How to Hinder Unit Readiness

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The Army's top priority is readiness, but maintaining a force that is ready to deploy units at any time—while taking care of soldiers physically, mentally, and in their careers—is a precarious balance. Human resource and medical fitness practices make units' deployment preparation unnecessarily difficult, as those practices did for the 13th Expeditionary Sustainment Command (13th ESC) in 2014 when it prepared to deploy to Kuwait. After receiving orders in January 2014, the 13th ESC managed to deploy in December at just 71 percent of mandated strength. The unit struggled to overcome issues common to the Army's personnel and medical systems practices that hinder operating units' readiness. To help units overcome these challenges, the institutional Army, sometimes called the generating force, needs to think like the operating force. The institution must focus on how to help each operational unit prepare as a whole for deployment.

13th Sustainment Command (Expeditionary) unit shoulder patch

The 13th ESC's analysis of its deployment preparation showed how certain systemic medical and personnel practices beyond the unit's control impeded its preparation. It found deficiencies in medical and personnel practices that the Army could remedy to more efficiently provide deployable soldiers to units. This article encapsulates those challenges and highlights medical and personnel aspects that play a pivotal role in a soldier's deployment availability. This article also offers solutions—where possible. It aims to help units conduct predeployment strength management and to help the Army improve strength management practices.

Policy recommendations include that the Army Human Resources Command (HRC) open the Distribution Conference (where unit vacancies are validated and prioritized for filling) to higher headquarters at the general officer level, to fully coordinate current and future deployments with the operating force. This collaboration could help human resource administrators to think like

Staff Sgt. Adrian Haley, 13th Sustainment Command (Expeditionary) Support Operations, discusses a training objective with a Kuwaiti army officer and others during a logistics tabletop training exercise 12 April 2015 at the Kuwait Ministry of Defense Logistic Operations Command Center. After overcoming significant readiness challenges during its predeployment period, the unit successfully conducted Kazma II, the first logistics and sustainment training exercise between the two partner militaries. (Photo by Staff Sgt. Jason Thompson, U.S. Army)

operators. The Army should ensure medical support personnel with experience in operational medicine are available to truly assess soldiers' deployable status prior to assigning them to deploying units. Human resource professionals should improve coordination at the unit, installation, and HRC levels to fine-tune and support deployment needs. In addition, it is time to make the Army's medical fitness standards established in Army Regulation (AR) 40-501, *Standards of Medical Fitness*, align with its deployment standards.[1] Moreover, units need help with processes for the Integrated Disability Evaluation System (IDES) and the Warrior Care and Transition Unit.[2]

13th Expeditionary Sustainment Command Deployment Preparation

In January 2014, the 13th ESC, based at Fort Hood, Texas, received its deployment orders for a nine-month temporary change-of-station mission to Kuwait at full modified-table-of-organization-and-equipment (MTOE) strength of 262 personnel. The unit's mission was to serve as the operational command post of the 1st Sustainment Command (Theater), providing mission command for sustainment to all U.S. and coalition forces serving in the United States Central Command (USCENTCOM) area of responsibility.

The 1st Sustainment Command (Theater) main command post is based at Fort Knox, Kentucky (formerly at Fort Bragg, North Carolina). The command sources its operational command post in Kuwait with an ESC to conduct logistics operations in theater. During its deployment, the 13th ESC provided 80 percent of the personnel needed for 1st Sustainment Command's operational command post in Kuwait, and 20 percent came from the 1st Sustainment Command's headquarters.

As the 13th ESC began its deployment preparation, numerous events hindered its ability to deploy at required strength:

- an officer separation board;
- an enhanced selective early retirement board;
- a Qualitative Service Program board;
- a Qualitative Management Program board;
- Fort Hood's deployment of forces in support of United States Africa Command, and to Korea, and to Ukraine;
- the October 2014 redeployment of the Multinational Forces and Observers Provisional Battalion headquarters, internally sourced several months earlier by the 13th ESC;
- the 13th ESC's deployment of the headquarters and three battalion headquarters from 4th Sustainment Brigade, 4th Infantry Division, in support of Operation Resolute Support;
- the reestablishment of logistical support to the Combined Joint Forces Land Component Command–Iraq and the Combined Joint Task Force–Operation Inherent Resolve; and
- the Afghanistan theater transition from Operation Resolute Support to Operation Freedom's Sentinel.

Deployment personnel strength management is a complicated, multifaceted moving target that often reflects the greater needs of the Army above the requirements of a single unit. There is a certain amount of flexibility built into the system to allow for the expansion and retraction of total strength to prepare a unit to deploy. Despite this flexibility, however, the ESC would have needed HRC to adopt a unit-focused approach to provide quality replacements as well as a much needed revision to the USCENTCOM deployment policy medical fitness standards specified in the document known as Modification Twelve, or MOD 12.[3] These changes probably could have helped the unit to acquire the soldiers it needed for deployment despite hindrances from the Army's medical and personnel systems.

The 13th ESC personnel readiness goal before deployment was to set the 13th ESC team and achieve a 90 percent deployable personnel strength ninety days prior to the latest arrival date. The unit was expected to receive gains during its deployment, with the final goal of attaining a greater than 95 percent deployable strength by the latest arrival date. The 13th ESC identified the required backfills on the unit's "mission-essential requirements list" and provided them to HRC in March 2014. The organization conducted video teleconferences with officers attending the intermediate-level education course at the U.S. Army Command and General Staff College and followed up with by-name requests. It continually tried to get as many soldiers deployable as possible and to move nondeployable soldiers to other assignments so the organization could receive qualified replacements.

The 13th ESC coordinated with the 1st Sustainment Command (Theater) on the deployment unit-manning roster in April 2014. Coordination was ongoing through mission command training and then through the 2014 predeployment site survey (see figure, page 99). The 13th ESC also conducted a pre–soldier readiness processing (pre–SRP) event from 9 to 11 September 2014, before final SRP in October, to identify remaining medical or administrative issues. Shortages and concerns were reported to 1st Sustainment Command (Theater), to III Corps, and to HRC through the monthly Unit Status Reports. Even with these efforts, the unit could only muster a 71 percent deployable rate by December 2014.

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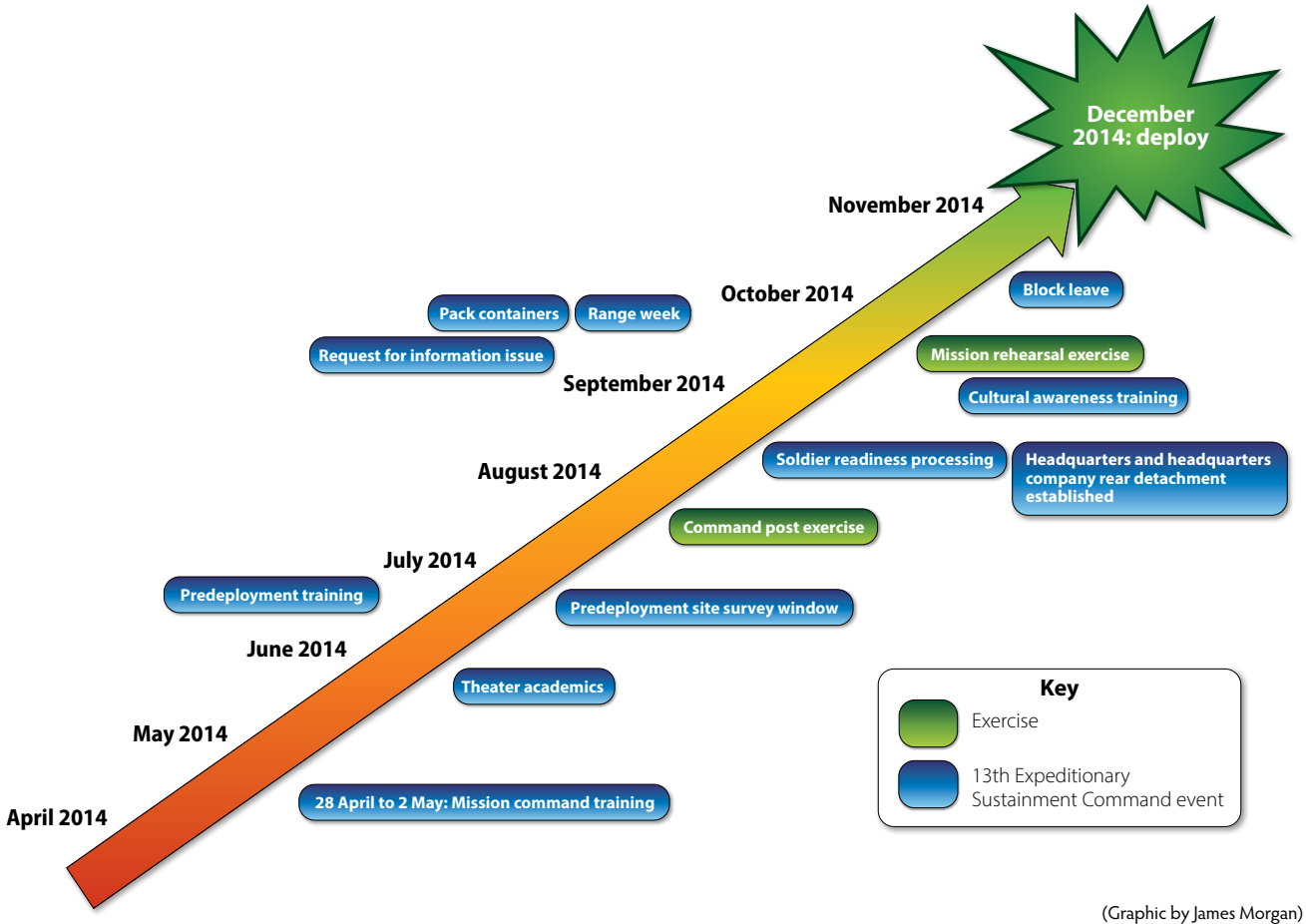

(Graphic by James Morgan)

Figure. Road to War

The many factors that directly affected the unit's numbers throughout the deployment included availability of quality (deployable) inbounds, retirements, resignations, individual medical needs, soldiers twice not selected for promotion, separation board results, and Fort Hood logistical responsibilities. The quality-of-fills data in table 1 (page 100) highlight nondeployable rate and status categories the organization contended with from April 2013 to November 2014 as it tried to fill the ranks for deployment.[4]

For the 13th ESC, from April 2013 to November 2014, the percentage of nondeployable inbounds for staff sergeant (E–6) to colonel (O–6) was nearly 20 percent. Thirty-one of 417 inbounds (about 7 percent) of the ESC's inbounds received medical profiles within the first sixty days of assignment to the ESC. Nineteen received medical profiles that required less than thirty days to recover, while seven received medical profiles that would require thirty days or more recovery time. Five soldiers arrived while on a medical profile from their previous units—three on medical profiles requiring thirty days or more to recover and two on medical profiles that require thirty days or less to recover. Ten had a history of profiles that ended just before their permanent change of station (PCS), which could be an indicator that they may have a more permanent medical condition. Subsequently, twelve were referred to medical evaluation boards (MEBs) for separation. In addition to medical nonavailabilities, the unit continued to receive soldiers with dwell time (mandated recovery time) built up from a previous deployment, which made them nondeployable. The return of the Task Force Sinai support battalion in December 2014—sourced from 13th ESC nine months prior—created a situation where the 13th ESC had a significant dwell population of fifty-four soldiers who would require nine months at home station before being deployed again.

The quality of fills due to separation and promotion boards played a role. During 2014, the 13th ESC experienced both a high separation board rate and a low promotion selection rate when compared to Army-wide statistics. Of course, unit fills typically consist of a range of quality; however, there generally should be a balance within a few percentage points of the Army-wide promotion selection averages. The 13th ESC board data are shown in table 2 (page 101).

The 13th ESC became, in effect, a quasi-holding unit for officer transitions, which counted against its deployable numbers and overall personnel readiness plan. The unit received a majority of officers who were selected for separation with a limited number of officers promoted. Some were already in the unit and some were on PCS orders to the unit, while others were III Corps–directed intrapost transfers from other units as those units were deploying.

Table 1. Nondeployable Rate of Inbound Personnel for the 13th ESC and the 4th Sustainment Brigade, April 2013 to November 2014

Types of nondeployable status	Nondeployable rate of 417 inbound personnel as a percentage*	Numbers of nondeployable inbound personnel
Scheduled for retirement or resignation	3%	14
Arrived with dwell time	2%	9
Referred to medical evaluation board	3%	12
Received long-term 3B** profiles first year assigned	11%	46
Total inbounds nondeployable	**19%**	**81**

*** Includes E-6 (staff sergeant) to O-6 (colonel). Percentages are approximate.**

**** Individual medical readiness category for a medical condition that cannot be resolved within 30 days.**

(Table by James Morgan)

An additional contributing factor was the need to source a sustainment brigade headquarters and three sustainment battalions to deploy to Kuwait. The 4th Sustainment Brigade lost three majors and five captains projected to deploy due to the fiscal year 2014 Officer Separation Board. The unit mitigated shortfalls through internal reorganization efforts. The 13th ESC headquarters moved two majors needed for the deployment down to fill the 4th Sustainment Brigade, thus increasing deployment manning concerns. Of the thirteen 90A (logistics) major positions, four would be filled by 90A captains.

During the 13th ESC's July 2014 predeployment site survey, the 13th ESC conducted a video teleconference with the HRC Office of Personnel Management Division, the 13th ESC account manager, and the III Corps G-1 (assistant chief of staff, personnel) to discuss possible solutions, including potential ways to reach 90 percent deployable strength for the 13th ESC Headquarters and the 4th Sustainment Brigade. To achieve this, one brigade and three battalion headquarters needed to be filled at rates of 119 percent to 148 percent over strength. Even with this effort, due to low-quality inbounds, separation boards, and medical issues, the 13th ESC deployed at 71 percent of the required deployment strength instead of 90 percent, with 45 percent of its total population nondeployable (see table 3, page 102).[5]

The Effect of Medical Factors on Deployable Status

Why did the 13th ESC need to get filled to such a high rate in order to deploy at 71 percent versus the 90 percent it was trying to achieve? The main contributing factors were the unit's lack of medical assets to examine soldiers early, the medical readiness of soldiers in general, and the various medical processes

Table 2. Boards in 2014 as Quality-of-Fill Indicators

Board	Quantity	13th Expeditionary Sustainment Command Army board selection rates	Overall Army board selection rates
Identified as high risk for separation	10 majors and 8 captains	N/A	N/A
Separation board for major	6 majors	17%	6.5%
Separation board for captain	9 captains	20%	11.7%
Centralized selection list command/key billet for lieutenant colonel	1 selected, 2 alternates, 3 not selected	N/A	N/A
Promotion to lieutenant colonel	1 selected	33% (3 not selected twice and 2 not selected once)	63%
Promotion to major	3 selected	38% (2 not selected twice and 5 not selected once)	65%
Promotion to chief warrant officer 5	0 Selected	0% (2 not selected twice and 3 not selected once)	18%
Promotion to chief warrant officer 4	0 Selected	0% (1 not selected)	65%
Promotion to chief warrant officer 3	3 Selected	50% (4 not selected twice and 3 not selected once)	68%

Note: Figures are rounded.

(Table by James Morgan)

and procedures that inadvertently limited the number of deployable soldiers in a unit.

One issue facing the 13th ESC concerning personnel medical readiness was not having the expertise on hand to examine medical readiness issues and advise the commander early on. A typical ESC's surgeon cell is staffed by a 68W noncommissioned officer (combat medic, sergeant first class, E–7) and a 70B Medical Service Corps officer (health services administration) but no medical providers. The noncommissioned officer and Medical Service Corps officer work in an administrative capacity and do not provide clinical decision making. The 13th ESC was authorized a medical provider, and one arrived in July 2014, approximately four months before deployment. It had been four years since the organization had a permanently assigned surgeon. The position normally was staffed by an Army Professional Filler System (PROFIS) assignment and only during deployments. The 13th ESC's only other medical providers before June 2014 were those assigned to the 4th Sustainment Brigade—a physician, a physician assistant, and seven medics. With the 4th Sustainment Brigade deploying four months before the ESC, few medical resources remained.

To exacerbate the situation further, the recent realignment of sustainment brigades to divisions has extremely limited an ESC's ability to influence medical readiness; any logistics battalions assigned to an ESC have no medical assets. Typical maneuver battalions, on the other hand, have an assigned active-duty physician or physician assistant and medics.

Like many providers filling 60A surgeon positions (operational medicine), the ESC surgeon was a subspecialist in pediatric allergy with only prior PROFIS assignments and no experience as a staff officer. During the initial two months, the surgeon attended required training, including the Brigade Surgeon Course and the Tactical Combat Casualty Care Course. During the two-week Brigade Surgeon Course, the unit surgeon received only one hour of instruction each on eProfile, IDES, and the medical protection system; all these systems play an integral role in the medical readiness of soldiers. Many health professionals have limited experience with these programs or others, such as Periodic Health Assessments and Post-Deployment Health Risk Assessment programs, which all influence the medical readiness of soldiers. Health professionals need familiarity with them.

With limited medical assets before deployment, the 13th ESC relied on the only system available for medical readiness—the troop medical clinic, where soldiers assigned to the unit, including the battalions, see civilian providers. These providers may have many years of civilian experience but often do not have military experience. In addition, they have no formal

Table 3. Comparison of Soldiers Assigned with Soldiers Deployable from May to December 2014

13th Expeditionary Sustainment Command (ESC)

Month	Number authorized	Number assigned	Percentage assigned	Number available to deploy	Percentage available to deploy	Number not deployable	Percentage not deployable	MTOE* deployable
August	262	288	110%	178	62%	110	38%	178/68%
September	262	290	111%	211	73%	79	27%	211/80%
October	262	311	119%	205	66%	106	34%	205/78%
November	262	314	120%	202	64%	102	36%	202/77%
December	262	339	129%	185	55%	154	45%	185/71%

4th Sustainment Brigade (SB)/Special Troop Battalion (STB)

Month	Number authorized	Number assigned	Percentage assigned	Number available to deploy	Percentage available to deploy	Number not deployable	Percentage not deployable	Actual deployed
July	262	318	121%	235	74%	83	26%	-
August	262	354	135%	283	80%	71	20%	-
September	262	387	148%	289	75%	98	25%	186/92%

553rd Combat Sustainment Support Battalion (CSSB)

Month	Number authorized	Number assigned	Percentage assigned	Number available to deploy	Percentage available to deploy	Number not deployable	Percentage not deployable	Actual deployed
May	69	61	84%	58	95%	3	5%	-
June	69	70	99%	68	97%	2	3%	-
July	69	144	141%	97	67%	47	33%	67/97%

49th Movement Control Battalion (MCB)

Month	Number authorized	Number assigned	Percentage assigned	Number available to deploy	Percentage available to deploy	Number not deployable	Percentage not deployable	Actual deployed
May	54	83	106%	57	69%	26	31%	-
June	54	83	124%	67	81%	16	19%	-
July	54	80	119%	64	80%	16	20%	54/100%

Units were filled at 119% to 148% strength to deploy at 92% or greater:
· 4th SB headquarters/4th STB authorized 262, assigned 387, assigned 148%, deployed 186 (92% of force tracking number [FTN]), nondeployable 25%
· 553rd CSSB authorized 69, assigned 144, assigned 141%, deployed 67 (97% of FTN), nondeployable 33%
· 49th MCB authorized 54, assigned 80, assigned 119%, deployed 54, (100%), nondeployable 20%
***Modified table of organization and equipment**

(Table by James Morgan)

connection to the units and the command. There are no opportunities for the providers to review their practice—such as by conducting profile review boards or unit readiness reviews—in light of the effect on the individual soldiers or the units. For example, a soldier who was on a temporary profile was seen for knee pain, and the provider gave a P2 (walking) profile after only four visits over several months. The soldier or the provider might not realize that the soldier's ability to attend schools or be promoted could be affected.

Some would say that it is not the provider's place to counsel a soldier on his or her promotion potential, and that medical professionals should treat disease regardless of rank. However, military providers provide options that take into consideration future implications in a soldier's career. Often, civilian medical providers make decisions that inadvertently result in a nondeployable soldier. Essentially, they take away a commander's ability to decide if a soldier should deploy. This occurs for many reasons even as providers are

trying to do the best job they can for patient care, but the situation often hampers the readiness of units.

One reason this occurs is due to how hospitals and clinics are evaluated and funded. Patient comments—positive or negative—often determine how a provider is evaluated. A hospital receives a portion of its funding based on the results of surveys (the Joint Outpatient Experience Survey replaced the Army Provider Level Satisfaction Survey in 2016). If survey results were negative, the hospital could potentially not receive additional funding. This might lead providers to cater to patient requests to gain positive survey results. It also could lead providers to liberally provide multiday restriction-to-quarters slips or profiles with strict duty restrictions, which would hurt a unit's morale and discipline, as physical training is an integral part of *esprit de corps*. Of particular concern is what are commonly referred to as "0900 work call" profiles (profiles that specify the start of the duty day) or those that specify an eight-hour duty day, usually due to health professionals prescribing psychiatric medication or other potentially debilitating drugs.

The Office of the Surgeon General addresses profiles and duty-hour restrictions in the "Behavioral Health Profiling Standardization Policy," which acknowledges, "Significant variability exists throughout the Army when medical providers communicate duty hour limitations."[6] Profiles prevent soldiers who could be considered fit for duty from deploying, so other soldiers have to perform their tasks because the formation does not receive replacements.

Soldier Readiness Processing Challenges

The 13th ESC conducted pre–SRP in September 2014, but due to the short period from the surgeon's arrival, mandatory training, and the deployment of the 4th Sustainment Brigade in October 2014, the medical providers had little opportunity to screen medical records. In fact, the previous SRP had been conducted nearly four years earlier, in December 2012, but the SRP for the pending deployment could not be scheduled before orders arrived. The headquarters company commander was told by the operations advisor during SRP that the unit could not go through processing without orders, even with the deployment pending.

The three months before deployment was a time of high operational tempo and not ideal for initial medical readiness processing. The result was delays in determining the deployment medical readiness of personnel due to required evaluations that then necessitated additional time-consuming tests and examinations. The local medical treatment facilities were cooperative and generally able to schedule initial appointments within seventy-two hours, but processing radiologic studies, labs, and off-post consultations often could not be accelerated. At the time of the initial SRP, Automated Neuropsychological Assessment Metrics testing and behavioral health reevaluation from the 2 April 2014 Fort Hood shooting were also scheduled.[7] These were in addition to a validation exercise, transfer of authority with a replacement unit coming to manage sustainment on Fort Hood, ranges, family time, and block leave.

Preferably, SRP should be scheduled no more than 120 days before the expected deployment date, which the 13th ESC accomplished in the September 2014 pre–SRP. The intent of the initial SRP is to help soldiers address medical concerns not previously addressed by their primary care manager so units can resolve issues or find replacements. However, 120 days may not give units enough time to obtain deployable replacements.

Several factors contribute to a growing medical class of personnel within the Army who are nondeployable. They take up valid and critical slots but cannot deploy, leaving units no recourse to gain deployable personnel. Troop medical clinic providers not well versed in deployment criteria may be treating soldiers to the standard of care, but they may not address stricter requirements to deploy, such as medical subspecialist clearances. Conducting SRP can assist—an example is a soldier with a small asymptomatic hernia who declined surgery. Based on MOD 12 guidelines, at a minimum, a soldier could not deploy without a USCENTCOM waiver, which would be determined by a surgical consultation, evaluation, and clearance—all which can take months to achieve.[8] In the meantime, a soldier's deployment status would be questionable and perhaps denied, resulting in the need for a replacement.

Another issue facing the 13th ESC's readiness came from conflicting regulatory guidance. Soldiers are screened for deployment eligibility based on multiple criteria, including AR 40-501 and MOD 12, as well as various U.S. Medical Command (USMEDCOM) requirements. These requirements are not always complementary. For example, a soldier can meet retention

criteria based on AR 40-501 but not meet MOD 12 deployment criteria. In addition, a soldier can meet both retention and MOD 12 criteria but not be deployable based on a USMEDCOM directive. For instance, the 13th ESC had a soldier with a history of systemic reactions to a bee sting whose allergy was confirmed by testing. He met retention criteria and in principle could deploy with a waiver for an EpiPen, but based on venom immunotherapy recommendations from the Office of the Surgeon General, the soldier needed allergy shots for three years.[9] Immunotherapy is not approved in deployed situations and is denied at the local combat support hospital, so the soldier would be nondeployable for three years. This soldier otherwise met retention standards and did not qualify for an MEB. The unit needed a replacement.

Seeing the increase of nondeployable soldiers within the 13th ESC, III Corps tried reorganizing personnel in a short amount of time to assist the unit, but due to other deployments and required specialties, the capability was minimal. HRC would need four to six months to reassign a replacement from across the Army. By 23 October 2014, 21 percent of the 224 soldiers scheduled to deploy had delays in their SRP due to medical clearance issues. By 4 December 2014, eleven of the fifteen late deployers were due to medical delays, including needs for medical stabilization for ninety days, CPAP (continuance positive airway pressure) therapy compliance downloads, and follow-up evaluations. Of the 339 soldiers assigned to the 13th ESC by December, 185 deployed, putting the unit at 71 percent of MTOE strength.[10]

To increase the number of deployable soldiers, the 13th ESC conducted monthly reviews of the status and treatment of soldiers who did not deploy. The reviews included examining the status of USCENTCOM waiver approvals; new profiles; changes to medical conditions, including if soldiers met their medical retention decision point (MRDP); and IDES criteria. The monthly meetings were attended by the 13th ESC commanding general, headquarters commander, rear detachment commander, G-1 (both forward and rear), surgeon (both forward and rear), and rear detachment chief of staff. With follow-up from the rear detachment command surgeon, by 15 January 2015, the 13th ESC had twenty-three soldiers in the IDES process versus twelve before the September 2014 SRP.

At least one soldier, who claimed he was deployable and was released from the MEB process, was then put on another temporary nondeployable profile within a week for another medical issue that did not allow him to clear SRP. Even though he continued to be nondeployable by MOD 12 standards, he was not eligible for the MEB. When the MEB states a service member is fit for duty, and the unit does not want to change the nondeployable soldier's duty station, the soldier provides little value to the unit during its deployment. Also, of similar concern are soldiers who undergo IDES and are found fit for duty but with limitations in deployment. This includes soldiers with medical conditions requiring frequent lab follow-up, those on medications that cannot be used in austere environments, or those who cannot tolerate long periods on combat rations. These soldiers then carry a "V" code on their profile that continues to count against the command as a 3B profile, in addition to holding a position in a deploying unit that must now be accounted for by others.

One of the most difficult situations that was noted during monthly reviews was soldiers with behavioral health issues. Several soldiers said they felt they were being punished for seeking care and being on behavioral health or sleep medication, which required a waiver that was subsequently denied. With so many senior soldiers with numerous deployments and combat experience, it is not uncommon that they have a diagnosis of posttraumatic stress disorder (PTSD) and receive medications. In December 2012, the U.S. Department of Veterans Affairs reported that nearly 30 percent of veterans of the wars in Iraq and Afghanistan whom it treated had PTSD.[11]

As a command, the 13th ESC strongly encourages its soldiers to seek appropriate behavioral health care. The command does not want to foster the impression that doing so negatively impacts the careers of otherwise functional soldiers. If soldiers felt ready to deploy, we, as medical providers and human resource administrators, advocated strongly for approval of waivers that would allow them to deploy. We, of course, understand the risks associated with these issues and the safety and care that must be balanced with such risks. We accepted waiver results but supported those soldiers who wanted waivers for their conditions and said they felt capable of deploying despite continued treatment. During the deployment, of soldiers who returned due to medical issues (including MOD 12 failure and medical evacuation) from December 2014 to April 2015, four were for, or included, behavioral health issues; this was about 36 percent of those medically released from theater. Of

those, only one had a MOD 12 behavioral health waiver before arrival. Therefore, most issues arose for the first time during the 13th ESC's deployment.

A waiver decision should be made with input from the command and consideration of a unit's deployment location and assets. As in our experience, with treatment received in theater, fewer soldiers returned due to behavioral health conditions than for orthopedic issues.

Another concern regarding behavioral health waivers is that soldiers would follow up with their off-post behavioral-health provider about the inability to deploy due to their medications. Civilian providers who have a limited understanding of deployment medical requirements would then—at a soldier's misinformed request—discontinue or modify medications if symptoms allowed, thinking the soldier could deploy. Based on MOD 12, a soldier then would become nondeployable for up to ninety days from that medication change. If the circumstance was noted at the soldier's revalidation SRP, then the best-case scenario would be deployment up to three months after the rest of the unit.

Sleep apnea also proved to be a confusing diagnosis during SRP. Some soldiers with mild obstructive sleep apnea who did not need a sleep study by the MOD 12 guidelines were referred to the sleep clinic for such and had waivers sent. The MOD 12 guidelines were not entirely clear, as a waiver was not required for mild obstructive sleep apnea, but soldiers using CPAP therapy still would need a compliance download. If soldiers did not meet the minimum criteria on their thirty-day download and settings were adjusted, they would need another thirty-day compliance download and so on until they were stabilized.

Orthopedic issues and their associated pain conditions are another common medical condition found in soldiers of all career lengths. These caused issues both before and during the 13th ESC's deployment. The most commonly found conditions were back and knee issues. Soldiers given narcotic pain medications for chronic pain required a MOD 12 waiver, which was generally disapproved if they were on narcotic pain medications in the prior six months. Soldiers may have chronic orthopedic conditions that flare and require an increase in pain medications. They can continue to take and pass their Army physical fitness tests and do not carry a nondeployable profile, making them retainable, but they are not deployable.

In addition, treatment plans and available resources while deployed can be confusing for both soldiers and providers. In theater, injections are routinely performed for joints but not for spine. Injections are only intermittently available if the medical support unit happens to receive a provider credentialed to provide this procedure.

Two soldiers with chronic back pain were sent home after only six weeks due to back pain not treatable in theater at the time. About three months after they departed, an anesthesia provider credentialed in pain management who could provide spinal injections arrived. While receiving treatment of injections every three to six months, soldiers are able to participate in physical training and do not have any deployment-limiting restrictions on their profile, but they cannot deploy.

Issues faced by the 13th ESC in trying to get personnel medically fit to deploy were the result of several factors, including health professionals not fully understanding the ramification of their treatment or of Army medical systems and procedures, patient-provided information, and conflicting medical regulations. For the latter, a holistic, integrated review and alignment of combatant-command-specific deployment criteria and AR 40-501 would best serve both soldiers and units. This is certainly an area that needs clarification as it affects a soldier's career and should not be left to interpretation.

There are too many cases when soldiers cannot deploy due to a declined waiver but do not require a profile, or their profiles do not qualify them for an MEB based on AR 40-501. When soldiers are found nondeployable due to a declined waiver and are then allowed a PCS, the process begins again with the following unit. As requirements are different for those on PCS versus deploying to the USCENTCOM area of responsibility, the inconsistencies in MOD 12 entry criteria should be addressed. To illustrate, a soldier just returned from a twelve-month tour to Bahrain, Dubai, or Kuwait could be declined a waiver months later without any changes to the individual's medical conditions during a nine-month rotation.

As for those who cannot deploy, the MRDP to enter an MEB is not a well-known published system for those outside of operational medicine; it is neither uniform nor consistent. This creates confusion for

providers with different interpretations or thresholds for MRDP, or confusion between the MEB clinic and the primary care manager. In some situations, readiness and retention depend on the soldier's length of service. This is apparent in our junior soldiers with few years in service. A young lieutenant with only three years of service is unlikely to complete a full twenty years if the lieutenant has already been on profile for greater than 180 days for foot, knee, or back pain without a clearly delineated cause that can be resolved.

While changes to eProfile pending at the time this article was written were aimed at improving command visibility of profiles and medical issues, and at continuing to allow overrides for some, getting soldiers on profile who cannot deploy into an MEB or the Warrior Care and Transition Unit continues to be challenging. The changes in readiness processes, as reported thus far, appear aimed at visibility and tracking, and not at resolving the disposition of soldiers with chronic medical conditions who are not deployable but do not meet MRDP.

Conclusion

In summary, soldier medical readiness continues to be of concern. For the shift to a smaller and more agile force, it is imperative that adjustments be made in how units manage assets and in how the Army manages its personnel.

Some of the circumstances we encountered were unique to the 13th Expeditionary Sustainment Command, but sustainment units throughout the Army have shared similar challenges. The Army is at a critical point, with the decrease in total strength after over a decade at war and the unpredictability of the force's part in global security efforts. Therefore, taking care of soldiers physically, mentally, and professionally while keeping units prepared for deployment is a precarious balance. The 13th ESC successfully deployed and completed its missions and tasks. The concerns and recommendations offered here are intended as a starting point for meaningful discussion and dialogue as the Army leans forward and remains ready. ■

Notes

1. At the time of the 13th Expeditionary Sustainment Command's preparation for deployment, medical fitness standards were governed by Army Regulation (AR) 40-501, *Standards of Medical Fitness*, (Washington, DC: U.S. Government Publishing Office [GPO], 14 December 2007, with Rapid Action Revision 2011), now obsolete. A revision was published 22 December 2016 although it did not address the issues discussed in this paper.

2. Refer to the Warrior Care and Transition Unit website for more information about the unit and the Integrated Disability Evaluation System (IDES), accessed 23 January 2017, http://wct.army.mil/.

3. United States Central Command (USCENTCOM), "Amplification of the Minimal Standards of Fitness for Deployment to the USCENTCOM AOR [Area of Responsibility] to Accompany MOD [Modification] Twelve to USCENTCOM Individual Protection and Individual–Unit Deployment Policy," December 2013, PPG-Tab A, p. 7, accessed 30 January 2017, https://www.cpms.osd.mil/.

4. James Morgan, table 1, comparison of arrival dates with medical history and administrative coding in Army human resource systems data queried from the Electronic Military Personnel Office (also known as Datastore) 4 December 2014 and compared with December 2014 Medical Protection System (MEDPROS).

5. James Morgan, table 3, data pulled on the first working day of the month May 2014 through December 2014 from the Electronic Military Personnel Office (eMILPO), MEDPROS, and the Total Officer Personnel Management Information System II (TOPMIS II). Information was compiled and submitted the 15th of each month May 2014 to December 2014 as part of the Unit Status Report.

6. Office of the Surgeon General/U.S. Medical Command (OTSG/USMEDCOM), Policy Memo 15-045, "Behavioral Health Profiling Standardization Policy," 6 August 2015, 2.

7. Eyder Peralta, "Shooting at Fort Hood Leaves 4 Dead, 16 Injured," NPR [National Public Radio] online, 2 April 2014, accessed 25 January 2017, http://www.npr.org/sections/thetwo-way/2014/04/02/298401578/fort-hood-goes-on-lockdown-after-reports-of-shooting.

8. USCENTCOM, "Amplification of the Minimal Standards of Fitness for Deployment to the USCENTCOM AOR; to Accompany MOD Twelve to USCENTCOM Individual Protection and Individual–Unit Deployment Policy," 2013, accessed 30 January 2017, https://www.cpms.osd.mil/.

9. OTSG/USMEDCOM, Policy Memo 13-008, "Stinging Insect Allergy Induction, Retention, and Readiness Policy."

10. Morgan, compiled 4 December 2014 as part of the Unit Status Report using data pulled on 1 December 2014 from eMILPO, MEDPROS, and TOPMIS II.

11. Epidemiology Program, Post-Deployment Health Group, Office of Public Health, Veteran's Health Administration, Department of Veterans Affairs, *Report on VA Facility Specific Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans Coded with Potential PTSD [Posttraumatic Stress Disorder]—Revised: Cumulative from 1st Qtr 2002 through 3rd Qtr FY 2012 (October 1, 2001–June 30, 2012)*, (Washington, DC: Department of Veterans Affairs, December 2012), accessed 25 January 2017, http://www.publichealth.va.gov/docs/epidemiology/ptsd-report-fy2012-qtr3.pdf.