National Guard and Army Reserve Readiness and Operations Support

Information Brief

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National Guard and Army Reserve Readiness and Operations Support Information Brief

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Briefing Outline

PURPOSE: To provide an overview of current medical readiness lines of effort in support of the Army Surgeon General’s Medical Readiness Campaign Plan and current status of Army Reserve Component’s Individual Medical Readiness metrics.

1. Outline
2. Where are we now?
3. Soldier Medical Readiness Campaign Plan
4. Reserve Component Not-Medically Ready Identification and Management
5. Injury Prevention/Human Performance Optimization (Soldier-Athlete Initiative)
6. Conclusion
Where are we now?

% Soldier Medical Readiness Classifications (MRC) 1 & 2
Army National Guard, US Army Reserves (ARNG, USAR)

**Ongoing Initiatives:**
- First Term Dental Readiness (FTDR)
- RC Dental Demobilization Reset (RC-DDR)
- Army Selective Reserve (SELRES) Dental Readiness System (ASDRS)
- Reduce Indeterminants (MRC 4), Dental Class 4
- PHA w/PDHA during Demobilization

**Medical Readiness Classification (MRC)**
- MR 1 – Meets all requirements
- MR 2 – IMR requirements that can be resolved within 72 hours
- MR 3A – IMR requirements that can be resolved within 30 days
- MR 3B – IMR requirements that cannot be resolved in < 30 days
- MR 4 – Current status is not known

*Target is established as 80% of the non-deployed RC assigned End strength

Source: MEDPROS
3 JAN 11
# Army RC Individual Medical Readiness

## % Soldier Medical Readiness Classifications (MRC) 1 & 2

**Army National Guard, US Army Reserves (ARNG, USAR) by IMR Category**

<table>
<thead>
<tr>
<th>ELEMENT</th>
<th>ARNG*</th>
<th>USAR*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Class 1 or 2</td>
<td>66%</td>
<td>70% (+1)**</td>
</tr>
<tr>
<td>Immunizations</td>
<td>78%</td>
<td>87% (+2)**</td>
</tr>
<tr>
<td>Medical Readiness Labs</td>
<td>91% (-1)**</td>
<td>93% (-1)**</td>
</tr>
<tr>
<td>No Deployment Limiting Conditions</td>
<td>89% (+1)**</td>
<td>86% (+1)**</td>
</tr>
<tr>
<td>Health Assessment</td>
<td>82%</td>
<td>84% (+4)**</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>81% (-1)**</td>
<td>79% (-1)**</td>
</tr>
</tbody>
</table>

* Non Deployed Population as of 31 Dec 2010
Source: Medical Protection System (MEDPROS)
** % change between Oct10 and Jan11 Reporting periods
Lessons Learned – What we know

• Nine years of persistent conflict have placed a strain on our forces
  – Average AC BCT non-deployable percentage increased from ~10% in FY07 to ~14% in FY10.
  – Army is evaluating the same data relative to the ARNG BCTs
  – The percentage of medical non-deployables (MRC 3A, 3B) is a substantial number of the total non-deployables

• The Army can reduce the number of indeterminants and focus on resolving cases with treatable issues (MRC 3A) and adjudicating those with non-fitting conditions requiring MEBs

• The following table shows the distribution of the Army in the various categories:

<table>
<thead>
<tr>
<th>Compo (Total Strength w/ Deferment)</th>
<th>Total Strength</th>
<th>Fully Ready</th>
<th>%</th>
<th>Partially Ready</th>
<th>%</th>
<th>Indeterminate</th>
<th>%</th>
<th>Not Ready</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>498267</td>
<td>388331</td>
<td>77.94%</td>
<td>21149</td>
<td>4.24%</td>
<td>52499</td>
<td>10.54%</td>
<td>36288</td>
<td>7.28%</td>
</tr>
<tr>
<td>Reserve</td>
<td>205286</td>
<td>94068</td>
<td>45.82%</td>
<td>24457</td>
<td>11.91%</td>
<td>41979</td>
<td>20.45%</td>
<td>44782</td>
<td>21.81%</td>
</tr>
<tr>
<td>Guard</td>
<td>363456</td>
<td>162041</td>
<td>44.58%</td>
<td>42999</td>
<td>11.83%</td>
<td>86088</td>
<td>23.69%</td>
<td>72328</td>
<td>19.90%</td>
</tr>
<tr>
<td>Total</td>
<td>1067009</td>
<td>644440</td>
<td>60.40%</td>
<td>88605</td>
<td>8.30%</td>
<td>180566</td>
<td>16.92%</td>
<td>153398</td>
<td>14.38%</td>
</tr>
</tbody>
</table>
Soldier Medical Readiness
Campaign Plan Overview
Mission Statement

US Army Medical Command executes a **coordinated, synchronized, and integrated** comprehensive Soldier Medical Readiness Campaign to support ARFORGEN in each of its phases in order to increase the medical readiness of the Army.

**Commander’s Intent**

Purpose: US Army Medical Command executes a Soldier Medical Readiness Campaign to **improve the medical readiness status** of the Army. This campaign seeks to leverage and optimize all components of the Army to ensure a healthy and resilient force.

Key tasks:

- Provide **Commanders** the tools, policy, regulations, and guidance to **manage** their Soldiers’ medical requirements
- Coordinate, Synchronize, and Integrate Wellness, Injury Prevention & Human Performance Optimization Programs across the Army
- Identify the Medically Not Ready (MNR) Soldier Population
- Implement Medical Management Programs to reduce the MNR Soldier Population
- Develop objective performance measures to monitor the success of this campaign
- Develop Army messages to educate and inform the force

End State: Support the deployment of healthy, resilient, and fit Soldiers and increase the medical readiness of the Army. Effectively manage the medically not ready population IOT return the maximum number of Soldiers to available/deployable status. Instill trust and value in Army Medicine.
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One unified effort to increase the medical readiness of the Army:
Coherence across identification, medical programs, health promotion, communications and assessment actions

Identify the Medically Not Ready (MNR) Soldier Population

Implement the Medical Management Programs for the MNR Soldier Population

Synchronize Wellness, Injury Prevention, & Optimization Programs Across the Army

Confidence in medical readiness system

Reduced MNR population, and increased medical readiness

Improved overall health, resilience, and reduced injury rates

Educate the Force AND Improve Continuously

STRATCOM AND ASSESSMENT
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**SMR-CP Overview (2 of 2)** **MEDCOM Lead**

### Key Task

**MG Stone**

- Coordinate, Synchronize, & Integrate Wellness/Injury Prevention Programs Across the Army
- Identify metrics to measure outcomes
- Develop Army Message

### Lines of Effort

#### 1.0 MNR Soldier Identification Process (**BG Thomas**)

- Identify and track MNR population
- Reduce MNR indeterminant population (MRC4, DFC 4)

#### 2.0 MNR management programs (**BG Gamble**)

- Manage the identified MNR Population
- Reform PDES
- Maximize Soldier medical encounter opportunities
- Maintain commitment to the Warrior Care and Transition Program

#### 3.0 Synchronize/Implement Evidence Based Health Promotion and Wellness, Injury Prevention (IP), and Human Performance Optimization (HPO) Programs (**BG Adams**)

- Integrate IP/HPO research programs
- Coordinate and synchronize IP/HPO programs across the Army

#### 4.0 Assess and Monitor Effectiveness of SMRC (**BG Adams**) Across all LOEs

#### 5.0 STRATCOM (BG Gamble/BG Adams) Across all LOEs

### Tools

1.3: OPORD 10-75
1.3: DA EXORD: e-Profile

2.1: OPORD 10-66
2.3: OPORD 09-04
2.4: WARNO 11-03
2.4a ALARACT 011/2011

3.2: OPORD 10-46, WARNO 10-68

### Objective

- Confidence in the medical readiness system
- Reduced MNR population and increase medical readiness
- Improved overall health, resilience, and reduced injury rates
- Ensure continuous improvement of MNR management
- Educate the Force
Management of Reserve Component Medically Not Ready
Identification of MNR Soldiers

- MEDPROS Coordinators for all installations
  - MEDPROS access to RC units
- Increased Automation of MEDPROS
  - Decrease omissions, data latency and errors
- E-profile – fully implemented by end of January, 2011
  - Significant benefit to the RC
- Align health assessments with ARFORGEN
  - Not just in time medicine
  - Provide the right care at the right place throughout the ARFORGEN cycle
- Reduce MR4 / Indeterminantes (currently 22.5% of the RC)
PDES Issues Synchronization

RC Medically Not Ready Soldiers
P3 and P4, MRC 3B

RC Centric Model

- RC Soldier Medical Support Center

Primary Services (Crawl Phase)
- Serve as primary liaison between RC and MEDCOM for MEB packet submission
- Provide Administrative & Medical Subject Matter Expertise (SME) to the RC regarding MNR packets
- Screen MEB packets for accuracy and completeness
- Provide Administrative and Medical Case review
- Coordinate with the RC on the medical management of MND Soldiers

MNR management does not include those AC or RC assigned/attached to Warrior Transition Units or RC referred through the mobilization/demobilization process

AC Centric Model

- Medical Management Centers (MMC)

- Identify MNR population for the Active Duty force
- Identify Medical Management Acuity
- Case Management
- Coordination with TRIAD /Unit Leadership
- Coordination of all PDES functions
- Senior Commanders have management responsibility

Medical Retention Decision Point/Referred MEB

- Physical Disability Evaluation System changes
- Implementation of the Integrated Disability Evaluation System with DVA
- Army’s Non-Deployable Campaign Plan

Endstate is the same, how to manage MNRs differs.

RCs will manage the FFD/Pre-MEB work; MEDCOM manage MEBs
Strategic Observations
(From the GEN Franks TF IPR Jul10)

• The Army’s utilization of the RC within the Operational Reserve and addition of new health assessment tools (PHA, PDHA, D-RAT, SAT(BH), PDHRA) has increased the visibility of not medically ready Soldiers, and thereby putting a demand on the military health care system that exceeds its capacity.

• The RC Medical system was designed years ago placing the responsibility on the Soldier to seek medical treatment when required and to use government programs when the condition was LOD. In spite of the current Operational Reserve role of the RC, the responsibility to navigate this system remains on the ‘backs of Soldiers’.
Injury Prevention/Human Performance Optimization Programs
• **Goal**: Reduce musculoskeletal injuries and related Initial Entry Training (IET) attrition while optimizing performance

• In 2008, 30.6% of medical encounters were from IET students at training installations

• Provide IET Brigade cadre advice and recommendations on proper execution of Physical Readiness Training

• Provide conditioning guidance for IET Soldiers in need of remedial training

• Provide nutritional guidance and dietary intake recommendations (fueling)

• Provide special conditioning to bridge gap between medical rehabilitation and PRT
Soldier-Athlete Initiative

Physical Readiness Training

Musculoskeletal Action Teams & Athletic Trainers

Soldier Fueling
• Program Evaluation: Fort Leonard Wood
  – Compares MAT to traditional role of ATs on reducing attrition, injuries and improving performance
  – Success dependent upon accurate data from MAT/ATs and the companies

• Surveillance
  – 5 sites: Fort Benning, Fort Lee, Fort Sill and Fort Jackson, Fort Leonard Wood
  – Metrics related to fitness, injury and attrition
Conclusion

The Army’s utilization of the Reserve Components within the Operational Reserve requires a different approach to readiness. The Soldier Medical Readiness Campaign Plan links many of the current initiatives and future efforts to support RC readiness.