Taking Holistic Health and Fitness to the Fight

A Case Example of One of the First H2F Teams to Deploy on Rotation to the Republic of Korea

Maj. Mikala K. Bruno, DPT, OCS, CSCS, U.S. Army
Capt. Sean M. Boulanger, DPT, OCS, CSCS, U.S. Army
Sgt. 1st Class Christian V. Olivarez, U.S. Army
Jason E. Hartman, CSCS

Defend the homeland, deter attacks and aggression, prevail in conflict, and build a resilient force. The *2022 National Defense Strategy* defines these priorities in detail and describes the future force needed to deter and prevail over threats to U.S. national interests, including those posed by China and North Korea.[1] Integral to success are the soldiers who will execute this strategy. Detering attacks and prevailing in conflict requires fit, resilient, and lethal soldiers, and the Army's Holistic Health and Fitness (H2F) program aims to produce and maintain a fighting force who can do just that.[2]

More than serving soldiers in garrison, H2F plays a vital role in a forward-deployed setting. The H2F team provides important health surveillance data, reduces evacuations and return-to-duty times, and maintains readiness. While limited staff deploy, H2F teams still positively impact a commander's ability to create human advantages and understand and to manage the effects of operations on soldiers. The 2nd Stryker Brigade Combat Team, 2nd Infantry Division (2-2 SBCT) H2F team was the first to deploy with a Stryker brigade on rotation to the Republic of Korea and one of the first to bring a full H2F team. Current and developing H2F teams and their commands can learn from our experiences during predeployment, rotation, and redeployment.

Predeployment

The predeployment period included opportunities to test forward roles for H2F at the National Training Center (NTC) and train medics for H2F support. During the NTC rotation, the H2F team embedded with the 2nd Brigade Support Battalion and operated out of the Role II medical treatment facility.

Positioning H2F personnel near the Role II facility allowed the team to access medical supplies and utilize preestablished lines of transportation, a critical need as H2F does not have organic vehicles. At NTC, the H2F team focused on treating real-world injuries and assisting in triage for mass casualty exercises. Coordination with battalion medical officers was key for rotations to battalion aid stations (BAS), which allowed H2F to augment BAS services and provided more opportunities for H2F team members to interact with soldiers.

Sgt. 1st Class Christian Olivarez instructs 2nd Brigade Support Battalion soldiers during a run class in the Republic of Korea. (Photo by Maj. Mikala Bruno, U.S. Army)

The largest lesson from NTC was the need to better integrate with the surgeon cell. Unfortunately, personnel shortages during predeployment due to professional military education attendance and normal personnel turnover led to missed opportunities to fully integrate into predeployment planning. Only three military H2F staff were able to attend NTC—a dietician, a physical therapist (PT), and a physical therapy technician—limiting the opportunity to develop procedures for forward operations. The H2F team did not proactively integrate with medical operations; consequently, H2F was not considered during medical planning, and the H2F team did not adequately understand the medical concept of support.

After the lessons learned at NTC, H2F staff prioritized training medical personnel to compensate for limited H2F resources. H2F staff conducted battalion medic training and emphasized enhancing medic skills to augment H2F capabilities. The focus was on injury identification and basic treatment. Each battalion engaged variably, and training may have been hampered by brigade medical staff shortages, the need for medics to assist with predeployment Soldier Readiness Program (SRP) processing, and medical staff turnover.[3]

Numerous vacancies in key medical positions—most notably the brigade surgeon, the brigade medical planner, and physician assistant shortages—and reduced deployability of assigned personnel limited our ability to remedy the difficulty with coordination first identified at NTC. The surgeon cell's primary focus was predeployment SRP. Manning requirements for the rotation meant the medical team needed to make every effort, within medical guidelines, to deploy soldiers. Medical staffing shortages and the demanding SRP schedule contributed to the limited capability for full medical coordination with H2F.

The H2F team additionally prioritized identifying space and equipment in each area of operations (AO) for the rotation. We obtained equipment estimates from the incumbent unit and from the brigade predeployment site survey. The survey did not include H2F team members, and the unit we replaced did not have a full H2F team; therefore, H2F infrastructure, equipment, and supplies were not fully considered. Additionally, the H2F team did not receive our deployment medical equipment set prior to container pack out. All these issues limited the ability to visualize the space, create new systems, and establish deployment processes prior to rotation.

The H2F team redistributed labor to ensure coverage of all existing H2F responsibilities. The 2-2 SBCT H2F program director appointed the senior ranking officer, the injury control (IC) director, as the acting program director for forward operations. Responsibilities included advising the brigade commander on forward H2F operations, oversight and supervision of all forward staff and services, and brigade- and division-level H2F communication. One active-duty H2F member stayed in the rear. This person served as the rear officer in charge who assumed responsibility of all property and facility management and maintenance. Civilian personnel were assigned to lead their respective sections, and the civilian PT assistant assumed responsibility for managing inventory and class VIII ordering.

Numerous lessons learned arose from predeployment. The chief lesson is that H2F must better integrate with brigade- and battalion-level operations through the orders process to support existing plans. Without adequate knowledge, H2F cannot sufficiently prepare soldiers for the challenges they will face on rotation; and without H2F's role defined in the deployment order, the section is overlooked for important preparatory steps. H2F staff must not expect any leadership to request their services. Rather, they must develop plans to deliver services around brigade and battalion operations, draft their inclusion in the order, and communicate the critical roles H2F will play forward.

An additional key lesson from predeployment is to seek out all necessary infrastructure information and not expect the outgoing brigade to understand needs. In our case, our H2F team was more than three times the size of the outgoing brigade's team and had been established in the brigade for twice as long. The space they designated for H2F was insufficient for our team. We recommend asking about square footage, administrative equipment (desks, tables, computers, medical ports, etc.), exercise equipment, methods of communication, and existing relationships and partners. Finally, consider where H2F will be located relative to the battalions and ask about best practices for communicating with soldiers.

Deployment

Deployed H2F operations focused on efficiency and prioritization of resources. In garrison, our H2F team totaled thirty-seven members at the time, including nine active-duty soldiers. Only the active-duty soldiers deployed on rotation, greatly reducing the team available to serve the brigade. With reduced staff and a modified structure, we considered how to maintain the services the brigade was used to with one-quarter of our usual staff. We did this by developing robust H2F infrastructure where there was none, continual health surveillance data, and constant assessment and revision of clinical and outreach processes.

H2F distributed personnel in Korea based on unit distribution in our two main AOs, Camp Humphreys and Camp Hovey. Four of the seven battalions were in Camp Hovey, so eight H2F personnel resided there. The three remaining battalions in Camp Humphreys were served by the brigade PT and PT NCO. Personnel from mental readiness (MR) and performance nutrition (PN) planned to rotate to Camp Humphreys at intervals throughout the rotation. Additionally, Camp Humphreys houses a medical center and most specialty referral services available in Korea, including orthopedics, nutrition, behavioral health, and radiology services. Camp Hovey had reduced services in comparison. The

distribution of H2F assets allowed the team to maximize access to medical resources in both locations.

Securing facilities for the H2F team was our first priority and one of the biggest successes. Upon arriving in Korea, the H2F team quickly realized the Hovey Aid Station and Camp Humphreys Soldier Centered Medical Home were inadequate for H2F needs. Within a few days, the team identified three locations with adequate space for the entire H2F team. The key to success for the facilities were their central locations and ease of access. Rotational soldiers at Camp Humphreys and Camp Hovey primarily walked or used buses and taxis for travel, and the population seeking services were often injured. The spaces secured at Hovey were close to the Hovey PX, theater, and dining facility, a well-traveled area and accessible by existing bus routes. The Camp Humphreys building was located near the main dining facility.

Connectivity for new facilities created unique challenges in each AO. Internet connection was established at the Hovey facility; however, the Humphrey facility was set up in a company space that did not have the appropriate internet connections to support medical documentation. Despite several work orders and communications with the Department of Public Works, an internet connection was never established. This left the Humphrey's team to leverage relations in a nearby facility to complete documentation and referrals after clinic hours, delaying medical management.

The intent of the new facilities was that they become a permanent H2F facility for future rotational units. This concept was briefed to Camp Casey garrison command, 2nd Infantry Division, Eighth Army, and U.S. Forces Korea. The H2F team was active in informing higher echelons of our plans. Echelons above brigade (EAB) were supportive of H2F efforts and key in helping H2F establish new facilities. The H2F team built relationships, briefed, and advised the Eighth Army surgeon cell to set conditions for future H2F teams. These relationships led to the commitment to purchase permanent gyms-in-a-box for all companies on rotation, saving valuable shipping space and time without equipment for future forces. Additionally, we built relationships with the medical treatment facility; Morale, Welfare, and Recreation; and the Army Wellness Center to procure equipment, supplies, and working agreements.

After establishing facilities, the team focused on new processes to allow replication of garrison services in a deployed environment. To maximize information dissemination, the team designed an H2F digital resource page for each location linked to a QR code in a flyer (see figure 1). The resource page included information on services, contact information, hours of operation, maps to H2F locations, and handouts.

Communication challenges required that H2F revamp medical processes. The IC team developed a revised triage system to guide soldiers to the correct H2F resource from BASs. The H2F teams trained medics in the BAS on musculoskeletal (MSK) injury triage by severity. Mild injuries received a short profile and a standard home program, moderate injuries were screened in group classes to determine level of care, and high severity injuries were seen within seventy-two hours.

Injury tracking comprises the mainstay of H2F health surveillance data and is used to keep commanders informed about the effects of operations on soldiers (see figure 2). The IC section manages an injury tracker that identifies injury trends by body region and mechanism of injury down to the squad level. We maintained injury surveillance and delineated between deployed and rear populations. Additionally, we tracked the days between injury and initial contact with H2F and length of initial profile. Robust data allowed for targeted interventions and informed conversations with leaders. Based on trends, our team performed rounds conducting physical training with units, provided resources to improve readiness, and coordinated training tailored to unit needs (see figure 3).

MR and PN services utilized similar systems, connecting soldiers to services through the H2F resource page. The MR section partnered with the behavioral health (BH) team to provide subclinical care for mild BH conditions; while PN addressed weight loss, taping certification, and performance nutrition education. Both MR and PN rotated between Camp Humphreys and Camp Hovey, and soldiers enrolled in regularly occurring classes through the H2F resource page. This channeled the flow of patients, creating predictability and reducing the administrative burden of walk-in services.

Normal operations with reduced staffing proved a challenge for all H2F but particularly IC. Normal garrison operations included thirteen staff members to

serve a population of roughly 4,800 soldiers. Only 30 percent of the IC staff deployed to serve 85 percent of the brigade. This led to PTs working at an average of 200 percent normal patient volume with a workload as high as 400 percent over normal volume in some months. At the same time the staff in the rear operated at an average of 32 percent of normal volume. The highest volume seen by rear staff during any given month was 68 percent of normal volume. The uneven division of labor resulted in an overall lower number of soldiers seen for care and an intense workload for deployed providers making clinical and administrative decisions. Nonetheless, the IC section ensured that on average throughput remained at 84 percent of the volume normally seen in garrison.

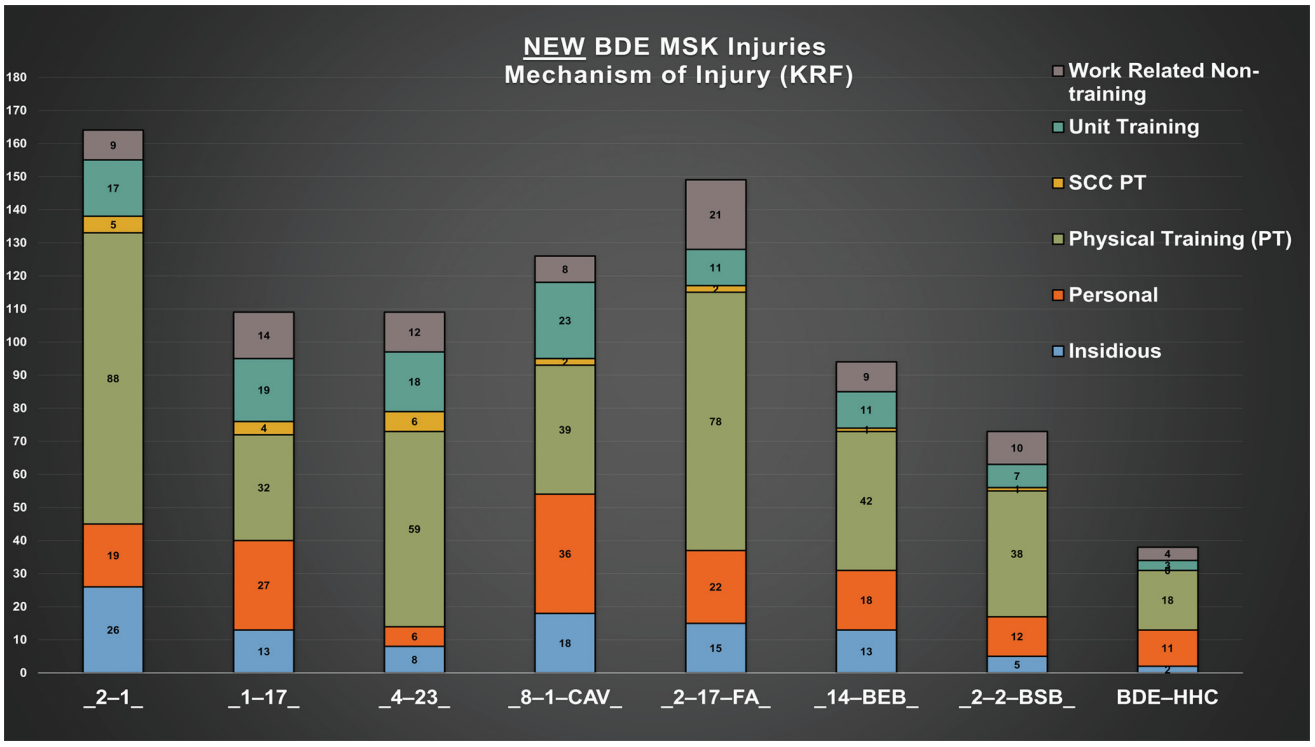
H2F providers faced complex injuries while hampered with degraded supply lines and only basic equipment. Due to the garrison-like environment, complex injuries were not evacuated; however, installation support and off-post referrals were not available to assist with increased volume. Off-site civilian hospitals provided Role III facilities and received patients throughout the rotation who then followed up with H2F. Significant postoperative conditions and orthopedic injuries requiring extensive medical attention added to provider caseloads in addition to routine MSK care. This was specifically challenging in Camp Hovey, where MTF referral sources were limited for imaging and orthopedics. Furthermore, H2F could only replenish basic supplies, meaning more serious cases often received treatments from equipment that traveled well like blood-flow restriction, and functional training in lieu of other standards of care like electrical stimulation.

The H2F team employed group classes to address lower-severity MSK issues, conserving time to manage complex MSK conditions. MSK triage and use of group screening and treatment sessions drastically improved access to care in both locations. The triage system kept access to care under seventy-two hours despite reduced H2F staff. The team had the luxury of using online resources during the rotation, but the same method could be used in austere environments using paper appointment slips.

While the IC team felt the brunt of the reduced staff, the nature of embedded battalion assets (contractors) left at home created obstacles for other H2F sections as well. Rotations between AOs were crucial

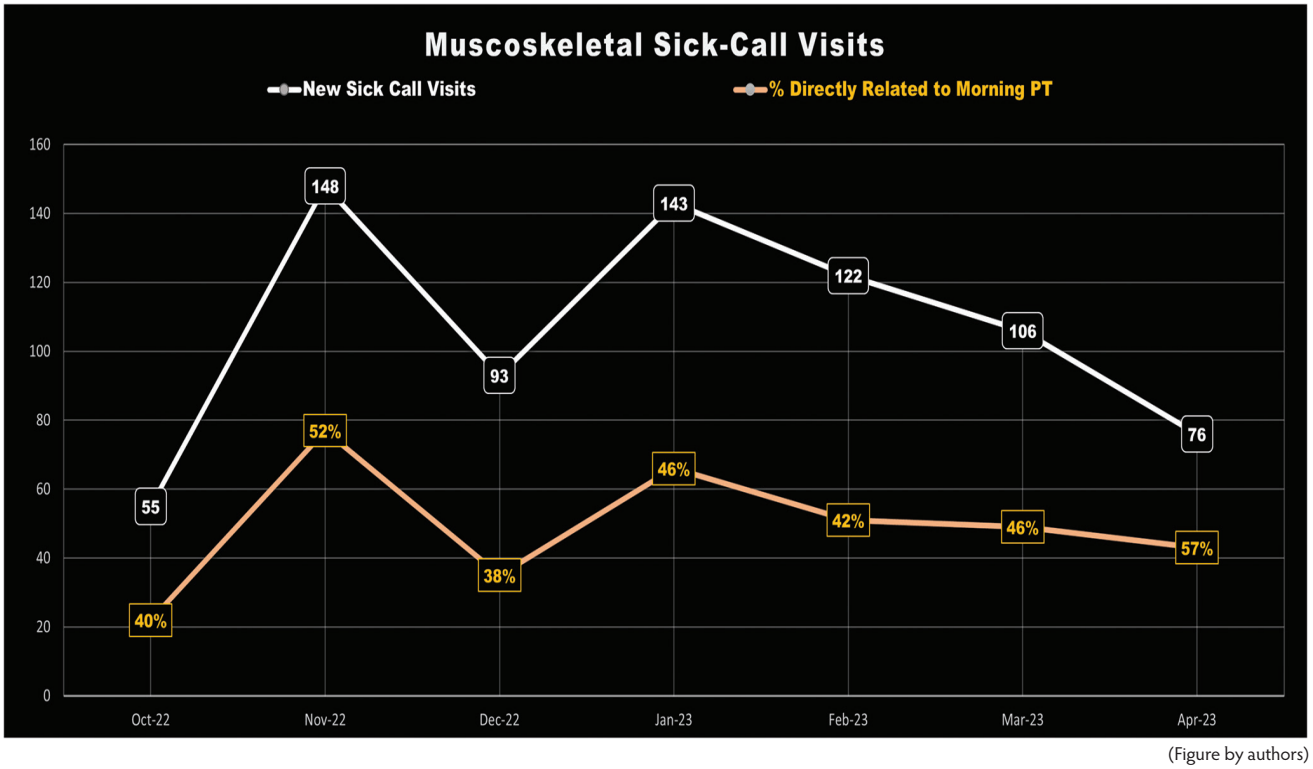
(Figure by authors)

Figure 1. H2F Flyer and Resource Page



Example of a chart produced from Injury Surveillance Data, sick call, and injuries from morning physical training. (Figure by authors)

Figure 2. Chart Produced from Injury Surveillance Data: Mechanism of Injury by Unit



(Figure by authors)

Figure 3. Chart Produced from Injury Surveillance Data: Sick Call Visits Related to Physical Training

to providing face-to-face interaction among the geographically distant battalions. PN and MR services were well established in Camp Hovey; however, rotations to Camp Humphreys ended up sporadic and with minimal planning. Online resources improved access, but class attendance was low. Without organic vehicles, rotating providers traveled by routine interbase buses several hours one way. Better communication with company leadership would have improved engagement in PN and MR resources.

Strength coaches had variable success with implementing exercise programming remotely across the time difference. Two similarly sized infantry battalions with similar field training demands in Camp Humphreys demonstrated the impact of remote strength-and-conditioning coach (SCC) programming. For example, one infantry battalion on Camp Humphrey's committed to their SCC program fully and sustained only 109 injuries from physical training while deployed. A second infantry battalion continued physical training without SCC programming and sustained 164 injuries. The battalion committed to SCC programming sustained 29 percent less injuries than the other through adherence to SCC programming alone.

The presence of at least one athletic trainer and one SCC per area would have drastically improved H2F operations while deployed. Given the nature of rotational operations versus deployed operations, the MSK injury caseloads accumulated due to the inability to adequately treat some conditions with limited resources. The MSK healthcare team completed over 2,200 appointments during the rotation. Assistance from an athletic trainer would have freed physical therapy NCOs to provide more treatment sessions for the complex caseloads. Presence of an SCC may have improved compliance with programming, potentially mitigating the 46 percent of sick call visits that were due to new injuries sustained during unit physical training alone.

Continual assessment, open communication with all H2F staff, feedback from key leaders, and a willingness to implement change were all keys to success. Limited information prior to arrival required the team to develop a plan once we landed. Within the first few weeks, processes and procedures changed multiple times and continued to improve throughout the rotation. The team's willingness to adapt drove the success.

Rear Operations

As previously mentioned, the majority of H2F staff remained in the rear. H2F civilians and contractors do not deploy; as a result, we had to find new ways for staff to interact with deployed soldiers and support deployed staff. The bulk of rear efforts focused on developing virtual resources, piloting new programs, and preparing for redeployment.

The rear detachment H2F personnel primarily supported the forward team through creation and delivery of digital resources. The time difference severely limited real-time communication, but soldiers were still able to make requests of rear H2F staff. When prior soldier-provider relationships were not established, forward H2F team members received requests for support and delegated to rear H2F team members. Email was the most utilized form of communication followed by Microsoft Teams. Five of our seven battalions purchased the TeamBuildr app ahead of the training rotation to allow SCCs to deliver programming and communicate through a chat feature in the app.[4] IC team members and occupational therapists built a library of video and home exercise programs to support the forward team's high-volume patient load.

The time difference was one of the greatest challenges. Rear H2F personnel had a generalized work schedule of 0600–1430 PST. With the time difference, the start of a soldier's duty day in Korea began at 1600 PST. Interperformance team communication often occurred ahead of morning formation, requiring forward performance team members to conduct work ahead of typical duty day hours. Rear detachment performance team members did flex their work schedule on occasion to accommodate soldier requests for real-time communication. This meant contractors started their workday later to be present at work later in the afternoon. The opportunity cost of flexing contractor work schedules was the loss of morning service delivery to the rear detachment when most soldier engagement generally occurs.

Support to the rear detachment soldier population was consistent with routine operations prior to the training rotation. H2F team members continued to deliver core services albeit to a significantly reduced soldier population. The rear detachment commander placed an emphasis on morale and family wellness. Occupational therapy acted as a referral hub for soldiers

and families to connect with other non-H2F enablers such as the Family Advocacy Program and military family life counselors. They additionally worked closely with the soldier family readiness group and held regular support meetings to assist with family wellness.

Although the numbers in the rear detachment ranged from six hundred to one thousand soldiers over the course of the rotation, the actual number of soldiers available to receive H2F services was limited. Soldiers attending schools, on temporary duty, changing stations, separating from the Army, and in the Medical Evaluation Board process all reduced actual soldier presence in daily operations. This greatly limited the workload across all H2F domains in the rear.

Preserving the contractor staff within our unit was a critical administrative effort during the rotation, but low work volume led to complacency. I Corps requested we share the H2F performance team contractors with nonresourced brigades. We sought to retain our staff in support of our rear detachment population that still exceeded the size of other H2F-resourced brigades on Joint Base Lewis-McChord, our home station. Additionally, data collected by the U.S. Army Research Institute of Environmental Medicine to track H2F performance compares resourced brigades to nonresourced brigades. Any H2F services delivered to nonresourced brigades would jeopardize the validity of their data. However, in retrospect, the nine months of low work volume for the contractor staff normalized a low operational tempo leading to deficiencies upon redeployment. Contractor staff struggled to rise to the operational efficiency necessary to support the surge in workload to which they were previously accustomed.

The low work volume did, however, provide an opportunity to pilot a major new brigade-level program and revise workflows. Prior to leaving for Korea, the IC team revised the policy for managing soldiers on profile during morning physical training. The program, named Recovery PT, involved major changes to physical training locations for those on profile and to accountability tracking. Due to the rotation, the brigade decided to implement a full pilot program for the rear detachment. The low volume allowed for low-risk implementation and leeway to revise coordination between sick call sites; communication between medical teams and within IC; and reporting to first sergeants, command sergeants major, and brigade leadership. Upon return from Korea, the pilot program was validated and ready for the full brigade to implement.

A final rear team focus was preparation for redeployment, which included partnership with the H2F and BH team forward. The brigade commander issued guidance to the forward teams that all soldiers would undergo a mental health screening before redeployment. The MR staff on rear detachment prepared to receive high-risk soldiers and initiate follow up. However, minimal coordination occurred with the division and the team conducting reverse SRP, and only one battalion was scheduled to receive H2F reintegration briefs. This oversight was mitigated after the arrival of advanced echelon (ADVON).

Redeployment

The H2F team both forward and in the rear proved to be a crucial element for redeployment and reintegration. Guidance from the brigade commander to perform mental health screenings for all soldiers before redeployment became one of H2F's most successful efforts. Individualized battalion-level reintegration briefs allowed H2F to reestablish care and services immediately after redeployment. H2F staff specialties allowed the team to mitigate many of the serious harmful behaviors often seen during this period.

H2F redeployment efforts focused primarily on mental health and preventing deaths by suicide. Aware of the double-digit deaths by suicide after redeployment of the brigade that proceeded ours, the brigade commander issued guidance that every soldier regardless of position or rank receive a one-on-one mental health screening before redeployment. The MR director worked with BH and battalion chaplains to provide an evidence-based screening that identified high-risk soldiers and coordinated care with rear providers. This effort reduced the stigma for soldiers seeking care and resulted in zero deaths by suicide within the first 120 days of redeployment.

The major challenge in conducting behavioral health checks aside from the logistics associated with the large number of soldiers proved to be acceptance by battalion leadership and chaplains. Resistance stemmed from the amount of work needed in a small window of time. This could have been mitigated with an earlier planning timeline and coordination with operations to include the H2F redeployment plan within the brigade

Capt. Sean Boulanger instructs soldiers from Company B, 2nd Brigade Support Battalion, on body mechanics during a deployment to the Republic of Korea. (Photo by Capt. Shawn Maddison, U.S. Army)

redeployment order. To overcome the lack of precoordination and short suspense, some battalions planned larger group briefings and asked soldiers in need to remain at briefing locations to receive additional assistance. However, this approach required individuals to advertise their need for assistance, which was counter to the brigade commander's intent.

Despite the challenge, we learned that keeping mental readiness forefront in redeployment efforts saves lives. Optimizing mental readiness is key when approaching new challenges, especially during transitions. Even with partial implementation, the brigade saw an incredible decrease in deaths by suicide compared to predecessors. This result alone demonstrates the vital role that H2F serves in a forward setting.

Upon redeployment, five out of seven battalions received individualized H2F briefings within one-week of arrival for ADVON through trail flights. Briefings lasted one to two hours and included a reintroduction of battalion-level H2F staff and a review of how to access H2F services in garrison. Additionally, the group received training on adequately adjusting to the time change, reregulating sleep patterns, and advice on nutrition and workouts. Briefings allowed the H2F team to provide detailed information to each battalion regarding SCC plans and explain the new process for seeking care for injury and Recovery PT. Inclusion of H2F staff from the rotation allowed H2F to personally connect with soldiers and ensure content was relevant to their experience.

Most challenges stemmed from difficulties deconflicting competing redeployment efforts. Planning for reintegration briefings started only two to three months prior to redeployment with minimal

coordination between organizations. In addition to H2F, military family life counselors, the Family Advocacy Program, and other support entities planned reintegration efforts in separate venues at separate times. The majority of non-H2F briefs were planned by 7th Infantry Division and coordinated with SRP. By the time the first active duty H2F assets arrived with ADVON, it was clear there was insufficient inclusion of H2F, and the team was unable to join already scheduled briefs. To counter the lack of inclusion, H2F members on ADVON and the rear team developed briefings specific to each battalion.

The small number of staff members and the model to brief each battalion flight separately became the largest redeployment challenge. The goal was to brief each flight from each battalion within three days of arrival and include at least one active-duty member who had also completed the rotation. However, only one to four active-duty members were available on a given day, and only two to three civilians qualified to deliver the relevant training. Staff often delivered up to four briefings a day, and many battalion main bodies did not receive briefings until one week after arrival. The information was helpful to soldiers; however, the sleep information is best received within two days for adequate implementation. Two battalions did not respond to requests to schedule. The lack of response may have been mitigated with prior coordination and inclusion in the redeployment order.

To mitigate challenges, we recommend planning for redeployment be a part of the H2F deployment planning itself. This is due to both the large amount of coordination and cross-training needed with staff, but also because there were early redeployers throughout the rotation. These soldiers did not receive H2F reintegration training. An early reintegration plan would have allowed H2F to utilize a similar model to the pilot Recovery PT program and refine products throughout the deployment timeline.

Additionally, redeployment efforts are better lead by H2F staff in the rear and must include robust coordination with EAB and other redeployment efforts. Due to the high operational tempo forward and the low volume in the rear, a better distribution of work would have been for the rear team to lead efforts with feedback from the forward team. The rear team has the capacity to coordinate with EAB and brigade to ensure H2F briefs are included, saving time and redundant efforts. However, our H2F staff did value the ability to tailor the message to each individual battalion. The trade-off between efficiency and individualized messaging are aspects to weigh and evaluate for each H2F team and unique deployment experience.

Conclusion

Overall, the 2-2 SBCT H2F team surpassed our goal of developing a lasting foundation for H2F for Korean rotational forces. As one of the first fully staffed H2F teams to deploy on rotation to the Republic of Korea, our team built new lasting facilities and developed new processes that future H2F teams can learn from, adapt, and implement. It is our hope that future teams can learn from our mistakes and challenges to ensure the best possible readiness and health outcomes for rotational forces and build the resilient force needed to deter attacks and prevail in conflict. ■

Notes

1. Office of the Secretary of Defense, *2022 National Defense Strategy* (U.S. Department of Defense, 2022), 1, https://uploads.mwp.mprod.getusinfo.com/uploads/sites/23/2022/11/2022-NATIONAL-DEFENSE-STRATEGY-NPR-MDR.pdf.

2. For more on the H2F program, see "Holistic Health and Fitness," U.S. Army, accessed 18 March 2025, https://h2f.army.mil/.

3. First Army G-5, "Soldier Readiness Program Information," U.S. Army, 21 February 2025, https://www.army.mil/article/283260/soldier_readiness_program_information.

4. Teambuildr, accessed 18 March 2025, https://www.teambuildr.com/. Teambuildr is an app that provides "a platform for any coach in any setting … to write training programs, build questionnaires and access athlete and client performance data."

Maj. Mikala K. Bruno, U.S. Army, is the Holistic Health and Fitness injury control director for 2nd Stryker Brigade Combat Team, 2nd Infantry Division, at Joint Base Lewis-McChord, Washington. She holds a doctorate in physical therapy from the U.S. Army-Baylor University Physical Therapy Program and is a board-certified orthopedic specialist and certified strength and conditioning specialist. Her assignments include medical leadership positions both within Forces Command and Medical Command units including a rotational deployment with the first Stryker brigade to serve in Korea.

Capt. Sean M. Boulanger, U.S. Army, is a brigade physical therapist embedded with 2nd Stryker Brigade Combat Team, 2nd Infantry Division, at Joint Base Lewis-McChord, Washington. He holds a doctorate in physical therapy and is an orthopedic certified specialist. He participated in the first Stryker brigade deployment to Korea, and his past experience includes civilian outpatient orthopedic physical therapy and medical center physical therapy leadership.

Sgt. 1st Class Christian V. Olivarez, U.S. Army, is a physical therapy technician serving with 10th Special Forces Group (Airborne) at Ft. Carson, Colorado. He holds a BS in healthcare administration from Grand Canyon University. A former combat medic, his previous assignments include tours in Korea and in support of Operations Iraqi Freedom and Enduring Freedom, as well as tenure as executive assistant to the Defense Health Agency senior enlisted leader.

Jason E. Hartman, CSCS, serves as the 2nd Stryker Brigade Combat Team, 2nd Infantry Division, Holistic Health and Fitness program director. He spent over a decade working as a strength and conditioning contractor within the U.S. Army Special Operations Command Human Performance program with 5th Special Forces Group and 160th Special Operations Aviation Regiment. Hartman serves as a member of the National Strength and Conditioning Association's Tactical Strength and Conditioning Editorial Review Panel. Prior to his work in the tactical community, Hartman served as the strength and conditioning coordinator for the U.S. Olympic Committee overseeing the training of Olympic, national team, and developmental athletes. He earned MS degrees in kinesiology and human movement science from Georgia Southern University and the University of Memphis, respectively.

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