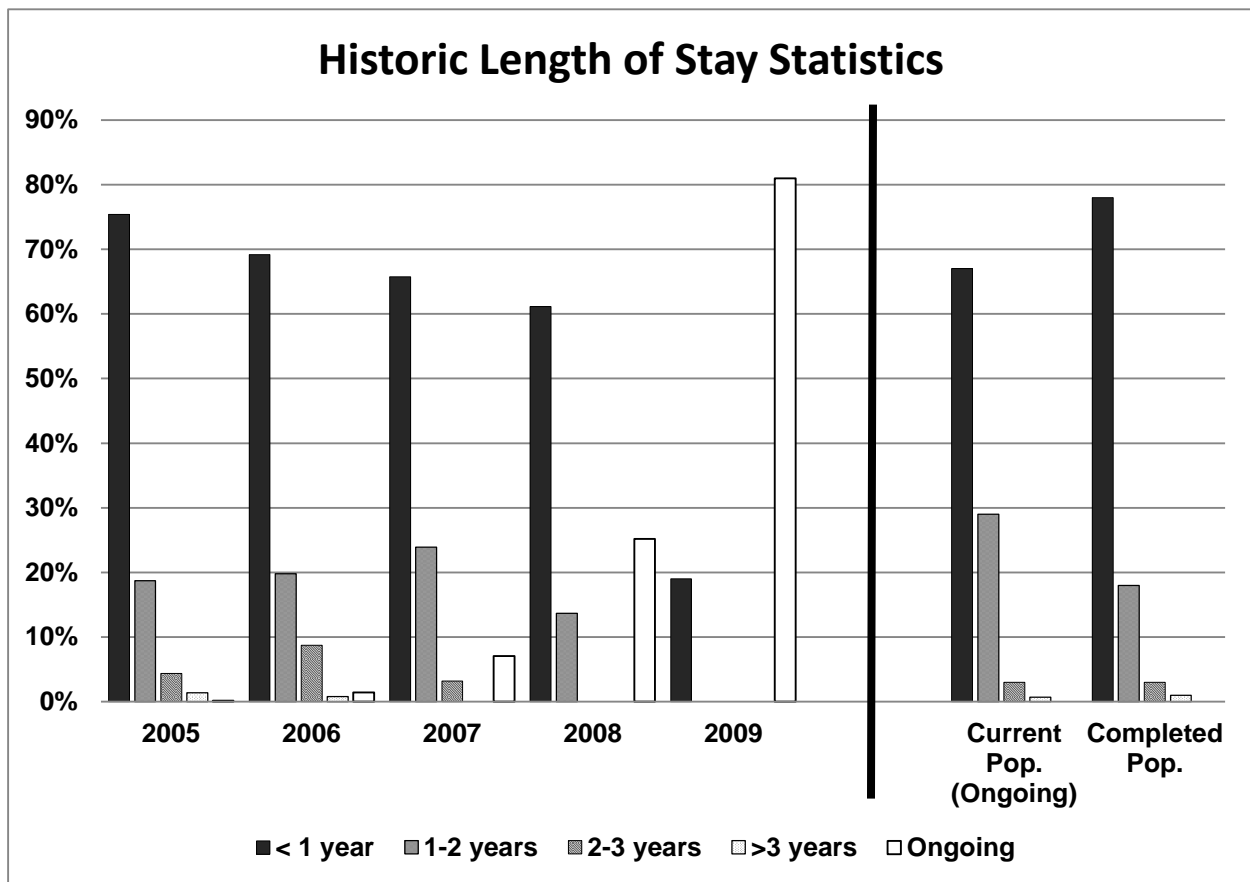


Figure 5. Length of Stay for Soldiers in WTU (Percentage).

The Center for Army Analysis and the Warrior Transition Command calculated the length of stay for Warriors in Transition for the years 2006 through 2009, with the current population shown as of the fall of 2009. The “Ongoing” category shows the Warriors in Transition that were still in WTUs for that year group. As can be seen on the chart, the trend indicates that most Soldiers in WTUs depart after 2 years or less. However, recent inspections indicate that more Soldiers may be staying longer, and a major factor could be the “discovery” of other medical conditions once an individual

enters into the Warrior in Transition program. This long-term population often does not return to duty in the Army and may be better candidates for long-term care in the VA system.¹²³

Early in 2011, the Center for Army Analysis performed some additional work to see what may be the potential impact on the WTUs given policy changes concerning medical non-deployable Soldiers. The overall parameters of this analysis capture the transfer of Soldiers from the WTUs into the VA system after a period of time. The analysis also examined the impact of moving permanent non-deployable Soldiers into the WTUs for processing.

WTU Population Forecast (COMPO 1)

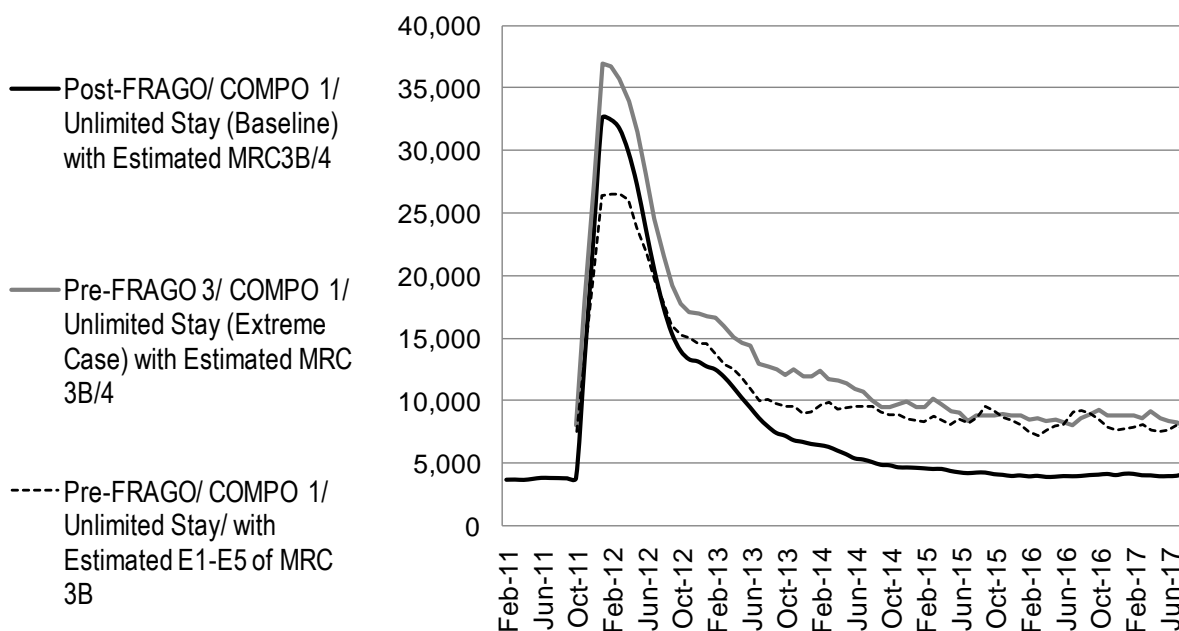


Figure 6. Warrior Transition Command Entry Policy Example (Extreme Cases Shown).

Figure 6 shows an example of what a major policy change can do to the system.

As shown in the figure, a policy to allow commanders to send non-deployable Soldiers to the WTU will create an initial surge. The actual size of that surge depends on the policy—the ones shown moves sets of non-deployable Soldiers with MEB Category 3B into the WTUs¹²⁴ within a 3 month period and represents extreme cases. As the WTU processes the soldiers out over time, an eventual equilibrium is achieved based on entry criteria and length of stay (two alternatives are shown from historical data). Note that an unlimited length of stay looks similar to the historical ones seen earlier. What is not shown is how a change of policy may also change the COMPO 2 and COMPO 3 populations.

Impact of Possible VA Transfer Policy on WTU

Length of Stay	Steady-State Population Estimate (including All COMPOs)	
	Min.	Max.
Unlimited	6,100	7,600
18 months	5,000	6,300
12 months	4,000	5,250

NOTE:

Figures in table are estimated WT population in WTU.
WT population in CBWTU not included.

Figure 7. Potential Impact of VA Transfer Policy on Warrior Transition Units.

Figure 7 highlights the impact of a different policy change. Currently, the Army and the Department of Veterans Affairs (VA) are working on a policy to move permanent medical non-deployable Soldier from Army care to VA care after a period of

time. Since such a policy would also apply to the Wounded Warrior population, the Center for Army Analysis conducted a series of “what-if” scenarios using available data to scope the impact of such a change. As Figure 7 shows, a reduction of the population of up to 30% could be done if all Soldiers with a permanent non-deployable medical condition were moved.

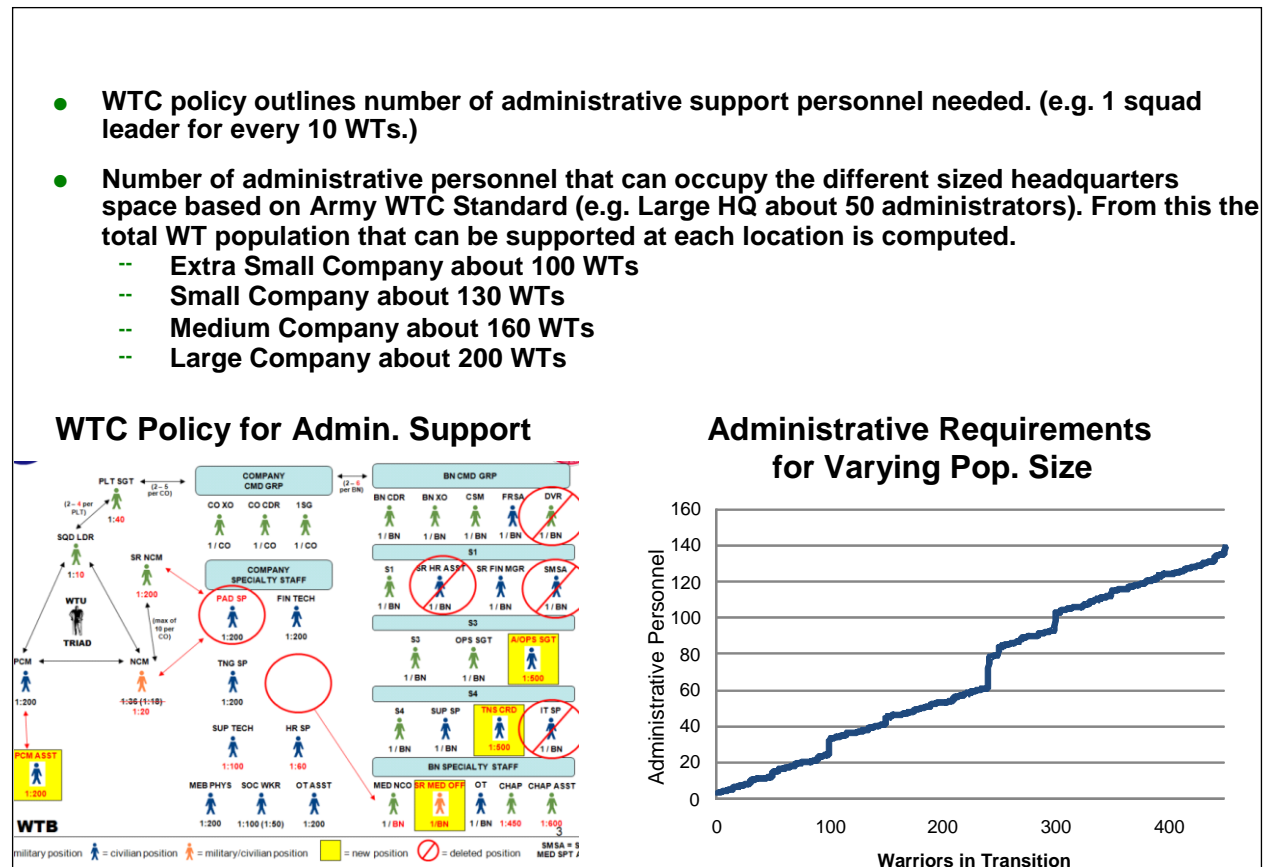


Figure 8. Warrior Transition Command Manning Policy.

Figure 8 provides insights into the personnel impact of establishing and running WTUs. As shown in the charts, the combination of squad leaders, higher leaders, care givers and administrative requirements results in a ratio of approximately one support/leader person for every four Warriors in Transition. Such a ratio makes sense if

“complex medical treatment” provides the standard for entry into the Warrior Transition program.

Recommendations: This appendix proposes no recommendations. The rationale for this approach centers on the fact that policy changes impact how the Warrior Transition Command executes its mission. In other words, Army decisions impact WTU populations, manning, and resourcing but the WTU does not put forth policy for the Army. However, the project can provide insights in the form of conclusions. Some basic conclusions and insights include the following:

1. The focus of the Warrior Transition programs centers on treating Soldiers with complex medical conditions or traumatic combat injuries. The design of the Warrior Transition Unit reflects the manpower-intensive demands such injuries and conditions place on the treatment processes. Therefore, any change of criteria for entry or change in numbers of injuries and medical conditions under current criteria greatly impact the overall number of support personnel needed for the Warrior Transition Units.
2. Any policy change resulting in the moving of medically non-deployable Soldiers from operational and institutional Army units to the WTUs will cause an initial surge followed by an eventual transition to a steady-state condition (until the next policy change). If policy implementation is not carefully crafted, the surge will overwhelm the WTU system and may cause a major strain on the overall medical care system.
3. A change in policy moving permanent medical non-deployable Soldiers from the Army to the VA within a timeline directly impacts the WTU

unless the policy excludes them (or modifies implementation). With a 12 to 18 month transition timeline, significant population drops in the WTU can be expected.

4. In all these cases, the analysis provides a parametric estimate on policy impacts. The numbers should not be taken as absolutes. If the Army intends to implement policy changes, more detailed analysis should be performed so that these estimates can be refined for decision-makers to use.

5. A focus on changing criteria that allows active component non-deployable Soldiers into the Warrior Transition program also ripples into the reserve component Soldiers serving full-time.

APPENDIX C – Glossary

SECTION 1 – TERMS

End Strength

The count of Army military positions the Army needs to have funded in each year of the Future Years Defense Program (FYDP) to accomplish all approved missions. End strength provides the basis for funded man-years within the personnel system, and provides the target for personnel plans, programs, and budgets. End strength is a resource provided to support approved force structure, programs, or missions. End strength changes do not drive force structure or mission changes; they are tied to programmatic increases and decreases in force structure or mission. FYDP end strength is allocated to commands by program element code and category.

Medical Readiness Classifications

AR 40–501 governs medical fitness standards, physical profiles, and medical examinations. Soldiers evaluated under the medical fitness standards contained in AR 40–501 are categorized by MEDPROS into one of four Medical Readiness Classifications. Soldiers who meet all medical requirements are Medical Readiness Class 1 (MR1) and Soldiers who have deficiencies that are correctable within 72 hours during final Soldier Readiness Programs are Medical Readiness Class 2 (MR2) will be considered available for deployment. Soldiers who have not completed the formal examinations required by AR 40–501 Medical Readiness Class 4 (MR4) also will be reported as available for deployment (AR 220-1) purposes, unless an appropriate medical or dental official has examined the Soldier and specified in writing that the Soldier should not be deployed with the unit. Reporting MR Class 4 Soldiers as available does not allow the commander to deploy these Soldiers before they have completed the required medical and dental examinations. Soldiers who have medical issues that will require longer than 72 hours resolving Medical Readiness Class 3A and 3B (MR3A and MR3B) will be reported as not available. (See appendix 1 for full definition of Medical Readiness Classifications according to AR 40-501)

Medically Not Ready

Medically Not Ready refers to those Soldiers with a medical condition that prevents deployment on the unit's deployment timeline. These Soldiers, with the required treatment, may subsequently deploy as follow on personnel. Typical conditions might include pregnancy or the prescription of a behavioral health medication within 90 days of LAD.

Medically Non Deployable

A Soldier designated as Medically Non Deployable has a medical condition, which either by theater-specific requirements or medical recommendation makes his/her non-deployable. This Soldier will not deploy with the unit or follow the flow of forces into a combat theater. Soldiers are recommended for this status by a medical provider, but ultimately medically non-deployable because they do not meet the deployment criteria as established in AR 40-501.

Medical Retention Determination Point (MRDP)

A service member with one or more conditions failing to meet medical retention standards will be referred into the DES by competent medical authority at the point of hospitalization or treatment when the member's progress appears to have medically stabilized, the course of further recovery is relatively predictable, and where it can be reasonably determined that further treatment will not cause the member to meet medical retention standards or render them capable of performing the duties required of their office, grade, rank, or rating. This MRDP will be made within 1 year of being diagnosed with a medical condition(s) that does not appear to meet medical retention standards, but may be earlier if the examiner determines that the member will not be capable of returning to duty within 1 year. Extensions for medical retention determinations requiring more than one year require approval by the Senior MTF Physician approving authority. Conditions discovered after identification of the initial medically disqualifying condition shall not delay referral into the DES, unless it is a condition which must be addressed and documented fully in order to be adjudicated by a PEB.

Non-deployable Soldier

A Soldier who because of a temporary or permanent condition fails to meet prescribed deployment criteria. See AR 614-30, Overseas Service, 30 March 2010, and Department of the Army Personnel Policy Guidance for Overseas Contingency Operations, 14 July 2010 (updated biannually).

SECTION 2 – ABBREVIATIONS

AFQT	Armed Forces Qualification Test
AHRC	Army Human Resources Command
AKO	Army Knowledge Online
ALARACT	All Army Activity
AR	Army Regulation
ARFORGEN	Army Force Generation
ARNG	Army National Guard
AWOL	Absent Without Leave
BCT	Brigade Combat Team
CENTCOM	United States Central Command
CSA	Chief of Staff of the Army
DA	Department of the Army
DAIG	Department of the Army Inspector General
DEIP	Deployment Extension Incentive Program
DES	Disability Evaluation System
DOD	Department of Defense
DODI	Department of Defense Instruction
ETS	Expiration of Term of Service
EMILPO	Electronic Military Personnel Office
EMR	Electronic Medical Record
FORSCOM	United States Army Forces Command
GCMCA	General Court Martial Convening Authority

HQDA	Headquarters Department of the Army
IDES	Integrated Disability Evaluation System
LAD	Latest Arrival Date
LOE	Line of Effort
MEB	Medical Evaluation Board
MEDPROS	Medical Protection System
MFE	Maneuver, Fires, and Effects
MILPER	Military Personnel [message]
MMC	Medical Management Centers
MMRB	MOS/Medical Retention Board
MNR	Medically Not Ready
MRC	Medical Readiness Code
MRDP	Medial Retention Decision Point
MTF	Medical Treatment Facility
NARSUM	Narrative Summary
NDAA	National Defense Authorization Act
OF/FS	Operational Support and Force Sustainment
OTH	Other Than Honorable
OTSG	Office of the Surgeon General
PDCAPS	Physical Disability Computer Assisted Processing
PDES	Physical Disability Evaluation System
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer

PHA	Periodic Health Assessment
PPG	Personnel Policy Guidance
PTS	Post Traumatic Stress
PULHES	Physical capacity/stamina, Upper extremities, Lower extremities, Hearing/ear, Eyes, Psychiatric
QDR	Quadrennial Defense Review
SMRCP	Soldier Medical Readiness Campaign Plan
SPCMCA	Special Court-Martial Convening Authority
SRP	Strategic Research Project
SRP	Soldier Readiness Processing
TBI	Traumatic Brain Injury
TDA	Table of Distribution and Allowances
TDRL	Temporary Disability Retired List
TF	Task Force
TOE	Table of Organization and Equipment
TRADOC	United States Army Training and Doctrine Command
TSIRT	Theater Specific Individual Readiness Training
TTHS	Trainees, Transients, Holdees and Students
UCMJ	Uniform Code of Military Justice
USAPDA	United States Army Physical Disability Agency
USAR	United States Army Reserves
USAWC	United States Army War College
USC	United States Code
USR	Unit Status Report

USAPDA	United States Army Physical Disability Agency
VA	Department of Veterans Affairs
WEB-AEFES	WEB AMEDD Electronic Forms Support System
WII	Wounded, Ill, and Injured
WTU	Warrior Transition Unit

Endnotes

¹ LAD, or Latest Arrival Date, refers to the latest date at which a deploying unit can arrive at the port of debarkation for its deployment, Joint Publication 1-02, Department of Defense Dictionary of Military and Associated Terms, 12 April 2001, as amended through 30 September 2010.

² The Army G-1 asked the United States Army War College (USAWC), with support from the Army staff, to research ways to reduce the number of non-deployable Soldiers. Since the formulation of the Study Group in August 2010, the Army has implemented several changes in policy and practices to gain a better visibility of, and effect a reduction in, the number of non-deployable Soldiers, including the implementation of eProfile, an electronic physical profile system to enable commander visibility of profiles.

³ eMILPO data as of 19 January 20, the excel spreadsheet shows the number of non-availables (including all History values). This data display summary of Soldiers by Rank and Gender, with history of Non-Available Status and Reasons. SOURCE: COL Debra Hanneman; Chief, Field Service Division, Army Human Resources Command (AHRC). Details on data-- Retrieved Non-Available Status and Reason codes according to current G-1 specifications of 'Non-Available' from eMILPO table view DEPLOY; Filtered first for active records, RECSTA= 7,8,G; Filtered for Non-Available status categories: NAP- all reasons, NAT-all reasons, and MRC= 3A and 3B; Counting values from whole history table regardless of start and end dates; same Soldier is counted for each entry populated and stored; Summary cross-tab of counts by Gender, Rank, Service Component, and Non-Available Status and Reasons.

⁴ Ibid

⁵ Ibid

⁶ As defined by Joint Publication 1-02, Department of Defense Dictionary of Military and Associated Terms, 12 April 2001, as amended through 30 September 2010, a brigade combat team (BCT) is a combined arms team which forms the basic building block of the Army's tactical formations. BCTs are the principal means of executing engagements. Three standardized brigade combat teams designs exist: heavy, infantry, and Stryker. Battalion-sized maneuver, fires, reconnaissance, and sustainment units are organic to a brigade combat team. For information on BCTs, see Army Field Manual 3-90.6, Brigade Combat Teams, Headquarters, Department of the Army, September 2010.

⁷ U.S. Army Public Affairs, The Pentagon, Fort Hood Fact Sheet No. 0715 3 March 2010, Army Soldiers Who Are Non-Deployable, (Source: US Army figures and senior leaders quotes in USA Today article of 3 MAR 10, "Army Sees Sharp Rise In Unfit Soldiers") <http://www.hood.army.mil/facts/FS%200715%20-%20Non-Deployables.pdf> (accessed OCT 28, 2010)

⁸ C. Todd Lopez, " Officials: 1 in 5 Undeployable by 2012", WASHINGTON (Army News Service, Nov. 4, 2010) <http://www.military.com/news/article/army-news/officials-1-in-5-undeployable-by-2012.html?col=1186032310810> (accessed Nov 4, 2010)

⁹ Deputy Chief of Staff G-1, United States Army, " Non-Deployable Campaign Plan" briefing slides, Army G-1, Pentagon Washington D.C., Oct 10, 2010.

¹⁰ Ibid

¹¹ FORSCOM Surgeon Brief on Medical non-deployable study in FORSCOM IG Brief given to USAWC non-deployable Study Group. Oct 2010.

¹² Deputy Chief of Staff G-1, United States Army, " Non-Deployable Campaign Plan" briefing slides, Army G-1, Pentagon Washington D.C., Oct 10, 2010

¹³ Army Regulation 40-501 Standards of Medical Fitness, Chapter 7, Physical Profiling, August 23, 2010.

¹⁴ Ibid

¹⁵ Ibid

¹⁶ Ibid

¹⁷ Ibid

¹⁸ Some key publications the Study Group reviewed included: LTC John Sena's *US Army War College Strategic Research Project - Non-Deployables*; *U.S. Army Forces Command Inspector General Inspection Report of Medically Non-Deployables*; General (retired) Franks' *Physical Evaluation Board (PEB)/Medical Evaluation Board (MEB) Process Study*; the Rand 1998 study titled *Deployability in Peacetime*; Chief Staff of Army Task Force on Manning Final Report – Manning the Force during an Era of Persistent Conflict and the Department of the Army Inspector General Agency Inspection of the Warrior Care and Transition Program.

¹⁹ AR 600–8–101 defines Soldier Readiness Program (SRP) requirements:

a. Maintaining individual preparedness for deployment is the basic concept of the SRP; therefore, Active Army soldiers, Army National Guard soldiers in units, and Army Reserve soldiers in troop program units will undergo an annual SRP check as specified in this chapter. An SRP check will be performed annually on RC soldiers who are not in units or whenever they serve on active duty if their active duty service is less often than once per year.

b. The SRP has two levels of readiness:

(1) Level 1 is the state of readiness that should be maintained at all times.

(2) Level 2 applies only in cases of individual TCS moves and unit deployments in support of a contingency when the home station is not the deployment station and is the state of readiness that must be achieved after the soldier has been alerted but before departure from the home station. Level 2 requirements include all of those of Level 1 plus some items that must be done at the home station (that is, those that cannot be done at the deployment station) but cannot be done until after the soldier has been alerted.

c. The SRP requires commanders to maximize soldier readiness by identifying and correcting non-deployable conditions. Personnel processing requirements include checking the status of individual soldier readiness during in-processing, at least once annually, during out-processing, and within 30 days before an actual unit deployment date or the date an individual soldier departs on a TCS move.

²⁰ In 2006, the Army established a rotational readiness model, called Army Force Generation (ARFORGEN), which is designed to effectively and efficiently generate trained and

ready forces for combatant commanders at sustainable rotational levels. It is also designed to provide ready contingency forces. ARFORGEN ensures that every deploying unit is the best led, trained, and equipped force possible prior to mission execution. It is a structured process generating Active Component (AC) and Reserve Components (RC) forces that progressively increases unit readiness over time. Operational requirements focus the ARFORGEN process to prioritize and synchronize institutional functions (recruit, organize, man, equip, train, sustain, mobilize, and deploy). ARFORGEN is a dynamic, cyclic process where the coordination of schedules, resources, and readiness assessments are critical to producing capabilities to meet Joint mission requirements.

²¹ Sources are Rear Detachment Reports submitted to the Army G-1 (data provided through October 15, 2010).

²² National Defense Authorization Act for Fiscal Year 2010, Public Law 111-84, (October 28, 2009), section 403; Ike Skelton National Defense Authorization Act for Fiscal Year 2011, Public Law 111-383, (January 7, 2011), section 401.,

²³ Authorizations—USAFMSA, Army G-1 and Army G-3; On-hand strength as of August 2010 (Army G-1). Legislated—NDAA 2010 and 2011.

²⁴ These reasons fall into the following categories: (1) initial entry enlisted trainees, (2) officer accession students, (3) Soldiers executing change of station moves, (4) USMA cadets, (5) students en route under permanent change of station (PCS) and temporary duty (TDY) orders, and (6) military personnel classified as holdees (prisoners, separatees, controlees, and patients). In almost all these cases, there are not specific authorization documents for the TTHS personnel. They are managed in various personnel accounts under the Army G-1 and the Human Resources Command.

²⁵ U.S. Army War College, *How the Army Runs: A Senior Leader Reference Handbook*, 2009-2010, 27th ed. (Carlisle Barracks, PA: U.S. Army War College, 2009), 307. The Army has one additional category of personnel that is not reflected in Table 1. Currently, the Army uses an Individual Augmentation Management System (IAMS) “to meet combatant command and Army service component command temporary individual augmentation requirements in support of National Command Authorities (NCA) directed operations.” Army personnel commonly refer to the individual augmentation positions and their associated request for a person as a “WIAS tasker.” WIAS is the acronym for the automated system that manages the positions and their status (Worldwide Individual Augmentation System). The personnel filling these positions often come from the institutional Army and the United States Army Reserve. For purposes of managing the Active Army end strength, these positions do not figure into the overall end strength due to their temporary status, and word “personnel” covers both military and civilian categories; both are eligible for the program. Department of the Army, *DA Pam 500-5-1, Individual Augmentation Management* (Washington, DC: Headquarters Department of the Army, December 2001), 1.

²⁶ U.S. Army Chief of Staff George W. Casey, Jr., memorandum on manning priorities and strategy for the Army through Fiscal Year 2011, Washington, DC, December 17, 2010.

²⁷ Ibid.

²⁸ The 2009 U.S. Army Posture Statement notes “ARFORGEN rotation planning goals are reflected in ratios. For deploying AC units, the ratio is the amount of time deployed or Boots on the Ground (BOG) time to the amount of time not deployed or Dwell time. The ratio is referred to as BOG:Dwell. For deploying RC units, the ratio is measured as time mobilized to time not mobilized (Mob:Demob). The Army’s rotation planning goals while in steady-state and surge security postures for AC and RC are shown below:

AC Rotation Goal--Steady State is 1:3 (Example: 9 months deployed and 27 months training in a 3 year cycle)

AC Rotation Goal—Surge is 1:2 (Example: 1 year deployed and 2 years training in a 3 year cycle)

RC Rotation Goal—Steady State is 1:5 (Example: 1 year mobilized and 5 years demobilized in a 6 year cycle)

RC Rotation Goal—Surge is 1:4 (Example: 1 year mobilized and 4 years demobilized in a 5 year cycle)

The demand for forces directly influences the length of both BOG and Dwell. These surge and steady-state planning goals highlight the flexibility of the ARFORGEN process and its ability to respond to demand.” Headquarters, Department of the Army, *2009 U. S. Army Posture Statement* (Washington, DC: U.S. Department of the Army, May 7, 2009), http://www.army.mil/aps/09/addenda/addenda_e.html (accessed February 19, 2011).

²⁹ The three categories noted in Table 1 account for all the Soldiers in the active force. In any given fiscal year, these three categories work interactively. If the Army designs an operational force that is too large, then the actual manning levels may fall short of ARFORGEN manning levels in the operational force, or the personnel may come from one of the other two sources, or both. If the Army underestimates the size of the TTHS account (most likely in the holdees category), then the leadership will face hard choices in providing enough soldiers to man both the operational force and the institutional force.

³⁰ Numbers were developed by applying the 22,000 reduction evenly across each category, then using MTOE authorizations from the United States Army Force Management Support Agency’s website. *United States Army Force Management Support Agency Home Page*, <https://webtaads.belvoir.army.mil/unprotected/splash/welcome.asp> (accessed January 31, 2011).

³¹ Data on other categories depend on reports from deploying units to the Army G-1 and the Army Human Resources Command; they do not provide a comprehensive picture of the entire Army.

³² Source is the Army G-1; specific data was developed in January 2011. Note that these Soldiers can be assigned anywhere in the Army, so a breakdown by category cannot be accomplished at this time.

³³ A Soldier with a condition that can be corrected within 30 days can be eligible for assignment to a deploying unit if the report date is earlier than 90 days prior to the unit’s scheduled deployment or if after the unit’s redeployment, as stated in the Chief of Staff of the

Army HQDA Active Component Manning Guidance for Fiscal Year 2011. Soldiers classified as Medical Readiness Class 3B (MR3B) are longer-term non-deployable personnel that probably would need to be reassigned under this policy. A Soldier qualifies as a MR3B if one of the following criteria are met: (1) medical requirements will take more than 30 days to correct, (2) deficiencies may include temporary profiles exceeding 30 days, and P3 or P4 profiles that require completion of a MMRB. (If the Soldier does not meet medical retention standards, Soldier requires a MEB.), (3) Soldiers who are pregnant, (4) Soldiers who are hospitalized (absent sick status), (5) Soldiers found "Unfit" but continued in COAD status, and (6) Soldiers are categorized as "Red" in MEDPROS.

³⁴ Casey memorandum on manning priorities.

³⁵ Source is the Army G-1; specific data was developed in January and February of 2011.

³⁶ In this case, the Army has defined "combat effectiveness" as a minimum deployed strength of 95% of authorized personnel. Casey memorandum on manning priorities.

³⁷ "Non-Deployer Population & The Medical Deployment Process," draft pre-decisional briefing slides, Human Capital Enterprise, 2010.

³⁸ AR 40-501 defines Medically Not Ready (MNR) as Soldiers with deployment limiting medical conditions. Soldiers who will not deploy with the unit for various medical reasons will be considered *medically not ready* and categorized as "Red" in MEDPROS. This definition is different than the Personnel Policy Guidance which uses the term *non-deployable* or AR200-1 which uses the term *not available*. All three terms mean a Soldier may not deploy without a waiver or their status changes.

³⁹ Temporary profiles. Soldiers receiving medical or surgical care or recovering from illness, injury, or surgery, will be managed with temporary physical profiles until they reach the point in their evaluation, recovery, or rehabilitation where the profiling officer determines that MRDP has been achieved but no longer than 12 months. A temporary profile is given if the condition is considered temporary, the correction or treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. Soldiers on active duty and RC Soldiers not on active duty with a temporary profile will be medically evaluated at least once every 3 months at which time the profile may be extended for a maximum of 6 months from the initial profile start date by the profiling officer.

⁴⁰ Anne L. Naclerio, "Medical Readiness Update AMSUS Army Physician Section," briefing slides with scripted commentary, Washington D.C. OTSG, November 2, 2010.

⁴¹ Brian Lein, FORSCOM Surgeon Brief on Medical non-deployable study in FORSCOM IG Brief given to USAWC non-deployable Study Group. Oct 2010.

⁴² Ibid.

⁴³ Ibid

⁴⁴ After evaluating the Soldier in the 9 required elements of Individual Medical Readiness, the Soldier will be categorized by MEDPROS into one of four medical readiness categories:

a. Medical Readiness Class 1 (MR1)

- (1) All medical requirements met.
- (2) Soldier is fully medically ready in all elements.
- (3) Optical devices ordered.
- (4) Soldiers categorized as “Green” in MEDPROS.

b. Medical Readiness Class 2 (MR2)

- (1) Medically ready within 72 hours (any deficiencies correctable during final Soldier Readiness Program (SRP)).
- (2) Deficiencies may include immunizations, Dental Class 2 conditions, lack of medical warning tags, need HIV or DNA lab tests, or optical prescription on file but eye equipment not ordered.
- (3) Soldiers categorized as “Green” in MEDPROS.

c. Medical Readiness Class 3A (MR3A)

- (1) Medically ready within 30 days.
- (2) Deficiency may include Dental Class 3.
- (3) This time frame allows for the medical treatment of abnormal screening tests.
- (4) Includes deficiencies that are resourced through Transition Assistance Management Program (TAMP) for correction in alerted Selected Reserve Soldiers.
- (5) Soldiers are categorized as “Red” in MEDPROS.

d. Medical Readiness Class 3B (MR3B)

- (1) Medical requirements will take more than 30 days to correct.
- (2) Deficiencies may include temporary profiles exceeding 30 days, and P3 or P4 profiles that require completion of a MMRB. (If the Soldier does not meet medical retention standards, Soldier requires a MEB.)
- (3) Soldiers who are pregnant.
- (4) Soldiers who are hospitalized (absent sick status).
- (5) Soldiers found “Unfit” but continued in COAD status.
- (6) Soldiers are categorized as “Red” in MEDPROS.

e. Medical Readiness Class 4 (MR4)

- (1) Medical readiness requirement deficiencies are considered in an indeterminate status.
- (2) Deficiencies may include:
 - (a) No current periodic health assessment (PHA).
 - (b) No current dental screen.
- (3) Categorized as “Gray” in MEDPROS.

⁴⁵ “Non-Available Soldier Management,” draft pre-decisional briefing slides, Human Capital Enterprise, November 22, 2010.

⁴⁶ Department of the Army Personnel Policy Guidance for Overseas Contingency Operations, 1 July 2009 (last updated 28 March 2011). This publication has been revised to update personnel guidance related to mobilized, employed, deployed, redeployed, and demobilized personnel in support of the overseas contingency operation (OCO).

This publication applies to active Army, the Army National Guard, U.S. Army Reserve, retired Soldiers, Department of the Army civilians, Department of Defense civilians, contractors, Red Cross employees, and Army Air Force Exchange Services employees. HQDA G-1 is not the sole author of the PPG, the following HQDA staff elements, commands and agencies contribute to its content: G-2, G-3/5/7, G-4, G-8, HRC, OTSG, OTJAG, IMCOM, TRADOC, FORSCOM, USARC, NGB, and First Army. Since the input provides Army wide guidance that affects the personnel community, any changes/updates submitted by HQDA staff elements, commands and agencies, must be properly staffed (i.e. legal review, external & internal staff coordination, etc.) before insertion in the PPG. Available at <http://www.armyg1.army.mil/MilitaryPersonnel/ppg.asp>. Last accessed on 29 Mar 2011; CENTCOM MOD 10- MOD TEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY. This mod provides medical deployability standards for military personnel, DoD civilians, DoD contractors, dependents and volunteers traveling or deploying to the CENTCOM AOR. Available at <http://usasam.amedd.army.mil/index/MOD10/index.htm>. Last accessed on 29 Mar 2011; Army Regulation 40-501 Standards of Medical Fitness, Chapter 3, August 23, 2010.

⁴⁷ Medical Retention Determination Point (MRDP): A service member with one or more conditions failing to meet medical retention standards will be referred into the DES by competent medical authority at the point of hospitalization or treatment when the member's progress appears to have medically stabilized, the course of further recovery is relatively predictable, and where it can be reasonably determined that further treatment will not cause the member to meet medical retention standards or render them capable of performing the duties required of their office, grade, rank, or rating. This MRDP will be made within 1 year of being diagnosed with a medical condition(s) that does not appear to meet medical retention standards, but may be earlier if the examiner determines that the member will not be capable of returning to duty within 1 year. Extensions for medical retention determinations requiring more than one year require approval by the Senior MTF Physician approving authority. Conditions discovered after identification of the initial medically disqualifying condition shall not delay referral into the DES, unless it is a condition which must be addressed and documented fully in order to be adjudicated by a PEB; ALARACT 185/2010 SOLDIER READINESS - AUTOMATION OF MEDICAL NON-DEPLOYABLE (MND) STATUS IN MEDPROS FOR P3 AND P4 PROFILES, DTG 171619Z JAN 10. This message informs commanders and staffs at all levels of pending automation of Medical Non-deployable (MND) classification for all permanent 3 and 4 profiles, potential impacts to unit readiness reporting, and guidance on how to adjudicate affected Soldiers. Currently, the entry of MND status in MEDPROS relies upon manual entries at the unit level. NLT 30 Jun 10, OTSG will implement changes in MEDPROS that will automate the entry of MND classifications for all Soldiers with P3 and P4 profiles. Soldiers with a P3 or P4 profile who have not been boarded (MMRB/MEB/PEB) will be coded automatically as MND Yes and medical readiness category (MRC) 3B.

⁴⁸ ALARACT 121/2009 MANDATORY USE OF MEDPROS AND DISTRIBUTION OF DA 3349 PHYSICAL PROFILE. Requires all units will comply with AR 40-501 requirements for distribution of the DD 3349 physical profile, and AR 40-501 requirements for recording of individual medical readiness (IMR) data to the medical protection system (MEDPROS). Findings of the FY09 Department of the Army Inspector General (DAIG) inspection on the medical readiness process concluded that many installations continue to rely on Soldier's hand-carrying their profiles (da 3349 physical profile) as the sole means to inform the chain of command. This is in direct violation of AR 40-501. An additional DAIG finding was that delayed updating of data within MEDPROS causes inaccurate reporting of Soldiers medical readiness.

⁴⁹ Naclerio, "Medical Readiness Update AMSUS Army Physician Section."

⁵⁰ Office of The Surgeon General, "Soldier Medical Readiness Campaign (SMRC)," OTSG decisional briefing slides, December 10, 2010.

⁵¹ Ibid.

⁵² MEDCOM OPERATION ORDER 10-75 (eProfile IMPLEMENTATION) 101330Q September 2010 orders implementation of eProfile across all Regional Medical Commands (RMC) no later than 31 January 2011 and establishes eProfile as the standard for generating, approving, and routing physical profiles in order to improve medical readiness across the Army.

⁵³ Medical Management Center (MMC) is a program, implemented by the U.S. Army Medical Command (MEDCOM) at Fort Knox, KY and Fort Stewart Georgia, to assist unit and rear detachment commanders with managing and supporting Medically Not Ready (MNR) Soldiers through the healing process. Lessons learned from these pilots will help MEDCOM develop standards to coordinate care for MNR Soldiers; decrease Soldiers recovery time; decrease the length of time Soldiers are unable to perform their duties and the timeline for identifying a Soldier's medical retention decision point; Office of The Surgeon General, "Soldier Medical Readiness Campaign (SMRC)."

⁵⁴ Comprehensive Soldier Fitness (CSF) improves resiliency by training specific skill sets along the five dimensions of health and fitness (Physical, Social, Emotional, Spiritual, and Family). It is believed that integrating CSF into Army training can result in greater "resilience", which is the sum of each individual's assets and resources in these dimensions. Resilience training—which teaches coping strategies among other skills—and self-development, are just some of the elements incorporated into the CSF program; U.S. Army Stand-To!, "Comprehensive Soldier Fitness," 1 October 2010 (Accessed March 10, 2011 at <http://www.army.mil/standto/archive/2010/10/01/>).

⁵⁵ Lein, FORSCOM Surgeon Brief on Medical non-deployable study.

⁵⁶ Medical Operational Data System (MODS). The Office of the Surgeon General (OTSG) is the proponent for MODS which is the authoritative database for the medical information of Army personnel. The Medical Protection System (MEDPROS) is the web module to MODS and is the primary tool to record, track, and report the medical readiness for Soldiers and units. NetUSR imports the medical readiness codes for individual Soldiers from MODS. AR 40-501, Medical Fitness Standards, is the authoritative publication governing the medical fitness standards reported into MODS via MEDPROS; Commander, United States Army Forces Command Memorandum, Subject: Personnel Readiness of Our force— Soldier Readiness Program (SRP) and Medically-Non-Deployable (MND). Identifies data accuracy as key to addressing MND issue. Directs units to perform a 100% scrub of MEDPROS data. 10 February 2011, 2, paragraph 5.

⁵⁷ Armed Forces Health Longitudinal Technology Application (AHLTA). The military's electronic health record (EHR), AHLTA, is an enterprise-wide medical and dental information management system that provides secure online access to Military Health System (MHS)

beneficiaries health records. It is used by medical clinicians in all fixed and deployed Military Treatment Facilities (MTFs) worldwide. This centralized EHR allows health care personnel worldwide to access complete, accurate health data to make informed patient care decisions - at the point of care - anytime, anywhere. AHLTA is the first system to allow for the central storage of standardized electronic health record (EHR) data that is available for worldwide sharing of patient information.

⁵⁸ Joseph Conn, "Military Officers Cite Problems with AHLTA at Hearing," ModernHealthcare.com, March 31 2009, (Accessed March 10, 2011 at <http://www.modernhealthcare.com/article/20090331/REG/303319994>).

⁵⁹ Physical profile serial system (PULHES)

a. The physical profile serial system is based primarily upon the function of body systems and their relation to military duties. The functions of the various organs, systems, and integral parts of the body are considered. Since the analysis of the individual's medical, physical, and mental status plays an important role in assignment and welfare, not only must the functional grading be executed with great care, but clear and accurate descriptions of medical, physical, and mental deviations from normal are essential.

b. In developing the system, the functions have been considered under six factors designated "P-U-L-H-E-S." Four numerical designations are used to reflect different levels of functional capacity. The basic purpose of the physical profile serial is to provide an index to overall functional capacity. Therefore, the functional capacity of a particular organ or system of the body, RATHER THAN THE DEFECT PER SE, will be evaluated in determining the numerical designation 1, 2, 3, or 4.

c. The factors to be considered are as follows:

(1) *P—Physical capacity or stamina*, (2) *U—Upper extremities*, (3) *L—Lower extremities*, (4) *H—Hearing and ears*, (5) *E—Eyes*, (6) *S—Psychiatric*.

d. Four numerical designations are assigned for evaluating the individual's functional capacity in each of the six factors. The numerical designator is not an automatic indicator of "deployability" or assignment restrictions, or referral to an MEB. The conditions listed in chapter 3 (Medical Fitness Standards for Retention and Separation, Including Retirement), and the Soldier's functional limitations, rather than the numerical designator of the profile, will be the determining factors for MEB processing.

(1) An individual having a numerical designation of "1" under all factors is considered to possess a high level of medical fitness.

(2) A physical profile designator of "2" under any or all factors indicates that an individual possesses some medical condition or physical defect that may require some activity limitations.

(3) A profile containing one or more numerical designators of "3" signifies that the individual has one or more medical conditions or physical defects that may require significant limitations. The individual should receive assignments commensurate with his or her physical capability for military duty.

(4) A profile serial containing one or more numerical designators of "4" indicates that the individual has one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited.

⁶⁰ General (Retired) Frederick Franks Jr., *Automated Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Process in I Will Never Leave a Fallen Comrade: Final Task Force Recommendations to Better Fulfill the Army's Duty in MEB/PEB*. (29 April 2009), Annex 15.

⁶¹ Ibid.

⁶² The USAWC Study Group drew from several sources in order to make this assessment to include General (Retired) Franks Task Force Report of 2009, DA IG Report of 2010, and interviews conducted with current students from the USAWC Class of 2011.

⁶³ General (Retired) Frederick Franks Jr., *I Will Never Leave a Fallen Comrade: Final Task Force Recommendations to Better Fulfill the Army's Duty in MEB/PEB* (29 April 2009),4.

⁶⁴ Ibid., 5.

⁶⁵ Ibid.

⁶⁶ Ibid.,22.

⁶⁷ Ibid.,23.

⁶⁸ Non-Deployable Campaign Plan Briefing Slides

⁶⁹ Ibid.

⁷⁰ AR 635-200, Chapter 14, Separation for Misconduct, authorizes the involuntary separation of Soldiers from the Army for conviction by a civilian court, minor disciplinary infractions, a pattern of misconduct, and commission of a serious offense. Army data on all administrative separation actions under AR 635-200 from FY 05 to FY 10 show that Chapter 14 constituted the leading provision under which Soldiers were involuntarily separated.

⁷¹ The notification procedure is used when the basis for the separation does not provide for an other than honorable (OTH) character of service or when an OTH is not sought in a case in which the basis for the separation authorizes an OTH, e.g, chapter 14 for commission of a serious offense. Soldiers are not entitled to a board under the notification procedure unless they have over six years of active service.

⁷² Army Regulation 635-200, Enlisted Separations, paragraph 1-32

⁷³ In accordance with Department of Defense Instruction (DoDI) 1332.14, Enlisted Administrative Separations, AR 635-200 establishes that a general officer in command (who has a Judge Advocate or legal advisor available) is the separation authority when a discharge under other than honorable (OTH) conditions is recommended by the initiating commander under the administrative board procedure

⁷⁴ The Fort Riley Transition Unit (FRTU) was a separate unit, with a derivative unit identification code, commanded by captain. The FRTU's sole mission was to process Soldiers transferred from deploying units for administrative separation. The FRTU commander exercised his independent judgment, in consultation with his Judge Advocate and First Sergeant, on disposition of each Soldier's case. Under the Fort Riley program, commanders of deploying units were authorized to transfer Soldiers pending administrative separations approximately 120 days before LAD.

⁷⁵ Chapter 7 is separation for fraudulent entry, Chapter 14 is separation for disciplinary infractions, and Chapter 15 is separation for homosexual conduct, which was repealed by law in December 2010 and it is currently under review for certification and implementation by DOD.

⁷⁶ U.S. Department of the Army, *Patient Administration*, Army Regulation 40-400 (Washington DC: U.S. Department of the Army, January 27, 2010), para 7-1, p 52.

⁷⁷ Under the legacy DES, a Soldier is medically evaluated and rated by the DoD, and then medically evaluated and rated again by the VA after separation.

⁷⁸ Brian Lein, from FORSCOM Surgeon Brief on Medical non-deployable study in FORSCOM IG Brief given to USAWC non-deployable Study Group. Oct 2010.

⁷⁹ U.S. Department of the Army, AR 40-400, para 8-3, 63.

⁸⁰ Department of the Army Personnel Policy Guidance for Overseas Contingency Operations 1 July 2009 (Bi-Annual Review) (last updated 4 March 2011) CENTCOM Theater Specific Individual Requirement Training (TSIRT).
<http://www.armyg1.army.mil/militarypersonnel/PPG/PPG.pdf> (accessed Mar 12, 2011).

⁸¹ U.S. Army G-1 ALARACT Message 160/2009, "Deployment Extension Incentive Pay (DEIP)," May 28, 2009,
https://www.us.army.mil/suite/portal/index.jsp;jsessionid=059D744DBA71B4A7DE0A2F96C4DEA5A9.appd04_2 (accessed January 5, 2011).

⁸² Nine months prior to LAD, DEIP is offered to Soldiers who are fully eligible for deployment in exchange for an agreement to extend and deploy with their unit. There are two windows for a Soldier to voluntarily accept an extension. Soldiers volunteering to extend between six months (180 days) and nine months (270 days) before LAD can receive an additional \$500 per full month extended. Second, when Soldiers extend from (179 days) before the unit's LAD until 90 days before their expiration of time in service (ETS) can receive \$350 per each full month extended. Meanwhile, Soldiers remain eligible for reenlistment if otherwise qualified.

In addition, Soldiers scheduled to ETS between LAD and 179 days after LAD who do not extend may be separated prior to their initial separation date depending on their time in service. Soldiers who decline the incentive and are at least six months from ETS at LAD will deploy for at least four months. Soldiers who decline and are less than six month from ETS will be separated 90 days early depending on their time in service. Soldiers must agree to the incentive at least 90 days prior to their ETS, which could allow them to agree to the incentive during deployment.

See U.S. Army Human Resources Command MILPER Message 10-246, "Deployment Extension Incentive Pay for Regular Army Soldiers," September 22, 2010,
<https://perscomnd04.army.mil/milpermsgs.nsf/WebFrameset?OpenFrameSet> (accessed January 5, 2011).

⁸³ Ott Siebert, "Deployment Extension Incentive Pay" briefing slides with scripted commentary, Washington, DC, U.S. Army G-1. January 4, 29, 2010.

⁸⁴ Ott Siebert, "DEIP Drilldown" briefing slides with scripted commentary, Washington, DC, U.S. Army G-1. December 29, 2010.

⁸⁵ Ibid.

⁸⁶ Ibid.

⁸⁷ Ibid.

⁸⁸ Brian Lein, FORSCOM Surgeon Brief on Medical non-deployable study in FORSCOM IG Brief given to USAWC non-deployable Study Group. Oct 2010.

⁸⁹ eMILPO data as of 19 January 20, the excel spreadsheet shows the number of non-availables (including all History values). This data display summary of Soldiers by Rank and Gender, with history of Non-Available Status and Reasons. SOURCE: COL Debra Hanneman; Chief, Field Service Division, Army Human Resources Command (AHRC). Details on data-- Retrieved Non-Available Status and Reason codes according to current G1 specifications of 'Non-Available' from eMILPO table view DEPLOY; Filtered first for active records, RECSTA= 7,8,G; Filtered for Non-Available status categories: NAP- all reasons, NAT-all reasons, and MRC= 3A and 3B; Counting values from whole history table regardless of start and end dates; same Soldier is counted for each entry populated and stored; Summary cross-tab of counts by Gender, Rank, Service Component, and Non-Available Status and Reasons.

⁹⁰ The United States Army Physical Disability Agency (USAPDA) manages the Army's Physical Disability Evaluation System (PDES) and acts on behalf of the Secretary of the Army. The PDES is used to determine the fitness and applicable disability benefits of Soldiers with duty related impairments. The PDES includes the Medical Evaluation Board (MEB) and the Physical Evaluation Board (PEB). The USAPDA is comprised of the HQ at Walter Reed and has three PEBs: one collocated with the Agency at Walter Reed, another at Ft. Sam Houston, TX, and the third located at Ft. Lewis, WA. Each of the Medical Treatment Facilities (MTFs) that conduct MEBs is aligned with one of these three PEBs. This alignment determines which PEB will adjudicate the case.

⁹¹ U.S. Army Physical Disability Agency Caseload & VASRD FY 2010 data provided by David Turbin, email david.turbin@us.army.mil, 28 March 2011, 1.

⁹² Dan Cassidy, "United States Army Physical Disability Agency Mission Brief," briefing slides with scripted commentary, Washington D.C., USAPDA, January 2010.

⁹³ U.S. Army Physical Disability Agency Caseload & VASRD FY 2010 data provided by David Turbin, email david.turbin@us.army.mil, 28 March 2011, 1.

⁹⁴ Ibid.,2.

⁹⁵ Assistant Secretary of Defense for Health Affairs issued policy guidance on 7 November 2006 for deployment-limiting psychiatric conditions and medications.

⁹⁶ U.S. Army Physical Disability Agency Caseload & VASRD FY 2010 data provided by David Turbin, email david.turbin@us.army.mil, 28 March 2011, 2.

⁹⁷ Robert M. Gates, "2010 Quadrennial Defense Review Report," (Washington D.C: Secretary of Defense, February 2010), 49.

⁹⁸ AR 635-40, paragraph 4-10 outlines the following function of the MEB. When a treating physician believes the Soldier is unable to perform full military duty or is unlikely to be able to do so within a reasonable period of time (normally 12 months), the Soldier is referred to a MEB at the MTF where treatment is being provided. The MEB is an informal process that documents the full clinical information of all medical conditions the Soldier manifests to determine whether each condition meets medical retention standards in accordance with AR 40-510, chapter 3. The MEB determines whether or not the Soldier meets retention standards; the PEB makes the fitness determination.

⁹⁹ The PEB is comprised of two types of boards, informal and formal. The Soldier's MEB, with allied documentation, is initially reviewed by the Informal PEB. This board conducts a review of the medical and non-medical evidence of record contained in the MEB. If the Soldier does not agree with the Informal PEB findings, he/she may appeal and submit additional information or demand a Formal PEB. All written rebuttals will be considered by the Informal PEB, which may issue revised findings based on the information provided or may affirm their original findings. A Soldier does not give up his/her right to a formal hearing by submitting a rebuttal. The Formal PEB is the Soldier's opportunity, with the assistance of legal counsel, to present evidence, testimony and documents in support of his/her case. The Soldier may appear in person or VTC and present evidence pertinent to the case. The Soldier may be represented by an appointed Judge Advocate General Corps (JAGC) attorney, or counsel of their own choosing (a civilian attorney or a representative from a National Service Organization such as Disabled Americans Veterans, American Legion, etc.). The Formal PEB members will hear and consider all evidence and testimony presented by the Soldier and his/her counsel. If unfit, and found eligible for compensation, the PEB will also vote on the rating percentage and disposition. Like the informal PEB. All findings are decided by majority vote. Soldiers have the opportunity to appeal the formal PEB findings as well. Soldier disagreement with the PEB is an automatic appeal to USAPDA. Final approval authority for all PEB findings and recommendations rests with the USAPDA. The Agency has the authority to issue revised findings or return a case to the PEB for reconsideration (should the evidence of record not support the PEB findings and recommendations). If USAPDA does issue revised findings, the Soldier will once again be afforded an opportunity to agree or disagree with the revised findings, and submit a written rebuttal. If a Soldier disagrees with the Agency's revised findings, his/her appeal will be forwarded to the Army Physical Disability Appeal Board for review. (USAPDA, Accessed 26 March 2011 at <https://www.hrcapps.army.mil/site/Active/tagd/Pda/pdapage.htm>).

¹⁰⁰ The PDES is a performance-based system. Simply because a Soldier has a medical condition(s) does not mean that the Soldier cannot continue to serve on active duty or in the Reserve Components. If the PEB determines the Soldier is unfit, it then determines if the Soldier is eligible for disability benefits. If eligible, the PEB determines the percentage of the Soldier's disability compensation using the Department of Veterans Affairs Schedule for Rating Disabilities established in 1949. The Army only rates those medical conditions that result in the Soldier being determined unfit for continued military service. The Soldier's disposition is determined by considering the severity of the illness/injury, stability of the Soldier's condition, and the Soldier's time in active service and Reserve Component equivalent service (when applicable). Based on this determination, the Soldier receives either permanent or temporary disability retirement or disability severance pay. (USAPDA, Accessed 26 March 2011 at <https://www.hrcapps.army.mil/site/Active/tagd/Pda/pdapage.htm>).

¹⁰¹ AR 635-40, paragraph 4-17.

¹⁰² Robert Dole and Donna Shelala, The President's Commission On Care For America's Returning Wounded Warriors, Final Report, JULY 2007, 5. (Accessed March 5, 2011 at <http://www.vawatchdog.org/07/nf07/nfJUL07/JULFILES/07%2025%202007%20wounded%20warriors.pdf>).

¹⁰³ Frederick Franks Jr. GEN. (Retired), "I Will Never Leave a Fallen Comrade: Final Task Force Recommendation to Better Fulfill the Army's Duty in MEB/PEB," April 29, 2009, 3.

¹⁰⁴ Ibid., 3.

¹⁰⁵ Ibid., 3.

¹⁰⁶ Under the legacy DES system, service members had to undergo two medical exams: one conducted by the service to determine their fitness for continued military service and ratings for any unfitting medical conditions; and one exam conducted by the VA to determine compensation payments and benefits for medical conditions incurred as the result of military service. Use of a single comprehensive VA-administered physical exam conducted by VA-certified physicians has eliminated the need for a second exam. Under the IDES, the PEB uses the VA physical exam to make its fitness determinations for continued military service, while the VA uses the same exam to award disability ratings. The PEB applies the disability ratings awarded by the VA Rating Board to any military unfitting conditions. The PEB also uses this rating as the basis for determining the Soldier's final disposition, such as separation with disability severance pay or disability retirement. The VA Rating Board's combined disability award, for all medical conditions rated, provides the basis for determining disability compensation payments and benefits administered by the VA.

¹⁰⁷ ALARACT 011/11 Integrated Disability Evaluation System (IDES) Implementation Plan, DTG 182144Z JAN 11.

¹⁰⁸ Cassidy, "United States Army Physical Disability Agency Mission Brief."

¹⁰⁹ The November 24, 2010 IDES report data revealed 16,000 Service members participating in the program and 3,800 Service members who had completed the program. Active component personnel averaged 318 days from enrollment to completion. This exceeds the IDES goal of 295 days, however, it is 41% faster than the legacy DES and subsequent VA claims process, which together total 540 days to complete. This is beneficial for the Soldier in that he or she receives their first VA disability payment faster, though the Soldier remains on active duty slightly longer.

¹¹⁰ Frederick Franks Jr. GEN. (Retired), "I will Never Leave a Fallen Comrade: Final Task Force Recommendation to Better Fulfill the Army's Duty in MEB/PEB," 37.

¹¹¹ Cassidy, "United States Army Physical Disability Agency Mission Brief," 18.

¹¹² Keith Gallagher, quoted in Frederick Franks Jr. GEN. (Retired), "I will Never Leave a Fallen Comrade: Final Task Force Recommendation to Better Fulfill the Army's Duty in MEB/PEB," 37.

¹¹³ Ibid., 38.

¹¹⁴ James Andrews, "Transformation of the Army's Physical Disability Evaluation System (PDES)," Unpublished USAWC Strategic Research Project, 2011, 17.

¹¹⁵ Ibid.

¹¹⁶ Ibid.

¹¹⁷ Lein, FORSCOM Surgeon Briefing.

¹¹⁸ Ibid.

¹¹⁹ USAWC Internal Revue Board (IRB) Approved on 2 Feb 11. USAWC IRB: AY11-04-USAWC.

¹²⁰ All figures and analysis used in this paper were extracted from projects performed for the Warrior Transition Command and this study group by the Center for Army Analysis from 2007 to 2011.

¹²¹ FRAGO 3 to EXORD 118-07 states that "Soldiers with complex medical conditions that require extensive case management qualify for assignment or attachment to the WTU. Soldiers with medical conditions that do not require case management should remain in their units and utilize standard healthcare system and access to care standards." All versions and revisions on policies concerning the WTU can be found at Headquarters, Department of the Army, *Warrior Transition Unit Consolidated Guidance (Administrative)* (Washington, DC: U.S. Department of the Army, March 20, 2009), <http://www.armyg1.army.mil/WTU/docs/WTUConsolidatedGuidanceAdministrative.pdf> (accessed February 3, 2011).

¹²² Ibid.

¹²³ The Army is considering changes in the management of the medical population at this time. No specifics are available for consideration or analysis.

¹²⁴ The populations used also include Soldiers classified as MRC4 (medical status unknown) who historically were subsequently diagnosed to come under 3B.

