

SUBCOMMITTEE ON NATIONAL SECURITY, EMERGING THREATS,
AND INTERNATIONAL RELATIONS
Christopher Shays, Connecticut
Chairman
Room B-372 Rayburn Building
Washington, D.C. 20515
Tel: 202 225-2548
Fax: 202 225-2382

March 25, 2004

MEMORANDUM

To: Members of the Subcommittee on National Security,
Emerging Threats, and International Relations

From: Kristine K. McElroy

Subject: Briefing Memorandum for the hearing, *Does the 'Total Force' Add Up?-The Impact of Health Protection Programs on Guard and Reserve Units?* for Tuesday, March 30, 2004, at 10:00 a.m. in Room 2154, Rayburn House Office Building.

PURPOSE OF THE HEARING

The purpose of the hearing is to examine the application and outcomes of force health protection programs on Reserve Component units.

HEARING ISSUES

- 1. How effective are force health protection programs for Reserve Component (RC) unit members?**

2. How does the Department of Defense (DOD) account for differences in health outcomes between active and Reserve Component (RC) unit members?

BACKGROUND

The Reserve Component (RC) is made up of the Army National Guard, the Army Reserve, the Naval Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserves and the Coast Guard Reserve. **(Web Resource 1)** According to the Department of Defense, as of September 30, 2002 there are about 1,812,355 members of the RC. **(Web Resource 1)** Since September 11, 2001 about 300,000 RC personnel have been called to active duty. **(Web Resource 2)**

According to 10 United States Code (U.S.C) 10102, the role of the RC is to “provide trained units and qualified persons available for active duty in the armed forces, in time of war or national emergency, and at such other times as the national security may require, to fill the needs of the armed forces whenever...more units and persons are needed than are in the regular components.” **(Web Resource 1)** The Army National Guard and the Air National Guard also assist the states in responding to emergencies such as disasters and civil unrest. **(Web Resource 1)**

During the Cold War era, the RC was rarely activated. The federal government involuntarily activated the RC four times from 1945 to 1989. However, since the end of the Cold War, reservists have faced increased activations. Since 1990, reservists have been involuntarily activated by the federal government six times. **(Web Resource 1)**

Public Law 105-85, National Defense Authorization Act, 1998

After the end of Operation Dessert Shield/Storm in 1991, more than 125,000 U.S. veterans of the Gulf War experienced health problems they attributed to their military service. However, due to a lack of health and deployment data, research efforts into determining the cause of illnesses has been hampered.

Public Law 105-85 was created to improve medical tracking systems for members deployed overseas in contingency or combat operations. The

law requires the Secretary of Defense to establish a system to evaluate the medical condition of deployed servicemembers. Elements of the system must include predeployment and postdeployment medical examinations, an assessment of mental health and the drawing of blood samples. The law mandates medical records including immunizations be maintained in a centralized location. The Secretary of Defense is also required to submit to Congress a report containing a plan for collecting and maintaining information regarding the daily location of units of the Armed Forces, and to the extent practicable individual members of such units. The law also requires all health care services received by servicemembers be maintained in a centralized location and for the Secretary of Defense to establish a quality assurance program to evaluate the success of these programs. **(Attachment 1, pp. 1-2)**

Department of Defense Force Health Protection

The Department of Defense has applied lessons learned from the Persian Gulf War to develop the Force Health Protection (FHP) strategy. The Force Health Protection strategy focuses on maintaining a healthy and fit force, casualty prevention and casualty care. These goals are to be accomplished through the use of military medical surveillance, environmental monitoring, personal protection, and personnel monitoring. The FHP program is designed to track service members' disease and injuries and to provide follow-up treatment for deployment-related health conditions.

The Department of Defense plan to provide force health protection includes improving risk communication, medical intelligence, providing environmental risk assessments to commanders on the battlefield, giving medical threat briefings and distributing pocket-sized health guides to deployed personnel. The Defense Medical Surveillance System has created a database on diseases military personnel may be exposed to during their deployment. **(Attachment 2, p. 1)**

The DOD has also established three deployment health centers for health surveillance, health care, and health research. The centers focus on prevention, treatment and understanding of deployment health concerns. **(Attachment 3, p. 1)**

Health Assessments

The DOD has created pre-deployment and post-deployment health assessments to validate an individual's medical readiness to deploy and address health concerns upon their return. The health assessments are questionnaires servicemembers fill out. Troops are asked to rate their health, and are asked whether they have any health concerns, or concerns about possible exposures or events during their deployment. Those service members who answer, "yes" to certain questions will be referred for further examination. Questionnaires are reviewed and signed by health care personnel. **(Attachment 4)**

After a physician reviews the form, it is sent to Walter Reed Army Medical Center in Washington, D.C., where it is scanned electronically and stored for future use. According to Kilpatrick, the health assessments are used "to see if there are any changes in service members' health or condition that may require attention before or after they deploy." **(Attachment 5, p. 2)** Data from the health assessments are maintained by the Defense Medical Surveillance System (DMSS). DOD believes its predeployment and postdeployment questionnaires fulfill Public Law 105-85 requirements to conduct pre-deployment and post-deployment medical examinations of soldiers.

On April 22, 2003 David S. Chu, Under Secretary of Defense, sent out a memorandum regarding enhanced post-deployment health assessments to the Secretaries of the Military Departments, Combatant Commanders and the Director of the Joint Staff. **(Attachment 6, p. 1)** The enhanced post-deployment health assessment was two pages longer than the original. **(Attachment 6, p. 4)** The memorandum also requires a blood sample be obtained no later than 30 days after arrival at a demobilization site or home station and forwarded to the DOD Serum Repository. Blood samples from National Guard and Reserve members are to be obtained during demobilization. **(Attachment 6, pp. 1-2)**

The memorandum states, "Within 30 days returning to a demobilization site or home station for all redeploying individuals, the Military Departments shall ensure that copies pre- and post-deployment health assessment forms (DD Forms 2795 and 2796), documentation of theatre health care encounters, and any indications of significant theater

environmental and occupation exposures are incorporated into the individual's permanent medical record. Each individual with indicated health referrals or concerns should meet with a health care provider for evaluation of deployment health issues” (**Attachment 6, p. 3**)

The memorandum states, “Post-deployment follow-up care for National Guard and Reserve members should be coordinated through their reserve unit.” Members requiring a more detailed medical evaluation or treatment shall (with the member's consent) be retained on active duty pending resolution of their medical condition, or may be ordered to active duty (with the member's consent).” (**Attachment 6, p. 3**)

The memorandum also notes, “since most deploying National Guard and Reserve members will be released from active duty, it is critical that documentation of deployment health care encounters be placed in each member's permanent medical record, and that they be made aware of how to access follow-up care for service-connected health issues.” (**Attachment 6, p. 3**)

DOD Deployment Health Quality Assurance Program

A September 2003 General Accounting Office (GAO) report entitled, *Quality Assurance Process Needed to Improve Force Health Protection and Surveillance* found the Army and Air Force did not comply with DOD's force health protection and surveillance policies for many active duty service members. For instance some service members did not receive health assessments before and after deploying from overseas and DOD did not maintain a complete, centralized database of health assessments and immunizations. The GAO recommended the Secretary of Defense for Health Affairs establish an effective quality assurance program, as required by Section 765 of Public Law 105-85 that would ensure military services comply with the force health protection and surveillance requirements for service members. (**Web Resource 2**)

DOD concurred with the recommendations and established a quality assurance program for pre and post-deployment health assessments. The quality assurance program will include reports on health assessments, reports on service-specific deployment health QA programs, and visits to military installations to assess deployment health program compliance and effectiveness. Findings and recommendations will be summarized in an

annual report and coordinated through the Force Health Protection Council. **(Attachment 7, p. 1)**

The health assessment and blood samples are being archived electronically at the Army Medical Surveillance Activity (AMSA). The Deployment Health Support Directorate has been monitoring health assessments going to AMSA on a weekly basis since June 2003. DOD has also implemented an automated theater-wide health surveillance data collection and reporting system and is developing DOD-wide individual medical readiness standards and reporting metrics. **(Web Resource 2)**

Health Monitoring for Early-Deploying Reservists

Congress passed four statutory requirements to monitor the health status of early-deploying reservists. These reservists are normally the first to be deployed in a ground conflict. There are approximately 90,000 early-deploying reservists. The remaining reservists 470,000 become early deploying reservists 75 days prior to their deployment date. The Army must provide annual medical screening, annual dental screening, selected dental treatment and a physical examination every 2 years for reservists over age 40. Early-deploying reservists are required to notify the Army about the status of their physical and dental condition and those under 40 years of age must have a physical examination once every 5 years. **(Web Resource 3)**

However, an April 2003 GAO report entitled *Army Needs to Assess the Health Status of All Early-Deploying Reservists* found, “The Army has not consistently carried out the requirements that early-deploying reservists undergo 5 or 2 year physical examinations, and the required dental examination. In addition, the Army has not required early-deploying reservists to complete the annual medical certificate of their health condition, which provides the basis for the required annual medical screening.” **(Web Resource 3)** GAO concludes the Army does not have current health information on early-deploying reservists. **(Web Resource 3)**

These examinations are valuable for the Army since they provide a means for determining the health status of reservists and ensuring their medical readiness. **(Web Resource 3)** According to GAO, “Without adequate examinations, the Army runs the risk of mobilizing early-deploying reservists who cannot be deployed because of their health...the Army loses not only the amount it invested in salaries in training but also the

particular skill or occupation it was relying on to fill a specific military need.” **(Web Resource 3)**

The Army planned on expanding in 2003 an automated health care information system to capture medical and dental information needed to monitor the health status of early-deploying reservists. MEDPROS is a component of the Medical Occupational Database System (MODS) which provides a web-based system that documents and monitors medical and dental readiness. **(Web Resource 3)** The Army has increased its efforts to automate tracking of all medical and dental readiness through MEDPROS.

Health Benefits

Reservists who injure themselves or become ill during inactive duty training (IDT), or while traveling to or from the IDT duty station are entitled to treatment at a military medical facility. During active duty or annual training AT, reservists are entitled to treatment at military medical facilities. Family members are eligible for military medical care when the reservist is ordered to active duty for more than 30 days. **(Web Resource 1)**

The Iraq Supplemental (108-106) allows non-active duty Reservists and National Guardsmen to enroll in Tricare if they are eligible for unemployment compensation or have no access to an employer-sponsored health benefits plan. **(Web Resource 4)**

The FY2004 Defense Authorization Act (P.L. 108-136) includes similar provisions and also extends transitional health-care benefits to 180 days after leaving active duty for all reservists and active-duty personnel. However, these provisions are temporary and will expire December 31, 2004, unless it is determined a permanent benefit should be authorized. Prior to this bill, Tricare coverage for transitioning service members and their families was limited to 60 days for those with less than six year of service and 120 days for those with more than six years. **(Attachment 8, p. 1)**

Reserve Component forces, who served on active duty in a theater of combat operation during a period of war after the Persian Gulf War or in combat against a hostile force during a period of hostilities after November 11, 1998, are eligible for 2 years after leaving the military for VA hospital care, medical services and nursing home care for any illness. This coverage

also applies to cases where there is insufficient medical evidence to conclude that their illness was a result of their combat service. **(Attachment 9, p. 2)**

Demobilization (DEMOB) Site Procedures

According to a February 26, 2003 Department of the Army memorandum entitled *MEDCOM Field Operating Guide (FOG) for Reserve Component (RC) Soldiers on Active Duty Medical Extension (ADME)* at the demobilization site each soldier will have, “a complete medical record review and receive a medical benefits and entitlements briefing.”

(Attachment 10, p. 9) The briefing should include the, “right to request a release from active duty (REFRAD) physical, Active Duty Medical Extension (ADME), Incapacitation (INCAP) pay, TRICARE benefits following Release From Active Duty (REFRAD), Point of Contact (POCs) for TRICARE claim issues, and Department of Veterans Affairs (VA) access.” **(Attachment 10, p. 9)**

Soldiers must complete the post deployment health assessment form within 5 days prior to REFRAD out-processing and DD Form 2697, Report of Medical Assessment. The health care provider (physician, physician’s assistant, or nurse practitioner) will review the forms and all medical records to determine if a physical exam, or further medical care is needed.

(Attachment 10, p. 9)

RC soldiers released from active duty for periods longer than 30 days are eligible for temporary medical care under the Transitional Assistance Medical Program and space available dental care at a Military Dental Treatment Facility. They are authorized health care for service connected in line of duty injury, illness, or disease at any Military Treatment Facility and can apply for eligibility with the Veterans Administration. **(Attachment 10, p. 20)**

Some soldiers who are disabled while on authorized military duty as a result of an approved line of duty, and are unable to perform military duty may be entitled to incapacitation pay. Soldiers who suffer a loss of nonmilitary income as the result of a Line of Duty (LOD) injury or illness may be entitled to the lesser of military pay and allowances for their grade and years of service or the demonstrated amount of nonmilitary compensation loss. **(Web Resource 5)**

Active Duty Medical Extension (ADME)

RC soldiers on active duty orders or inactive duty training that require medical treatment/evaluation for more than 30 days past their current orders/training period need to obtain a Line of Duty (LOD) statement. The LOD is needed for a medical condition when it is determined the service member is unable to perform normal military duties in his/her Military Occupational Specialty/Area of Concentration (MOS/AOC). LOD investigations are used to determine and document eligibility for medical care. **(Attachment 11, p. 1)**

RC members are eligible for ADME subject to their consent and Department of the Army (DA) approval. This enables RC members to be retained on active duty pending resolution of their medical condition or completion of the physical disability evaluation system. A soldier may receive ADME even if the condition occurred prior to service. **(Attachment 10, p. 1)** In addition, an RC soldier who is on orders for more than 30 days and does not meet medical retention standards can be retained on active duty to complete medical evaluation board/physical evaluation board (MEB/PEB) processing regardless of whether the condition existed prior to service. **(Attachment 10, p. 3)**

Eligibility for ADME occurs when soldiers “incur or aggravate an injury, disease or illness in the line of duty (LOD), while on active duty, annual training, additional duty for training, active duty for special work or while performing in and inactive duty training (IDT) status.” **(Attachment 10, p. 9)** A military medical authority will make the determination whether a soldier is unable to perform normal military duties in their military occupational specialty/area of concentration (MOS/AOC). Should a RC soldier be able to perform military duties but their ability to return to civilian occupation is impaired, Incapacitation Pay (INCAP) should be considered**(Attachment 10, p. 9)**

The DOD memorandum states, “If the ADME RC soldier’s duty unit is and he lives more than 50 miles and/or 1-hour drive time from a MTF, the soldier will enroll in TRICARE Prime Remote (TPR). The responsible MTFs will maintain medical management and tracking for these RC soldiers until they are released from AD.” **(Attachment 10, p. 4)**

All RC soldiers on ADME have the same priority status for access to military health care as active duty soldiers. (**Attachment 10, p. 7**) They accrue leave and retirement points while in an ADME status. (**Attachment 10, p. 16**)

DISCUSSION OF HEARING ISSUES

1. How effective are force health protection programs for Reserve Component (RC) unit members?

Adme

Incap

Record keeping

treatment

Physical examinations

There have been some problems with force health protection programs for RC members. Some RC soldiers have come back from being deployed and have not been thoroughly briefed on medical programs. Injured RC members have come back without being aware they could apply for active duty medical extension. Some soldiers have fallen through the cracks and have had a hard time trying to obtain treatment and reimbursement for injuries suffered on active duty.

Many RC members who have come back from deployment complain they were not given information about where to obtain medical care, or what their options were. Some were not told about ADME. When they returned they were forced to try to find care.

Those RC soldiers who have placed on ADME have complained about the treatment they have received. In October 2003, more than 1,000 National Guard and Army Reserve Soldiers at Fort Stewart, Georgia and Fort Knox, Kentucky waited weeks and months in medical hold to see doctors. RC soldiers complained of being shoddy housing in barracks without running water and air conditioning. The military's solution to fixing this problem was to move soldiers to hotels and to provide \$77 million to improve conditions. However these hotels were as far away as 50 miles from the base. (**Attachment 13, p. 2**)

The Army also opened up a Troop Medical Clinic at Fort Stewart in order to alleviate some of the waiting time.

To alleviate the backup of RC soldiers on medical holdover, the Army has implemented a 25 day rule which states RC troops who arrive at bases to go to war and are sick will be sent home within 25 days. Since many RC soldiers had arrived at Fort Stewart and Fort Knox unfit for duty, they clogged up health care facilities at mobilization sites. **(Attachment 13, p. 3)** However, some believe this just puts a bandaid on a problem and does not address how to make these soldiers fit for duty or why these soldiers were able to be on RC status when they were not fit for duty.

The RC soldiers in medical holdover status felt they were not treated equal as their active duty component counterparts. **(Attachment 13, p. 2)**

Many RC unit members have faced difficulty in being put on active duty medical extension. Many RC unit members who have been injured in service have faced difficulties in being put on adme and staying on adme. Some of the challenges they have faced are being far away from their family, waiting for appointments.

Many complain reserve units fall through the cracks when it comes to health protections.

Some feel active duty personnel are treated faster, and better than reserve component units. Many RC members claim they are treated like second class citizens in comparison to the active duty force. They site examples of receiving older, damaged materials, while the active duty have all their needs met.

Many RC soldiers complain about treatment they received when on active duty medical holdover.

DOD policy has not always been followed. While DOD memorandum clearly states RC soldier should not be any further than 50 miles from their house, many soldiers are being assigned to far off hospital and bases. Some

say the reason for this is because these bases want the extra money these soldiers bring in. Fort Stuart has 40% Florida National Guard soldiers. Congress infused money into the system now they don't want to lose funding. Many reserve component units face difficulties in being far away from families when injured. They were stationed miles from their family, some on long waiting lists to get treatment.

Others have seen their health ADME due to a 30 day renewal process that tends to take longer than 30 days.

Since soldiers are kept on medical hold during treatment while the Army determines their status. They will be treated on active duty medical extension until they are "fit for duty" and released or until they can be evaluated for leaving. **(UPI GI Denied care after speaking, p. 1)**

2. How does the Department of Defense (DOD) account for differences in health outcomes between active and Reserve Component (RC) unit members?

Fit for duty

Injury rate

Training fitness

While there are Congressional requirements to monitor the health status of early-deploying reservists through medical screenings and physical examinations, the GAO found the Army has not consistently carried out these exams.

DOD does a poor job accounting for difference in health outcomes between active and RC unit members.

Many Reserve and Guard units showed up at bases unfit for duty during the recent Operation Iraqi Freedom deployment. These units have clogged the health care facilities at mobilization sites such as Fort Stewart and Fort Knox. **(Army fixing medical failure p. 3)** The Army recently implemented a rule that RC unit troops who show up at bases to go to war and are sick are sent home within 25 days, however the Army has not come up with a plan to decrease the amount of sick RC unit troops.

The DOD set aside \$77 million to amend medical hold problems.
(Army fixing medical failure p. 3)

In October of 2003, more than 1,000 National Guard and Army Reserve soldiers at Fort Stewart and Fort Knox waited for weeks and months to see doctors while in “medical hold.” At Fort Stewart, Georgia many soldiers were forced to wait in hot concrete barracks without air conditioning or running water. **(Army fixing medical failure p. 1)**

Reserve Units may be forced back to their unit, and not have time to

Since Reserve Component forces do not train as often as active duty forces they are not always as fit as their active duty counterparts.

Reserve Component units face unique challenges compared to active duty units. While active duty members are always training, RC members only train for up to 39 days per year. In most cases, RC units train on older equipment compared to active duty forces. These challenges make it difficult for RC members to develop the skills of the active duty units thereby leading to potential injuries.

That National Guard and Army Reserve account for 27 percent, or about 350,000 of the 130,000 US forces in Iraq. However, they compromise 40 percent of the nonhostile injuries. Through October 29, 2003, there were 2,600 nonhostile injuries suffered by reserves and 3,987 nonhostile injuries suffered by active duty soldiers. **(Attachment 12, p. 1)**

Disease Non-Battle Injury (DNBI)

Many RC units were not prepared for long deployments such as the one year deployment to Iraq. Extended deployments can increase the stress RC members experience since they have jobs back home, and families who aren’t used to long separations. They may not be as prepared to deal with the psychological consequences of long deployments. **(Attachment 12 p. 2)**

In many cases family support networks are weak for RC family members as opposed to active duty family members. Typically family assistance is not close to where RC family members live, thereby leaving them to feel isolated.

While active duty members have full health coverage when they come back from deployment, reserve component units only have 1 year of coverage.

They also are last on the list for seeing physicians after active duties.

First Sergeant Gerry L. Mosley, will present testimony regarding his evaluation of the pre and post deployment health assessment forms, in theatre medical care, medical care since returning to the United States, and medical record keeping.

SPC. John A. Ramsey will present testimony regarding the challenges he has faced in trying to obtain care and reimbursement for injuries he suffered while on Active Duty.

Mrs. Laura Ramsey will testify about her views regarding the challenges her husband, SPC. John A. Ramsey has faced in obtaining care and her thoughts on family support programs.

Mr. Scott Emde will present testimony regarding the care he received for injuries suffered while serving on active duty.

Mrs. Lisa Emde will testify about her views regarding the medical care and assistance her husband Mr. Scott Emde received.

Mr. Timothy McMichael will present testimony regarding difficulties he and his fellow RC soldiers have experienced while on active duty medical extension.

Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs will present testimony regarding the status of pre and post deployment health assessment forms, in theatre medical care, medical record keeping, health prevention, and family support programs. Dr. Winkenwerder will also provide information regarding medical holdover, demobilization procedures and fit for duty requirements.

Lt. General James B. Peake will present testimony regarding the status of health protection programs for RC soldiers.

ATTACHMENTS

1. Public Law 105-85, National Defense Authorization Act, 1998
2. Captain David H. Trump. "Force Health Protection: 10 Years of Lessons Learned by the Department of Defense." *Military Medicine* (March 2002).
3. Information for Member of Congress entitled, "Department of Defense Force Health Protection" (March 12, 2003).
4. Pre-deployment and Post-deployment health assessments.
5. Sgt. 1st Class Doug Sample, "Pentagon Has A New Strategy for Monitoring Deployment Health Care" American Forces Press Service (February 11, 2003).
6. Under Secretary of Defense, David S. Chu, Memorandum entitled, "Enhanced Post-Deployment Health Assessments," April 22, 2003.

7. The Assistant Secretary of Defense, Dr. William Winkenwerder Memorandum entitled, "Policy for Department of Defense Deployment Health Quality Assurance Program." January 9, 2004.
8. Funk, Deborah. "Health care extended for those leaving active duty" *Army Times* November 19, 2003.
9. "A Summary of VA Benefits for National Guard and Reserve Personnel," May 2003.
10. Office of the Army Surgeon General Memorandum from Colonel James K. Gilman, Acting Assistant Surgeon General for Force Protection, entitled "MEDCOM Field Operating Guide (FOG) for Reserve Component (RC) Soldiers on Active Duty Medical Extension February 26, 2003.
11. U.S. Army Human Resource Command, Information on Line of Duty Determinations.
12. Bender, Bryan and Robert Schlesinger, "Injury Rate For Reservists on Rise," *Boston Globe*. November 5, 2003.
13. United Press International, "Army Fixing Medical Failure" January 22, 2004.

WEB RESOURCES

1. CRS Report for Congress, "Reserve Component Personnel Issues: Questions and Answers." RL30802 August 22, 2003
<http://www.crs.gov/>

2. General Accounting Office Report entitled, “Defense Health Care Quality Assurance Process Needed to Improve Force Health Protection and Surveillance” GAO-03-1041, September 2003.
<http://www.gao.gov/>
3. General Accounting Office Report entitled, “Defense Health Care Army Needs to Assess the Health Status of All Early-Deploying Reservists GAO-03-437, April 2003 <http://www.gao.gov/>
4. CRS Issue Brief, “Military Medical Care Services: Questions and Answers.” IB93103 January 14, 2004 <http://www.crs.gov/>
5. Incapacitation pay.
<http://www.neguard.com/dpa/HSS/IncapacitationPay.htm>