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MILITARY PERSONNEL

Top Management Attention Is Needed to Address Long-standing Problems with Determining Medical and Physical Fitness of the Reserve Force



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Highlights of [GAO-06-105](#), a report to congressional committees

Why GAO Did This Study

The Department of Defense's (DOD) operations in time of war or national emergency depend on sizeable reserve force involvement and DOD expects future use of the reserve force to remain high. Operational readiness depends on healthy and fit personnel. Long-standing problems have been identified with reserve members not being in proper medical or physical condition. Drilling members in the reserve force by law are required to have a medical exam every 5 years and an annual certificate of their medical status. Also, DOD policies require an annual dental exam and an annual evaluation of physical fitness. Compliance with these routine requirements is the first step in determining who is fit for duty. Public Law 108-375 required GAO to study DOD's management of the health status of reserve members activated for Operations Enduring Freedom and Iraqi Freedom. GAO assessed DOD's (1) ability to determine reserve force compliance with routine exams, and (2) visibility over reserve members' health status after they are called to duty and the care, if any, provided to those deployed with preexisting conditions.

What GAO Recommends

GAO is making a number of recommendations to improve DOD's management of the health status of reserve members. In commenting on a draft of this report, DOD did not concur with two of our six recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-06-105.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Derek B. Stewart, (202) 512-5559, stewartd@gao.gov.

MILITARY PERSONNEL

Top Management Attention Is Needed to Address Long-standing Problems with Determining Medical and Physical Fitness of the Reserve Force

What GAO Found

DOD is unable to determine the extent to which the reserve force complied with routine examinations due to lack of complete or reliable data. Although each reserve component employs a tracking system capable of monitoring compliance with medical exams, only one component has taken the necessary quality assurance steps to ensure the reliability of its data. While the Office of the Under Secretary of Defense for Personnel and Readiness has the responsibility for overseeing medical and physical fitness policy and processes, it has not established a management control framework and executed a plan to oversee compliance with routine examinations. Specifically, this office has not enforced holding all responsible levels accountable, ensuring that all requirements are being met, and that complete and reliable data are being entered into the appropriate tracking system. For example, this office has not enforced its own requirement for the services to report on the components' physical fitness status. Without complete and reliable data, DOD is not in a sound position to provide the Secretary of Defense or Congress assurances that the reserve force is medically and physically fit when called to active duty.

DOD has only limited visibility over the health status of reserve members after they are called to duty and is unable to determine the extent of care provided to those members deployed with preexisting medical conditions despite the existence of various sources of medical information. The components collect various types of medical data, but vary in their ability to systematically identify, track, and report information on those with temporary and permanent conditions that may limit deployability. In addition, medical information is captured on predeployment forms for all members and entered into a DOD-wide centralized database. GAO has previously reported that the database has missing and incomplete health data, and DOD is working to correct this through its quality assurance program. GAO found during this review that DOD has continued to make progress entering the data from the forms into the database, but the data are still incomplete and the reasons why members are determined medically nondeployable are not captured in a way that is easily discernable. While the Under Secretary of Defense continues to have responsibility for overseeing the medical and physical fitness of reserve members after they are called to duty, the combatant commanders, under the Joint Chief of Staff, have this responsibility for the theater. DOD is unable to determine the care provided to those deployed with preexisting medical conditions because DOD has not determined what preexisting conditions may be allowed into a specific theater and, thus, does not know what conditions to track. Evidence GAO developed suggests that members are deployed into theater with preexisting conditions, such as diabetes, heart problems, and cancer. The impact of those who are not medically and physically fit for duty could be significant for future deployments as the pool of reserve members from which to fill requirements is dwindling and those who have deployed are not in as good health as they were before deployment.

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Abbreviations

AFAA	Air Force Audit Agency
AFFMS	Air Force Fitness Management System
AMSA	Army Medical Surveillance Activity
ANG	Air National Guard
APFT	Army Physical Fitness Test
CENTCOM	U.S. Central Command
DIMHRS	Defense Integrated Military Human Resources System
DNBI	Disease Nonbattle Injury
DOD	Department of Defense
GAO	Government Accountability Office
HCP	Health Care Provider
IMR	Individual Medical Readiness
JMeWS	Joint Medical Work Station
JMROC	Joint Medical Readiness Oversight Committee
JPTA	Joint Patient Tracking Application
MEDPROS	Medical Protection System
MND-TM	Medical Nondeployable Tracking Module
MODS	Medical Operational Data System
MORDT	Mobilization Operational Readiness Deployment Test
MRRS	Medical Readiness Reporting System
NDAA	National Defense Authorization Act
OSD	Office of the Secretary of Defense
OUSD/P&R	Office of the Under Secretary of Defense for Personnel and Readiness
PHA	Preventive Health Assessment
PHAM	Periodic Health Assessment Monitor
PIMR	Preventive Health Assessment and Individual Medical Readiness
PRIMS	Physical Readiness Information Management System
RCPHA	Reserve Component Periodic Health Assessment
TRAC2ES	TRANSCOM Regulating Command and Control Evacuation System
TRANSCOM	U.S. Transportation Command

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United States Government Accountability Office
Washington, DC 20548

October 27, 2005

The Honorable John Warner
Chairman
The Honorable Carl Levin
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Duncan L. Hunter
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The Department of Defense's (DOD) operations in time of war or national emergency are currently dependent upon sizeable National Guard and Reserve involvement and DOD expects future use of the reserve force to remain high. DOD policy acknowledges the importance that reserve component¹ members are medically and physically fit² for deployment³ when called to active duty. As of June 2005, more than 323,000 reserve component members had deployed in support of Operation Enduring Freedom and Operation Iraqi Freedom,⁴ which is almost three times the number of reserve component members deployed in support of Operations

¹ DOD's reserve components include the collective forces of the National Guard including the Army Guard and the Air Guard, as well as the forces from the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air Force Reserve, and the Coast Guard Reserve. This report does not address the Coast Guard Reserve.

² For the purposes of this report, medical fitness equates to compliance with routine or periodic medical (physical) examinations that identify the diseases and medical conditions that may prevent members from performing their military duties. Physical fitness equates to compliance with routine or periodic examinations that test a member's physical skills needed to perform the mission.

³ Deployment is a troop movement resulting from a Joint Chiefs of Staff and Unified Command Deployment Order for 30 continuous days or greater to a land-based location outside the United States.

⁴ Operation Enduring Freedom includes ongoing operations in Afghanistan and in certain other countries; Operation Iraqi Freedom includes ongoing operations in Iraq.

Desert Shield and Desert Storm. Reserve forces played a vital role in Operations Desert Shield and Desert Storm. However, problems were revealed with reserve component members not being in proper medical or physical condition for these deployments. Some members could not deploy to the Persian Gulf, and others had difficulty performing their missions while there. In an effort to help obviate similar problems in the future, Congress passed legislation during the 1990s to help monitor and track the health status of deployed members of the Armed Forces, including reserve component members.⁵

Public Law 108-375, the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, requires GAO to study DOD's management of the health status of reserve component members ordered to active duty in support of Operation Enduring Freedom and Operation Iraqi Freedom. Specifically, GAO assessed: (1) DOD's ability to determine the reserve components' compliance with routine medical and physical fitness examinations, and (2) DOD's visibility over reserve components' health status after they are called to duty and the care, if any, provided to those deployed with preexisting conditions.

To address our first objective, we reviewed federal statutes and Office of the Secretary of Defense (OSD) applicable directives and instructions to identify and understand the roles and responsibilities of the offices within DOD for management of the health status of the reserve components. We discussed these statutes and guidance with senior officials in the Office of the Under Secretary of Defense for Personnel and Readiness. We discussed service policies for medical and physical fitness with military officials within the service surgeon general offices and officials responsible for physical fitness in the service personnel and operations functions. We also analyzed reserve component regulations and policies and discussed these with responsible reserve component officials. We took steps to assess the reliability of these reserve component compliance data and we discuss the results of our assessment in the report. We also visited several unit-level commands in all six reserve components. In addition, we conducted a limited medical and personnel file review and group discussions at an Army National Guard unit in the Mid-Atlantic and an Army Reserve unit in the Mid-west for the purposes of understanding some of the issues confronting the Army components in terms of compliance.

⁵ 10 U.S.C. § 1074f.

To address our second objective, we interviewed reserve component headquarters officials and active component officials responsible for mobilizing the reserve components and observed an Army mobilization of Army National Guard and Army Reserve members at Fort Bliss, Texas to obtain information on processes used to screen members for their medical deployability. We obtained and analyzed data provided on medical deployability from DOD's centralized database on pre- and postdeployment health assessments, maintained at the Army Medical Surveillance Activity (AMSA) and discussed available data with AMSA officials. We also obtained and analyzed data on Army reserve component members held at mobilization stations for medical reasons and discussed these data with officials from the Office of the Assistant Secretary of the Army for Manpower and Reserve Affairs and the Army Office of the Surgeon General. Based on our review of the AMSA database we used, we determined that the data from it were reliable for the purposes of this report. To address the extent of medical care provided in theater for preexisting medical conditions, we reviewed the Joint Chiefs of Staff policy for Deployment Health Surveillance and Readiness and information provided by the U.S. Central Command (CENTCOM) Surgeon General office regarding medical deployment criteria for Operation Enduring Freedom and Operation Iraqi Freedom and discussed these policies with the appropriate DOD officials. We met with medical officials who served in theater and discussed situations they witnessed related to reserve members who had deployed with preexisting conditions. We conducted our review from October 2004 through September 2005 in accordance with generally accepted government auditing standards. A more thorough description of our scope and methodology is provided in appendix I.

Results in Brief

DOD is unable to determine the extent to which the reserve components comply with routine medical and physical fitness examination requirements due to a lack of OSD guidance and oversight, and incomplete or unreliable compliance data supplied by the components. Although the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD/P&R) has the responsibility for overseeing medical and physical fitness policy and processes, this office has not established a management control framework and executed a plan to oversee compliance with routine examinations. For example, OUSD/P&R has not provided guidance to the reserve components regarding requirements for the 5-year medical examination and an annual medical certificate. Thus, each reserve component has developed its own implementing policies with differences in scope, frequency, and administration of the medical examination. Lack of OSD guidance makes oversight difficult because uniform criteria

against which to measure compliance do not exist. DOD's ability to determine the extent of compliance has been hindered because OSD does not track reserve components' compliance with routine medical examinations. In addition, the data reported at the reserve component level have been incomplete and unreliable for purposes of determining compliance with routine medical and physical fitness examination requirements, and responsibility for compliance has not been enforced. For example, although each reserve component employs a tracking system capable of monitoring compliance with medical examinations, only one reserve component—the Navy Reserve—has taken the necessary quality assurance steps to ensure the reliability of its data on compliance.

Further, DOD has not enforced its own requirement for the services to report on the status of the reserve and active components' physical fitness. No reserve component has a tracking system that can report complete and reliable data on compliance with physical fitness examinations on a componentwide basis. Moreover, although the reserve components place the responsibility for tracking compliance with medical and physical fitness examinations on the unit commander, the reserve components do not always hold the unit commanders accountable and the unit commanders do not always enforce the compliance of their members. OUSD/P&R has not enforced holding all responsible levels accountable, ensuring that all requirements are being met, and complete and reliable data are being entered into the appropriate tracking system. Despite DOD's inability to determine the extent of reserve component compliance with routine medical and physical fitness examinations, we found indications of noncompliance. For example, a limited review of medical files at one Army National Guard and one Army Reserve location, data from a Navy report, test results of two units in a Marine Corps battalion, and data from a review conducted by the Air Force Audit Agency indicate some noncompliance at all components with routine examination requirements. OSD's lack of oversight could negatively impact operational readiness for future deployments as the number of needed personnel may not be medically and physically fit when called to active duty.

DOD has limited visibility over the health status of reserve component members after they are called to duty and is unable to determine the extent of care provided to those members deployed with preexisting medical conditions despite the existence of various sources of medical information. For example, the reserve components all collect various types of medical data, but vary in their ability to systematically identify, track, and report information on members with both temporary and permanent conditions that limit medical deployability. In addition, medical

information is captured on predeployment forms for all reserve members and entered into a DOD-wide centralized database, but the data are incomplete and the reasons why members were found nondeployable are not captured in a way that is easily discernable. Furthermore, DOD is unable to determine the care provided to those deployed with preexisting medical conditions because DOD has not determined what preexisting conditions may be allowed into a specific theater of operations and therefore does not know what conditions to track. The medical deployment criteria specific to Operations Iraqi Freedom and Enduring Freedom are still evolving, and although DOD has a number of systems for tracking medical conditions in theater, the current databases do not capture data on known preexisting conditions. Developing and updating specific medical criteria for a theater of operations are the responsibilities of the combatant command. In the absence of specific theater guidance, the services relied on their own deployment criteria. For the Army, specific deployment medical criteria did not exist until February 2005. Evidence we developed suggests that reserve members did deploy with preexisting medical conditions that could not be adequately addressed in theater, such as diabetes, heart problems, and cancer. The impact on operations of those determined nondeployable or those deployed with mission-limiting medical conditions is unknown. However, the impact could be significant for future deployments as the pool of Guard and Reserve members from which to fill requirements is dwindling and those who have deployed are not in as good health as they were before deployment.

We are making several recommendations in this report. For DOD to have visibility over the reserve components' compliance with routine examinations, we recommend that DOD establish a management control framework and execute a plan for improving oversight and take steps to enforce the service reporting requirement on the status of their members' physical fitness. To improve DOD's visibility over reserve component members' health status after they are called to duty, we recommend that DOD oversee the development of the reserve components' tracking systems to identify and track members' temporary and permanent medical conditions that limit deployability and modify the predeployment forms to better capture the reasons for nondeployment and medical referrals. To help prevent the deployment of members with preexisting medical conditions that could adversely affect the mission and strain resources in theater, we recommend that DOD develop medical criteria for specific theaters and explore using existing tracking systems to track those with treatable preexisting medical conditions.

In written comments on a draft of this report, DOD did not concur with our first and fourth recommendation, partially concurred with our fifth recommendation, and concurred with our second, third and sixth recommendations. DOD did not concur with our first recommendation that it establish a management control framework and execute a plan for issuing guidance, establishing quality assurance for data reliability, and tracking compliance with routine medical examinations. DOD did not state that it disagreed with our findings; however, DOD stated that it had initiatives underway that addressed our recommendation. We disagree with DOD's conclusion because, based on our review, we do not believe that DOD's initiatives are far enough along to dismiss further action, and we continue to believe that our recommendation has merit. DOD concurred with our second recommendation that DOD take steps to enforce the services' reporting requirement on the status of their members' physical fitness. During our review none of the reports had been submitted to the Principal Deputy as required. We raised concerns in this report about the data reliability of the tracking systems for physical fitness. Just as we found with routine medical examinations, we also found that DOD lacked quality assurance of the data on compliance with physical fitness examinations in its tracking systems. We note that the responsible office for physical fitness oversight, the Office of Morale, Welfare, and Recreation, does not participate on the Joint Medical Readiness Oversight Committee that is directed to oversee improvements in medical readiness, nor are we aware of any DOD plans to include improvements in the oversight of physical fitness in its comprehensive medical readiness plan. Therefore, we have expanded our first recommendation to include routine physical fitness examinations in the actions to be addressed.

DOD concurred with our recommendation that DOD oversee the development of the reserve components' tracking systems to identify and track members' temporary and permanent medical conditions that limit deployability. DOD did not concur with our recommendation that DOD modify the medical predeployment form to better capture reasons for nondeployment and medical referrals. DOD stated that the best sources of accurate information about what medical reasons kept service members from deploying are the permanent medical records. We continue to believe our recommendation has merit because DOD has no way to systematically analyze the information to determine why servicemembers are medically nondeployable. DOD partially concurred with our recommendation that DOD determine what preexisting medical conditions should be allowed into a specific theater of operations, especially during the initial stages of operations, and take steps to consistently utilize these criteria for determining medical deployability. DOD also noted that due to the ever-

changing nature of a theater of operations and the inexact nature of medicine, a list of nondeployable preexisting conditions will never be fully comprehensive or fully enforceable. We agree that a list of nondeployable preexisting medical conditions can never be fully comprehensive; however, we still believe DOD could establish a list of what preexisting medical conditions should be allowed into specific theaters of operations, especially during the initial stages of operations, so that in future deployments DOD would not experience situations such as those that occurred with members being deployed into Iraq who clearly had preexisting conditions that should have prevented their deployment. DOD concurred with our recommendation that DOD explore using existing tracking systems to track those who have treatable preexisting medical conditions in theater. DOD noted that refinements to medical tracking system are ongoing. We wish to note that before DOD's tracking systems can be used to track those who have treatable preexisting medical conditions in theater, DOD must determine what preexisting medical conditions should be allowed into a specific theater of operations as called for in our fifth recommendation.

Background

As required by law,⁶ each reserve component is to make available qualified personnel for active duty in the armed forces in time of war or national emergency and at such other times as national security requires. With this requirement comes the responsibility that each reserve component provides personnel who are medically and physically fit for active duty. As noted in DOD guidance,⁷ fitness specifically includes the ability to accomplish the task and duties unique to a particular operation, and ability to tolerate the environmental and operational conditions of the deployed location, including wear of protective equipment.

Reserve Components and Routine Medical and Physical Fitness Examinations

DOD reserve components include the Army Reserve, the Army National Guard, the Air Force Reserve, the Air National Guard, the Navy Reserve, and the Marine Corps Reserve. Reserve forces consist of three categories: the Ready Reserve, the Standby Reserve, and the Retired Reserve. The Ready Reserve had approximately 1.1 million National Guard and Reserve members at the end of fiscal year 2004, and its members were the only

⁶ 10 U.S.C. § 10102.

⁷ Minimal Standards of Fitness for Deployment to the CENTCOM Area of Responsibility, January 2005.

reservists who were subject to involuntary mobilization under the partial mobilization authorized by President Bush following the attacks of September 11, 2001. Within the Ready Reserve, there are three subcategories: the Selected Reserve, the Individual Ready Reserve, and the Inactive National Guard. Members of all three subcategories are subject to a mobilization under a partial mobilization but routine medical and physical fitness policies apply primarily to the Selected Reserve, consisting of about 850,000 members at the end of fiscal year 2004.⁸

DOD administers medical examinations to military personnel for various reasons at different intervals. These include examinations at accession, mobilization,⁹ for special duty assignments, and at separation and retirement. The examinations that are required routinely for Selected Reserve members to ensure ongoing medical and physical fitness include two that are prescribed by federal statute and the second two prescribed by DOD regulations and policy. Compliance with these routine requirements is the first step toward determining who is fit for duty.

Federal statute¹⁰ prescribes that each member of the Selected Reserve¹¹ who is not on active duty is required to:

- be examined as to the member's physical (medical) fitness every 5 years, or more often as the respective Secretary considers necessary; and
- complete an annual certificate of medical condition.

DOD policy prescribes that each member of the Selected Reserve:

- receive an annual dental examination; and

⁸ The Selected Reserve's members include individual mobilization augmentees—individuals who train regularly, for pay, with active component units—as well as members who participate in regular training as members of National Guard or Reserve units.

⁹ Mobilization is the process of assembling and organizing personnel and equipment, activating or federalizing units and members of the National Guard or Reserves for active duty, and bringing the armed forces to a state of readiness for war or other national emergency.

¹⁰ 10 U.S.C. § 10206(a).

¹¹ Prior to 2002, this statute applied to members of the Individual Ready Reserve and Inactive National Guard as well. Currently, the law requires that the Individual Ready Reserve be examined as to their medical fitness as a condition of military duty or promotion, or attendance at a military school or other career-related action. 10 U.S.C. § 10206(b).

-
- be evaluated annually for physical fitness for duty, to include an assessment of aerobic capacity, muscular strength, muscular endurance, and desirable fat composition.

Reserve Components Differ in Approaches to Mobilize and Medically Screen Members for Deployment

Within the constraints of the existing mobilization authorities¹² and DOD guidance, the services have flexibility as to how, where, and when they conduct mobilization processing. As a result, the services differ in how they mobilize and consequently medically screen members upon notification that a unit or individual will be called to active duty. The Army and Navy use centralized approaches, mobilizing their reserve component forces at a limited number of locations. The Army uses 15 primary sites that it labels “power projection platforms” and 12 secondary sites called “power support platforms.” The Navy has 15 geographically dispersed Navy Mobilization Processing Sites but is currently using only 5 of these sites because of the relatively small numbers of personnel who are mobilizing.

By contrast, the Air Force uses a decentralized approach, mobilizing its reserve component members at their home stations—135 for the Air Force Reserve and 90 for the Air National Guard—where all medical screening is performed. The Marine Corps uses a hybrid approach. It has five Mobilization Processing Centers to centrally mobilize individual reservists and is currently using three of these centers. However, the Marine Corps uses a decentralized approach to mobilize its units. Selected Marine Corps Reserve units do most of their mobilization processing at their home stations, including medical screening, and then report to their gaining commands.

Roles and Responsibilities for Developing and Implementing Examination Requirements

Within the Office of the Under Secretary of Defense for Personnel and Readiness, the Office of the Assistant Secretary of Health Affairs is responsible for developing medical policies and processes; the Principle Deputy to the Under Secretary oversees the Office of Morale, Welfare, and Recreation for developing physical fitness policies; and the Office of the Assistant Secretary for Reserve Affairs serves in an advisory capacity to the Under Secretary to determine how the reserve components can better implement these requirements. Each service’s Assistant Secretary for

¹² Most reserve members who were called to active duty for other than normal training after September 11, 2001, were mobilized under one of three legislative authorities: 10 U.S.C. § 12304, 12302, 12301(d).

Manpower and Reserve Affairs provides force management policy for both the active and reserve components. It is then the responsibility of each National Guard and Reserve Command—the Chief, Army Reserve, the Director of the Army National Guard, the Chief of the Navy Reserve (Commander of Navy Reserve Forces and Commander of Marine Corps Reserve Forces), Chief of the Air Force Reserve, and the Director of the Air National Guard—that the policies for medical and physical fitness examinations are properly implemented for their respective commands. Each National Guard and Reserve unit commander is responsible for ensuring that the members under his or her command are provided routine medical and physical examinations in a timely manner, and for identifying and processing members who are not medically qualified or physically fit for active duty. The reserve component member is responsible for meeting scheduled medical examination requirements, obtaining any recommended follow-up medical and dental care from his or her personal (civilian) medical provider, and truthfully reporting any changes in his or her medical or dental condition to military unit commanders and military medical personnel. Upon mobilization, responsibility for the medical and physical fitness of the reserve component members transfers to the active duty counterparts.

Problems Identified with Medical Deployability during Operations Desert Shield and Desert Storm

Several studies identified medical issues with the reserve component members called to duty for Operations Desert Storm and Desert Shield. A 1991 Army Inspector General report¹³ estimated that as many as 8,000 reserve component personnel were found to be medically nondeployable upon arrival at mobilization stations. Even though all but 1,100 eventually deployed, the nondeployable soldiers disrupted the mobilization process because units had to undergo extensive efforts to replace nondeployable reserve members with those who could be deployed. The report also noted that some soldiers who had coronary bypass surgery, cancer, and amputations had not been identified at their home stations and reported to their mobilization station. In 1991, we reported¹⁴ that medical screenings conducted at mobilization stations identified numerous problems that impaired soldiers' ability to deploy, including ulcers, chronic asthma,

¹³ Special Assessment of Operations Desert Shield/Storm Mobilization, Department of the Army, Inspector General, December 1991.

¹⁴ GAO, *National Guard: Peacetime Training Did Not Adequately Prepare Combat Brigades for the Gulf War*, [GAO/NSIAD-91-263](#) (Washington, D.C.: Sept. 24, 1991).

spinal arthritis, hepatitis, seizures, and diabetes. In 1992, we reported¹⁵ that because many medical personnel were found nondeployable for various reasons, including medical reasons, many units deployed with medical personnel shortages and were not fully mission capable upon arrival in the Persian Gulf. For example, two reserve component surgeons—one who was unable to stand for more than 30 minutes and another who had Parkinson’s disease—reported for duty but were unable to deploy due to their conditions. A 1992 Sixth U.S. Army Inspector General report¹⁶ stated that many soldiers deployed to Southwest Asia had to return to the United States because of medical conditions that had not been previously diagnosed. This report noted that home unit commanders were not identifying soldiers with severe medical problems, some permanent, to determine if they were medically fit to perform their duties and job assignments before deploying.

In 1994,¹⁷ we did a comprehensive review of the medical and physical fitness policies for reserve component members serving in Operations Desert Storm and Desert Shield and found that at one Army mobilization station nearly 4 percent of the reserve component members reporting for duty had serious medical conditions including cancer and heart disease. One soldier had double kidney failure, one had muscular dystrophy, and another had a gunshot wound to the head. We found that DOD medical policy, which permits the services to retain nondeployable reservists, was inconsistent with a military strategy that requires forces to be capable of responding quickly to unexpected military contingencies anywhere in the world and we recommended that DOD revise its policy that allows members not to be worldwide deployable, but DOD disagreed and did not take action. We also found that DOD was not aware of the physical fitness problems because the services were not reporting fitness information as DOD required and GAO recommended that DOD revise its directive to require services to report on their members’ physical fitness status. DOD concurred with our recommendations and agreed to take actions. Other related GAO products are found at the end of this report.

¹⁵GAO, *Operation Desert Storm: Full Army Medical Capability Not Achieved*, [GAO/NSIAD-92-175](#) (Washington, D.C.: Aug. 18, 1992).

¹⁶Sixth U.S. Army Inspector General Nondeployable Soldiers Special Inspection, August 1992.

¹⁷GAO, *Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards*, [GAO/NSIAD-94-36](#) (Washington, D.C.: Mar. 23, 1994).

DOD's System to Assess Active and Reserve Component Members' Health Status Prior to Deployments

Section 1074f of Title 10, United States Code requires that the Secretary of Defense establish a system to assess the medical condition of members of the armed forces (including members of the reserve components) who are deployed outside of the United States or its territories or possessions as part of a contingency operation or combat operation. It further requires that records be maintained in a centralized location to improve future access to records, and that the secretary establish a quality assurance program to evaluate the success of the system in ensuring that members receive pre- and postdeployment medical examinations and that record-keeping requirements are met.

DOD policy requires that the services collect pre- and postdeployment health information from their members, and submit copies of the forms that are used to collect this information to the Army Medical Surveillance Activity (AMSA).¹⁸ Initially, deployment health assessments were required for all active and reserve component personnel who were on troop movements resulting from deployment orders of 30 continuous days or greater to land-based locations outside the United States that did not have permanent U.S. military treatment facilities. However, on October 25, 2001, the Assistant Secretary of Defense for Health Affairs updated DOD's policy and required deployment-related health assessments for all reserve component personnel called to active duty for 30 days or more. The policy specifically stated that the assessments were to be done "whether or not the personnel were deploying outside the United States." Both assessments use a questionnaire designed to help military healthcare providers in identifying health problems and providing needed medical care. The predeployment health assessment is generally administered at the service mobilization site or unit home station before deployment.

On February 1, 2002, the Chairman of the Joint Chiefs of Staff issued updated deployment health surveillance procedures. Among other things, these procedures specified that active and reserve component personnel must complete or revalidate the health assessment within 30 days prior to deployment. The procedures also stated that the original completed health assessment forms were to be placed in the military member's permanent medical record and a copy "immediately forwarded to AMSA."

Both forms include demographic information about the servicemember, member-provided information about the member's general health, and

¹⁸ AMSA operates the Defense Medical Surveillance System, which was established in 1997.

information about referrals that are issued when service medical providers review the health assessments. The predeployment assessment also includes a final medical disposition that shows whether the member was deployable or not.

In September 2003,¹⁹ we reported that DOD did not maintain a complete, centralized database of the active Army and Air Force components' member health assessments and immunizations. Following our 2003 review, DOD established a deployment health quality assurance program to improve data collection and accuracy. The department's first annual report documenting issues relating to deployment health assessments was issued in May 2005.

In September 2004,²⁰ we reported similar findings for the reserve component members. We reported that DOD's ability to effectively manage the health status of its reserve component members is limited because its centralized database has missing and incomplete health records and it has not maintained full visibility over reserve component members with medical problems. For example, the Marine Corps did not send predeployment health assessments to DOD's database as required, due to unclear guidance and a lack of compliance monitoring. The Air Force has visibility of involuntarily mobilized members with health problems, but lacks visibility of members with health problems who are on voluntary orders. As a result, some Air Force reserve component personnel had medical problems that had not been resolved for up to 18 months, but the full extent of this problem was unknown since the Air Force did not have a mechanism for tracking members who are on voluntary duty orders with medical problems. We made several recommendations regarding improvements in this area and DOD generally concurred with our recommendations and agreed to take actions.

¹⁹ GAO, *Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance*, [GAO-03-1041](#) (Washington, D.C.: Sept. 19, 2003).

²⁰ GAO, *Military Personnel: DOD Needs to Address Long-term Reserve Force Availability and Related Mobilization and Demobilization Issues*, [GAO-04-1031](#) (Washington D.C.: Sept. 15, 2004).

Recent DOD Efforts in Response to the 2005 National Defense Authorization Act

Section 731 of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 (NDAA) requires the Secretary of Defense to develop and implement a comprehensive plan to improve medical readiness of members of the Armed Services by focusing on areas such as health status, health surveillance, and accountability for medical readiness. The mandate also required that the Secretary of Defense establish a Joint Medical Readiness Oversight Committee (JMROC) with a specified membership to oversee the development and implementation of a comprehensive medical readiness plan.²¹

In response to the act, the first meeting of the JMROC was held in February 2005 during this review. The committee is chaired by the Under Secretary of Defense for Personnel and Readiness and membership includes the Assistant Secretaries of Defense for Reserve Affairs and Health Affairs, the Joint Staff Surgeon, the Chief of the National Guard Bureau, Army Reserve, Navy Reserve, Air Force Reserve and the Commander of the Marine Corps Reserve, as well as the Vice Chiefs of Staff of the Army, Vice Chief of Navy Operations, the Vice Chief of Staff of the Air Force and the Assistant Commandant of the Marine Corps as well as their respective Surgeon Generals and Assistant Secretaries for Manpower and Reserve Affairs, and a representative of the Department of Veterans Affairs.

A draft copy of the Comprehensive Medical Readiness Plan which addresses all defense medical issues identified in the act was signed by the Under Secretary of Defense for Personnel and Readiness on June 23, 2005. Officials from the Force Health Protection Directorate in the OSD Office of Health Affairs—which is providing the staff for drafting and overseeing this effort—stated that financial and legislative constraints, which may limit the implementation of the plan, will have to be identified and addressed, and indicators for measuring progress will have to be developed before the plan is finalized.

²¹ The mandate directed that the Secretary establish the committee 120 days after passage of the act, which was in October 2004.

Among other things, the draft plan specifies that DOD:

- (1) institutionalize the Individual Medical Readiness²² (IMR) reporting process by developing a DOD instruction for the IMR and requires that this information be provided to commanders to assist them in improving the health status of members of their units;
- (2) expand and improve the pre- and postdeployment assessment process by refining the predeployment survey to improve consistency with the postdeployment survey and develop periodic postdeployment health reassessments;
- (3) develop a policy defining the circumstances under which treatment for medical conditions may be provided in theater and circumstances under which medical conditions are to be resolved prior to deployment; and
- (4) review the results of this GAO study.

²² OSD's Office of Health Affairs has begun a process requiring each active and reserve component to quarterly report the percentage of its members who are in compliance with six medical readiness elements: (1) dental class I or II; (2) immunizations; (3) medical readiness laboratory tests, such as DNA blood sample; (4) no deployment-limiting conditions; (5) periodic health assessment; and (6) medical equipment, such as eyeglass inserts for gas masks.

Lack of DOD Oversight Hinders DOD's Ability to Determine Reserve Components' Compliance with Routine Medical and Physical Fitness Examination Requirements, but Indications of Noncompliance Exist

DOD is unable to determine the extent to which the reserve components are in compliance with routine medical and physical fitness examination requirements primarily due to a lack of OSD guidance, oversight, and incomplete or unreliable compliance data supplied by the components. Although the Office of the Under Secretary of Defense for Personnel and Readiness (OSD/P&R) has the responsibility for overseeing medical and physical fitness policy and processes, this office has not established a management control framework and executed a plan to oversee compliance with routine examinations. For example, OSD/P&R has not provided guidance to the reserve components regarding requirements for the 5-year medical examination and an annual medical certificate. Thus, in the absence of OSD guidance, each reserve component has developed its own implementing policies, resulting in differences in scope, frequency, and administration making it difficult because uniform criteria against which to measure compliance do not exist; however, OSD has provided consistent guidance for dental and physical fitness examinations. DOD's ability to determine the extent of compliance has been hindered because OSD does not oversee reserve component members' compliance with the routine physical fitness or medical examination requirements. Furthermore, the data reported at the reserve component level have been incomplete and unreliable for purposes of determining compliance with routine medical and physical fitness examinations, and responsibility for compliance has not been enforced. We found indications of noncompliance during our site visits and reviews of existing audit reports and investigations. OSD's lack of oversight could negatively impact operational readiness for future deployments, as the number of needed personnel may not be medically and physically fit for active duty.

Lack of OSD Guidance Contributes to Variations in Examination Policies among the Components

Although OSD/P&R has the responsibility for overseeing medical and physical fitness policy and processes, this office has not established a management control framework and executed a plan that includes issuing guidance to the reserve components on compliance with the requirements for the 5-year medical examination and an annual medical certificate. For example, the statutory requirement for the 5-year medical examination has not been defined by OSD, leaving each reserve component to develop implementing guidance, resulting in differences in scope, frequency, and administration of the examination among the components. In addition, there has not been any OSD implementing guidance regarding the statutory requirement for an annual medical certificate, and so different guidance has been developed by the surgeons' general offices responsible for each of the six reserve components. Lack of OSD guidance makes oversight difficult to determine because the uniform criteria against which

5-Year Medical Examination Requirements Vary among the Components

to measure the components' compliance do not exist. OSD, through the Office of the Assistant Secretary of Defense for Health Affairs, has established a consistent requirement and implementation policy for an annual dental examination. OSD has also established a consistent requirement for a physical fitness examination, although the specific content of the physical fitness examination varies among the components and it is not coordinated with the medical examinations.

The requirement for a routine medical examination has been in effect for all active and reserve components since at least 1960.²³ Yet, as of September 2005, OSD has not developed a plan or provided direction to the components on how to implement this requirement.²⁴ In the absence of OSD guidance, the surgeons general responsible for the four services and six reserve components have each developed their own separate implementing guidance for the current requirement²⁵ for a 5-year medical examination, resulting in differences in scope, frequency, and administration among the components as illustrated below.

Routine medical examinations include assessments in six areas: physical capacity or stamina, upper extremities, hearing and ears, lower extremities, eyes/vision, and psychiatric.²⁶ For Army active and reserve component members older than age 40, there are additional age-specific

²³ 10 U.S.C. § 10206 states that "each member of the Selected Reserve who is not on active duty shall be examined as to his physical fitness every five years, or more often as the Secretary concerned considers necessary." In 1993, the interval was changed from every 4 years to every 5 years.

²⁴ In 2003, DOD asked the Armed Forces Epidemiological Board to review the appropriate methodology and interval for routine medical examinations to be applied similarly across all services. Based on the board's recommendations, the Assistant Secretary of Defense for Health Affairs is currently drafting a policy that would replace the 5-year medical examination with an annual periodic health assessment. Congress is currently considering changing the frequency requirement for a physical examination from every 5 years to annually as part of the 2006 national defense authorization act.

²⁵ In 1993, Congress mandated that these examinations be conducted at least once every 5 years. Prior to 1993, the requirement was once every 4 years.

²⁶ Members are given a (PUHLES) physical capacity or stamina, upper extremities, hearing, lower extremities, eyes, psychiatric score of 1 to 4 for each of the six assessment areas. P1 represents a nonduty-limiting condition, meaning that the individual is fit for duty and possesses no physical or psychiatric impairments. P2 means a condition may exist; however, it is not duty-limiting. P3 or P4 means that the individual has a duty-limiting condition in one of the six assessment areas. P4 means the individual functions below the P3 level. A rating of either P3 or P4 puts the servicemember in a nondeployable status or may result in the changing of the reserve component member's job classification.

screenings such as prostate examination, a prostate-specific antigen test, and a fasting lipid profile that includes testing for total cholesterol, low-density lipoproteins, and high-density lipoproteins. The Department of the Navy conducts routine medical examinations on all Navy and Marine Corps active component and reserve members that include height and weight measurements, blood pressure testing, urinalysis, serology, and mental issues. Those being examined are also questioned about their past and present medical history, including serious illnesses, injuries, chronic conditions, and operations. The Air Force reserve components' medical examination for nonflyers has been significantly reduced to minimize lost training time due to annual medical requirements. The scope of the current testing exam requirement is essentially limited to brief skin exams for scars and cancer and limited laboratory blood work, and excludes EKGs, cholesterol, lipid panels, depth perception, glaucoma, and mammograms. One question asked on the questionnaire addresses mental status and whether the member has a history of anxiety or depression.

In addition to the differing scope, the different implementing guidance across the services has resulted in variations among the services in the frequency and administration of the 5-year medical examinations. For example, Army guidelines require that Selected Reserve members complete a medical examination once every 5 years. During our review, the Navy and Marine Corps personnel were examined at slightly different intervals: every 5 years through age 50, every 2 years through age 60, and annually after age 60. The Air Force is even more different, in that it no longer requires a traditional medical examination physical be completed every 5 years for nonflyers.²⁷ Instead, members are required to complete an annual Preventive Health Assessment (PHA), the answers to which—combined with the member's age, gender, health risk factors, medical history, and occupations—will determine the types of screening and laboratory tests required and if the member needs to be seen by a military health care provider. At a minimum, however, Air Force reserve component members are required to have a visit with a military health care provider, or Periodic Health Assessment Monitor (PHAM),²⁸ at least once every 3 years, while Air National Guard members are required to visit

²⁷ The Air Force Reserve and Air National Guard discontinued utilizing the “complete or comprehensive” long physical exams in July 2001 and January 2003, respectively. However, annual physical exams for flying personnel continue to be conducted in both components.

²⁸ A PHAM is a credentialed health care provider, and may be a physician, nurse practitioner, or physician's assistant. A PHAM performing examinations for flying personnel must be a flight surgeon.

Annual Certification of
Members Medical Condition
Varies among Components

a Health Care Provider (HCP)²⁹ at least once every 5 years. Thus, differences exist between the two Air Force reserve components.

In the absence of any implementing guidance from OSD, guidance for the annual certification of medical condition has been developed by the surgeon general's offices responsible for each of the six reserve components. Like the 5-year medical examination, the annual certificate of medical condition is prescribed by statute³⁰ which states that "each member of the Selected Reserve who is not on active duty shall execute and submit annually to the Secretary concerned a certificate of physical condition." This requirement has been in law since at least 1960 and is especially important for the reserve components, since they are not seen by military health care providers as often as the active duty.

The different guidance from each of the services has resulted in differing definitions from each service as to what is involved in the annual medical certificate. For example, Department of Army regulations require that all members of the Army Reserve and Army National Guard certify their medical condition annually on a two-page certification form, where members report physician and dentist visits since their last examination, describe current medical or dental problems, and disclose any medications they are currently taking. Navy and Marine Corps Selected Reserve members complete an Annual Certificate of Physical Condition that provides information including the location of their health and dental records, the dates and purpose or type of their last complete physical and dental examinations, and the date of their last HIV blood test among others. Reservists are also expected to disclose any injury, illness, or disease that occurred within the last 12 months and resulted in hospitalization, or caused them to be absent from work, school, or duty for more than 3 consecutive days; if they have been under a physician's care or taken prescription medications during the past 12 months; and any physical defects, family issues, or mental problems that would prevent them from being mobilized. The Air Force has combined this annual requirement into its PHA screening process. Within the Air Force Reserve, the PHA process involves all members initially completing a Reserve Component Health Risk Assessment, which was formerly known as the

²⁹ An HCP is a credentialed health care provider, and may be a physician, nurse practitioner, or physician's assistant. An HCP performing flying personnel examinations must be a flight surgeon.

³⁰ 10 U.S.C. § 10206(a)(2).

Dental Examination
Requirements Are Consistent
among Components

Annual Medical Certificate. In the Air National Guard, the PHA involves all the members initially completing an annual Health History Questions/Interval History, which was formerly known as the Annual Medical Certificate.

The annual dental examination is a consistent requirement across the reserve components that was established by DOD policy and provided consistent standards for active duty and Selected Reserve members to improve dental readiness.³¹ In 1998, the Office of the Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, directed that all active duty and Selected Reserve members obtain an annual dental examination so that DOD would have a clear picture of members' dental readiness and fitness for duty.³² Although the 1998 directive required all services to provide implementation plans for completing all dental examinations by 2001, Health Affairs recognized that the services were having difficulty identifying both the mechanisms for compliance and the tracking system for documentation, and extended the goal of 90 percent compliance until February 2004. A year and half later, DOD still does not have complete and reliable information on all reserve components' compliance.

According to Army regulation, all soldiers within the Army National Guard are required to have a dental examination on an annual basis.³³ The current annual dental examination requires an assessment of the current state of oral health; risk for future dental disease, including periodontal assessment; and oral cancer screening. Prior to early 2004, the Army

³¹ On December 19, 1996, the Assistant Secretary of Defense for Health Affairs issued DOD policy in Health Affairs Memo 97-020, standardizing dental classifications: Class I indicates no dental treatment or reevaluation required within the next 12 months; Class II indicates patients have the potential for dental emergencies with the next 12 months but it is not likely if certain treatments are obtained; Class III represents patients with oral conditions that if not treated are expected to result in dental emergencies within the next 12 months; and Class IV represents patients requiring a dental examination and whose dental classification is unknown.

³² On February 19, 1998, the Assistant Secretary of Defense for Health Affairs issued DOD policy, in Health Affairs Memo 98-021, requiring annual dental examinations and stipulating that personnel shall not deploy in Dental Class III or IV except under extreme circumstances.

³³ While Army regulation, AR 40-501, only addresses an annual dental examination for the Army National Guard, according to the Army Dental Command and the Army Reserve, Army Reserve members adhere to the same dental standard.

Physical Fitness Examination Requirements Consistent among the Components, but Content Varies and It Is Not Coordinated with Medical Examination Requirements

reserve components were still conducting only a dental screening.³⁴ In March 2000, the Navy issued instructions requiring Navy and Marine Corps reservists to undergo an annual dental examination. Currently, both the Air Force Reserve and Air National Guard require annual dental examinations in line with DOD's requirement. The Air Force Reserve made this a requirement in January 2003, but the Air National Guard did not make it a requirement until September 2004. Prior to these times, the required dental exam interval was once every 3 years for the Air Force Reserve and once every 5 years for the Air National Guard.

Although the specific content of the physical fitness examination varies among the components, the requirement for at least an annual physical fitness examination is consistent across the components because it was established by DOD policy which is to be monitored by the Principal Deputy Under Secretary of Defense for Personnel and Readiness, Office of Morale, Welfare, and Recreation.³⁵ Specifically, the policy requires that all military services and reserve components develop and use physical fitness tests that evaluate aerobic capacity (e.g., a timed run), muscular strength, and muscular endurance (e.g., push-ups, pull-ups, sit-ups), and that all service members be formally evaluated and tested for the record at least annually (unless they are under a medical waiver).

The specific content of the physical fitness examination varies among the components because different physical abilities are needed to meet the services' different missions. The Army Physical Fitness Test (APFT) is a performance test that indicates a member's ability to perform physically and handle his or her own body weight. The APFT is required annually for the Army National Guard. As of October 2004, the Chief of the Army Reserve required Army reservists to be tested twice a year, as are their active component counterparts. The APFT consists of 2 minutes of push-ups, 2 minutes of sit-ups, and a 2-mile run (the same test is administered to both the active and reserve component). The number of push-ups and sit-ups and the 2-mile run time are based on the soldier's age range and sex (the physical fitness test required to enter the Army has the same requirements for all ages, but different requirements for gender). All Navy personnel, regardless of age and component (active or reserve), are required to participate semiannually in a Physical Fitness Assessment that

³⁴ The dental screening was more limited than the current dental examination. It included a mouth-mirror, and explorer or tongue depressor evaluation only.

³⁵ DOD Directive 1308.1, "DOD Physical Fitness and Body Fat Program".

includes a Body Composition Assessment and Physical Readiness Test unless medically prohibited from doing so. Body composition is assessed by an initial weight and height screening or an approved circumference technique to estimate body fat percentage. Testing includes a series of physical events designed to evaluate an individual's flexibility through a sit-reach activity, muscular strength and endurance through curl-ups and push-ups, and aerobic capacity through a 1.5-mile run/walk, or 500-yard or 450-meter swim. Individuals who fail either the Body Composition Assessment or the Physical Readiness Test or both are considered to have failed the entire assessment. The Marine Corps has also developed a Body Composition Program and Physical Fitness Test to assess each Marine's fitness level. Active component Marines are tested semiannually while Marine Corps Reservists are tested annually. Body composition standards are health- and performance-based limits for body weight and body fat. Physical fitness testing includes pull-ups for males, flexed-arm hang for females, a timed abdominal crunch event, and a timed 3-mile run. These events are designed to test the strength and stamina of the upper body, midsection, and lower body, as well as the cardiovascular system. The Air Force fitness program requires an annual physical assessment to motivate all members to participate in a year-round physical conditioning program, including proper aerobic conditioning, strength/flexibility training, and healthy eating. Fitness assessment results are based on a composite score calculated from results of an aerobic assessment (1.5-mile run), muscular fitness assessment (push-ups and crunches), and body composition measurement (abdominal circumference measurement).

Although DOD has directed the military physical fitness programs to complement the health promotion program within OSD's Office of Health Affairs and senior medical officials have told us that medical and physical fitness go "hand-in-hand," physical fitness policies are not coordinated with medical fitness policies at the OSD, service, reserve component, or unit levels. Furthermore, DOD did not consider physical fitness a factor for determining the medical deployability of reserve component members prior to deployment to Iraq and Afghanistan, even though we reported in 1994³⁶ that several Army reports on Operations Desert Shield and Desert Storm noted fitness-related problems that hindered wartime operations. For example, one report noted that poor fitness contributed to the deaths

³⁶GAO, *Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards*, GAO/NSIAD-94-36 (Washington, D.C.: Mar. 23, 1994).

by heart attack of eight reserve component personnel deployed to the Persian Gulf.

OSD Does Not Oversee Compliance with Routine Medical and Physical Fitness Examinations

OSD does not have a plan to oversee reserve components' compliance with the routine medical or physical fitness examinations, which hinders DOD's ability to determine the extent of compliance. For example, OSD does not track reserve component members' compliance with routine medical examinations. In addition, OSD does not enforce its own directive requiring the services to report on their members' compliance with physical fitness examinations.

OSD Does Not Track Compliance with Routine Medical Examinations

Although OSD's Office of Health Affairs has begun to track medical readiness indicators, it does not have a plan to track compliance with routine medical examinations and does not attempt to track compliance with physical fitness examinations. OSD's Office of Health Affairs has initiated a process requiring that all reserve components report quarterly the percentage of their members who are in compliance with the following six indicators of medical readiness: dental class I or II; immunizations; medical readiness laboratory tests, such as providing a blood sample; no deployment-limiting conditions; periodic health assessment; and medical equipment, such as eyeglass inserts for face masks. This process continues to evolve as the Office of Health Affairs wrestles with inconsistencies in requirements among the reserve components, especially in regard to the periodic health assessment since each reserve component implements the requirement for a periodic 5-year medical examination differently.³⁷ Without centralized oversight and management for tracking compliance, DOD's ability to determine the extent of compliance with routine medical examinations may be impeded.

OSD Has Not Enforced Its Directive Requiring the Services to Report on Compliance with Physical Fitness Exams

OSD has not enforced its own directive requiring the reserve and active components to report on their members' compliance with physical fitness examinations by March 2005. Although DOD policy states that physical fitness is a vital element of combat readiness and is essential to the general health and well-being of military personnel, OSD and the reserve components have been lax in reporting compliance with physical fitness examination requirements and do not fully utilize available systems that could report physical fitness status on a servicewide basis. DOD

³⁷ The Assistant Secretary of Defense for Health Affairs is currently drafting a policy intended to help standardize implementation of the medical examination requirements.

established a reporting requirement for physical fitness in November 2002, in response to recommendations from our prior reports; however, it has not enforced compliance with this new requirement.

The new physical fitness policy requires that each military service establish and maintain a data repository that provides baseline statistics and a tracking mechanism that monitors physical fitness and body fat for both the active and reserve components. The policy was developed over the course of many years. In response to a recommendation in our 1994 report,³⁸ the Under Secretary of Defense for Personnel and Readiness stated that revised DOD guidance³⁹ would “require the services to provide an annual report assessing their physical fitness and health promotion programs, to include a brief summary on how physically fit and healthy they view their military members, both active and reserve components.” Not only did the original directive fail to require the services to submit an annual report on the status of servicemembers’ physical fitness, but senior military officials in the office responsible for developing these directives told us that no service ever submitted a status report on their physical fitness programs as required by the revised directive. In 1998, we again reported that DOD’s oversight of the physical fitness program was inadequate and that DOD had not enforced the annual reporting requirement.⁴⁰ Officials in the Office of Morale, Welfare, and Recreation stated that in response to our report, DOD guidance was again revised in November 2002, to require the services to report annually to the Principal Deputy Under Secretary of Defense for Personnel and Readiness⁴¹ on a number of very specific physical fitness statistics, including the number of personnel tested, the number of personnel who failed the test, and the number placed in remedial training programs. The first report was due to the Principal Deputy Under Secretary of Defense for Personnel and Readiness by the military services by March 31, 2005. However, during our review we were told by officials in the Office of Morale, Welfare, and Recreation that none of the reports had been submitted to the Principal

³⁸ GAO, *Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards*, [GAO/NSIAD-94-36](#) (Washington, D.C.: Mar. 23, 1994).

³⁹ DOD Directive 1308.1.

⁴⁰ GAO, *Gender Issues: Improved Guidance and Oversight Are Needed to Ensure Validity and Equity of Fitness Standards*, [GAO/NSIAD-99-9](#) (Washington, D.C.: Nov. 17, 1998).

⁴¹ This position was referred to as the Assistant Secretary of Defense (Force Management Policy) at the time the directive was revised in 2002.

Deputy as required. The Air Force, Navy, and Marine Corps were developing their information during this review. The Army had until March 2007 to report because, according to a signed memorandum by the Principal Deputy Under Secretary of Defense for Personnel and Readiness, the Army is taking steps to report this information as part of the Defense Integrated Military Human Resources System (DIMHRS). Until this reporting requirement is enforced, DOD's ability to determine compliance with the physical fitness examinations may continue to be hindered.

Reporting of Compliance at Reserve Component Level Is Hindered by Incomplete and Unreliable Data and Lack of Enforcement

Incomplete and unreliable data at the reserve component level regarding compliance with routine medical and physical fitness examinations have hindered DOD's ability to determine the extent of the reserve components' compliance with the examination requirements. Each reserve component employs a tracking system capable of monitoring compliance with medical examinations, but only one reserve component—the Navy Reserve—has data that are reliable for determining compliance with routine medical examinations. Furthermore, even though DOD policy calls for each military service to establish and maintain a physical fitness data repository, no reserve component has demonstrated that its tracking system can report complete and reliable compliance data on physical fitness. Although the reserve components place the responsibility for tracking compliance with medical and physical fitness examinations on the unit commander, the reserve components do not always hold the unit commanders accountable and the unit commanders do not always enforce the compliance of their members. No centralized oversight exists to hold all levels accountable, thus ensuring that all requirements are being met.

Most Reserve Component Data on Compliance with Routine Medical Examinations Are Unreliable

All of the reserve components are now employing systems that can track compliance with medical examinations, but only one reserve component—the Navy Reserve—has taken the necessary quality assurance steps to ensure the reliability of its data on compliance with routine medical examinations. In contrast, we found that the data captured by the systems used by the Army and the Air Force were unreliable for determining compliance with routine medical examinations. We did not assess the reliability of the data used by the Marine Corps because it is in the process of implementing and testing the use of the Navy's system.

Assessing data for their reliability includes quality assurance steps to consider the completeness and currency of the data, i.e., determining whether there are assurances that all members are included and the information is up to date; quality control measures, such as conducting periodic testing of the data against medical records, to ensure the accuracy and reliability of the data; and examining who is using the data

and for what purposes, and how reliable the user thinks the data are. We found that the Navy Reserve had taken such quality assurance steps. For example, the Navy has directed its Readiness Commands to conduct routine inspections to verify medical data accuracy in the Navy Reserve's Medical Readiness Reporting System (MRRS) and required reserve units to review 10 percent of their medical records for accuracy after each drill weekend. In addition, Navy Reserve units are also required to keep the Commander, Navy Reserve Forces Command informed about medical and dental compliance on a biweekly basis.

In contrast, we found that the compliance data on routine medical examinations captured by the Army Medical Protection System (MEDPROS) were unreliable for the purposes of determining compliance with routine medical examinations. MEDPROS was developed in 1998 to track anthrax compliance and has since matured to meet current mobilization requirements. All Army components—active, reserve, and guard—are required to enter members' medical compliance data into MEDPROS. We found the data captured by this system are unreliable for monitoring compliance with routine requirements for several reasons, including missing data, failure to include data for all Army units, and lack of quality assurance assessments on data content being performed to test the data's reliability. Until quality control measures are instituted, the Army will not be able to reliably use MEDPROS to track compliance with the requirements for the 5-year medical examination, the annual medical certificate, and the annual dental examination.

We also found that the Air National Guard's Preventive Health Assessment and Individual Medical Readiness (PIMR) system and the Air Force Reserve's Reserve Component Periodic Health Assessment (RCPHA) system were unreliable for the purposes of determining compliance with routine medical examinations. We found that neither system produces data that are reliable for the purposes of determining compliance with routine medical examinations because: (1) both the Air Force Audit Agency and Air Force Inspection Agency have reported discrepancies in their review of medical records and the data from these systems, and (2) there is a high reliance on unit commands to test and verify the reliability of the data. In addition, during our site reviews, we found medical staff at several commands having difficulty entering large backlogs of medical data, which raised concerns about the timeliness of the data. Often, this backlog took several weeks to resolve and required the assistance of full-time reservists. However, according to program managers and database administrators, the quality of the data, in terms of their completeness and accuracy, ranges from quite good to exceptional

Reserve Components Are
Unable to Report Complete and
Reliable Data on Compliance
with Routine Physical Fitness
Examinations on a
Componentwide Basis

when subjected to internal system software checks. Until resources necessary to input and verify the data in a timely manner are provided, the Air Force will not be able to rely on PIMR and RCHPA data to determine compliance with routine medical examination requirements.

We did not assess the reliability of the data used by the Marine Corps because it is in the process of implementing and testing the use of Navy's system. According to a Marine Corps official, once the new system is fully implemented, the Marine Corps will have the same oversight capability over medical compliance that the Navy Reserve currently has.

Even though DOD policy calls for each military service to establish and maintain a physical fitness data repository, no reserve component has a tracking system that can report complete and reliable data on compliance with physical fitness examinations on a componentwide basis. In fact, the Army Reserve, the Army National Guard, and the Marine Corps Reserve do not have systems that are designed to track compliance with physical fitness examinations on a componentwide basis.

The Navy Reserve, the Air National Guard, and Air Force Reserve each have systems that can track compliance with physical fitness examinations on a componentwide basis. The Navy Reserve system, however, may not be producing reliable data at this time. Further, we have concerns regarding the reliability of the data produced by the Air National Guard and the Air Force Reserve because such data are not reviewed or validated on a regular basis.

The Army does not report physical fitness on a componentwide basis. According to a Department of Army memo, dated April 19, 2004, and confirmed through our discussions with Army and OSD officials, physical fitness and body composition data will eventually be tracked in DIMHRS, in which the Army is the first component to participate. Until DIMHRS is used, the Army will be unable to report complete and reliable data on componentwide compliance with the physical fitness examination requirements. According to Army Reserve officials, physical fitness data can be tracked in the regional level application software database, but the information may not be updated by the units in a timely or consistent manner. This information is then updated in the Total Army Personnel database, which updates the Individual Training and Readiness System. In the Army National Guard, the states may use the personnel database to record the scores and dates of physical fitness examinations, but not consistently. The Army's first report on the status of its physical fitness compliance for all its components will be due March 31, 2007, because the

Office of the Under Secretary of Defense for Personnel and Readiness granted the Army a 2-year extension for its requirement to report on the physical fitness status of all members (active, reserve, and guard). The data in this report, if complete and reliable, could enable DOD to determine the Army's compliance with the physical fitness examination requirement. According to the 2004 Department of the Army Memo, if DIMHRS is not on line by September 2006, the Army will manually report these data.

Compliance with physical fitness examination requirements is tracked at headquarters level for the Navy Reserve, but we found that the Navy is unable to report complete and reliable compliance data. The Navy requires all commands to report their physical fitness assessment data, including physical readiness test results, through the Physical Readiness Information Management System (PRIMS). However, we found the data generated by this system to be unreliable because, according to a Navy Official, there are about 2,000 duplicate records that need to be purged and about 25 percent of the Body Composition Assessment scores have not been reported by unit commanders. Until internal controls are established to eliminate duplication and ensure completeness of data, the Navy will be unable to report complete and reliable data on componentwide compliance with the physical fitness examination requirement. The Navy submitted its annual report on physical fitness, due March 31, 2005, to DOD 3 months late, on July 8, 2005. According to a DOD official, the Navy did not request an extension or provide an explanation for the late submission. Because the data in this report came from the PRIMS system that we found to be unreliable, we do not believe that DOD can reliably use the information in the report to determine the Navy's compliance with the physical fitness examination requirement.

The Marine Corps is unable to report complete and reliable data on compliance with the physical fitness examination because, in contrast to the Navy, the Marine Corps does not have a dedicated physical fitness reporting system. Instead, the Marine Corps requires unit commanding officers to record physical fitness scores in unit diaries, personnel records, and the Marine Corps Total Force System, a Marine Corps-wide personnel system. Units that input data into this system are responsible for reviewing the data and certifying that they are correct. However, a Marine Corps official indicated that the data are assumed to be correct when transmitted to higher commands, but no steps are taken to verify accuracy of the data. As of August 2005, the Marine Corps had provided DOD with a draft report addressing calendar year 2004 physical fitness scores. According to a DOD official, the Marine Corps did not request an extension or provide an

explanation for the late draft submission. Further, as of September 2005, the Marine Corps had not responded to our official request for the annual physical fitness report. Without an ongoing quality assurance program to consistently and continuously ensure the completeness and reliability of the data in the Marine Corps Total Force System, we did not rely on the data in the draft Marine Corps Physical Fitness Report provided to DOD.

Although both the Air Force Reserve and Air National Guard each have a dedicated system to track the physical fitness status of their members, we found quality assurance procedures lacking, possibly leading to incomplete and unreliable data with which to track physical fitness compliance. The Air Force Reserve's software system Program—the Air Force Fitness Management System (AFFMS)—only tracks fitness program results on a current basis and only retains data entered from 2004 forward. However, quality assurance procedures are not followed. For example, there are delays in entering data; compliance of individual units is only reviewed if there is a question; and headquarters does not routinely assess members' currency. This program relies on a fitness program manager within each unit command to monitor program metrics. According to an AFFMS system official, the only true way of determining the reliability of the data in this system is to compare these data with the data in the respective member's personnel files, and this has not been done. The Air National Guard (ANG) tracking system for compliance with physical fitness examinations is ANG's Fitness Age and was first implemented in late 2003, although many ANG units lagged in their use of Fitness Age until after April 2004. ANG's Fitness Age database only reflects calendar year information as of a specific point in time, and does not track or measure performance based on a running 12-month period. The ANG Fitness Program requires an assessment on all ANG members once per calendar year. According to ANG officials, most physical fitness testing is performed within the last few months of the calendar year. Because the data are cumulative, the only time that physical fitness information can be assessed for all members taking the test is at the end of the calendar year. In other words, most reservists would appear out of compliance until they take their annual exam even though they are probably still within their 1-year window for testing. Furthermore, information on the number of reservists not tested at all or who are overdue is not captured by the ANG Fitness Age database. According to an ANG official, the responsibility for managing the physical fitness program rests with the respective ANG installation's command. The respective ANG installations (unit commands) have visibility over their respective "overdue" members. However, ANG headquarters lacks sufficient oversight to assess compliance. Without ongoing quality assurance programs to consistently

and continuously ensure the completeness and reliability of the data in the Air National Guard and Air Force Reserve systems, we did not rely on the data in these systems.

Accountability to Comply with Routine Medical and Physical Fitness Examination Is Not Always Enforced

In general, throughout the reserve components, the individual members are responsible for maintaining their physical and medical fitness and the unit commanders are responsible for ensuring members' compliance with medical and physical fitness examinations; however, the reserve components do not always hold the unit commanders accountable and the unit commanders do not always enforce the members' compliance. Accountability for compliance is fragmented at various levels of command. No centralized oversight exists to hold all levels accountable ensuring that all requirements are being met. Individual members are responsible for attending all scheduled examinations and assessments, seeking timely medical advice when necessary, reporting changes in their medical health on the annual medical certificate, and successfully completing the requirements of the physical fitness examinations. False statements may result in reassignment, discharge, or other disciplinary action. Unit commanders are responsible for implementing any administrative and command provisions for examinations, informing members of the examination requirements, establishing training programs for physical fitness, taking actions against reserve members who fail to comply with the requirements, and reporting the current medical and dental status of reservists through the applicable tracking systems, and they are ultimately responsible for the accuracy of medical and physical fitness information relied on by higher commands. However, reserve components do not always hold the unit commanders accountable for these responsibilities and the unit commanders we interviewed expressed concern about the many competing responsibilities they have, such as meeting training requirements, and how they must prioritize the use of their limited resources. One unit commander also expressed concern about enforcing medical and physical fitness policies if it meant losing a "good soldier" who otherwise performs his duties well. Without oversight and accountability at the OSD and respective service and reserve component levels, unit commanders may not have the incentive or resources to fully enforce the medical and physical fitness examination requirements and compliance may suffer.

Indications of Noncompliance with Medical and Physical Fitness Examination Requirements Exist

Although DOD can not determine the extent of reserve components' compliance with routine medical and physical fitness examinations, we found indications of noncompliance during our site visits and in our reviews of existing audit reports and investigations. For example, a limited review of medical files at one Army National Guard and one Army Reserve location, data from a Navy report, test results of two units in a Marine Corps battalion, and data from a review conducted by the Air Force Audit Agency indicate some noncompliance at all components with the routine medical examination, annual medical certificate, annual dental examination, and annual physical fitness examination.

Indications of Noncompliance with 5-Year Medical Examination and Annual Medical Certificate Exist at All Components

A review of available medical files at one Army National Guard and one Army Reserve location, data from a Navy report, test results of two units in a Marine Corps battalion, and data from a review conducted by the Air Force Audit Agency indicate some noncompliance with the routine medical examination and the annual medical certificate at all components. For example, in April 2005 we conducted a review of 39 medical files at an Army National Guard unit that was deployed to Iraq in 2003 for 1 year. We found that 13 members were not in compliance with the routine medical examination at the time of our review. Further, while 36 members were in compliance with the annual medical certificate at the time of our review, only 3 members were in compliance with the annual medical certificate prior to the unit being alerted of their most recent mobilization date for deploying to Iraq. According to the commander of this unit, there are a number of actions that need to be accomplished during weekend drills, and with limited time and resources available, completing routine medical requirements is low on the long list of priorities. In addition, during June 2005, we reviewed 175 medical files of an Army Reserve unit that deployed to Afghanistan in 2003 for 10-month deployment. We found that all but 2 members were in compliance with the 5-year medical examination. While 150 members were in compliance with the annual medical certificate at the time of our review, not a single member was in compliance with the annual medical certificate prior to the unit receiving alert orders of their mobilization. Furthermore, many of the soldiers that we spoke with during our review stated that they were unfamiliar with the annual medical certificate. In addition, a February 2005 Army Inspector General Report noted that virtually all reserve component leaders they contacted during their review expressed frustration with their inability to maintain the medical deployability status of their soldiers using the annual medical

certificate process.⁴² Leaders noted the certificate only reflects what a soldier is willing to share. Often the only medical personnel available to review and sign the certificate is a unit medic, who can do little more than ask if the data are correct.

In July 2005, the Navy reported that 96.8 percent of reserve members had completed the routine 5-year medical examination and 94 percent of reserve members had completed the annual medical certificate. These high rates are due, in part, to the high priority placed on medical and dental compliance throughout the Navy Reserve.

Although the Marine Corps Reserve does not currently have componentwide automated information on medical compliance, it does conduct a periodic site inspection called the Mobilization Operational Readiness Deployment Test (MORDT). We reviewed the results of the MORDT at two units of a Selected Reserve Battalion that had been mobilized. The first unit test results we reviewed indicated that 98 percent of the reservists had completed a routine physical examination within 5 years, and 90 percent had submitted annual health certifications. The second unit test results also indicated that 98 percent of the reservists had completed a routine annual physical within 5 years, and 88 percent had submitted annual health certifications. According to Marine Corps Reserve officials, all Marine Corps Selected Reserve units are subjected to an unannounced test prior to mobilization to ensure the unit can deploy.

The Air Force Audit Agency (AFAA) recently concluded its review of the Service's Individual Deployment Process, during which it found significant problems with the Guard's and Reserve's medical records. Ten Air National Guard and Air Force Reserve installations included in a sample of 20 installations designed to be able to produce estimates for all Air Force personnel who were eligible to be deployed during the 90-day window between June 1, 2004, and August 31, 2004, were in compliance with medical requirements such as, but not limited to, annual medical assessments and dental examinations. The AFAA reviewed the medical records and associated documentation for accuracy and completeness. Based on AFAA's review and analysis of 14,121 eligible Guard and Reserve members combined, about 13 percent⁴³ were found to have medical

⁴² Over 1,400 active and reserve component leaders, soldiers, and civilians in 35 locations in the United States were contacted by the Army Inspector General during its review.

⁴³ We are 90 percent confident that the true percentage of medical discrepancies is within +/-6.1 percentage points of our estimate.

discrepancies in their medical records. At 2 of the unit commands included in AFAA's review that we also visited in our review, command officials said that they agreed with the AFAA's findings and were taking corrective action.

Indications of Noncompliance with Dental Examinations Exist at All Reserve Components

Indications of noncompliance with the dental examination requirement were also present at all the reserve components. For example, as previously noted, in April 2005, we conducted a review of 39 medical files of an Army National Guard unit; of these, 33 were not in compliance with the annual dental examination at the time of our review. Furthermore, 32 members were not in compliance with the annual dental examination prior to alert. In June 2005, we visited an Army Reserve unit to conduct a review of 175 medical files. Although only 13 members were not in compliance with the annual dental examination at the time of our review, over 130 members were not in compliance with the dental examination prior to alert.

Other evidence indicates that compliance with dental requirements has been a particular matter of concern for the Army reserve components. According to a February 2005 Army Inspector General Report,⁴⁴ there are examples of reserve component service members with multiple tooth extractions at nearly every mobilization station. Furthermore, in cases where members presented dental records during mobilization, often the only entries are dated to the members' basic training and initial exams and procedures. We found a stark example of what happens during mobilization when a member's dental status is allowed to remain below Class I or II. In one unit we visited, we interviewed a member who had 30 teeth extracted prior to deployment. According to the member, although dental screenings were conducted annually, indicating that he was a dental class III he took no follow-up action to correct his dental problems because he had no dental insurance and correcting the problem was not a priority. At the time this servicemember was being mobilized, a Department of the Army memo dated December 6, 2002, stated that soldiers assigned to designated units scheduled to deploy within 75 days of mobilization and identified as being within dental class III or IV have necessary dental treatment initiated to bring them up to dental classification II, the deployment standard.

⁴⁴ *Department of the Army Inspector General Special Inspection of Army Mobilization/Demobilization in Support of Recent and Ongoing Operations, November 2003-June 2004*, February 28, 2005.

Although we did not review individual medical and dental records at Navy and Marine Corps Reserve sites we visited, we did review specific reports to assess whether these components monitored members' dental status. We found that the Navy Reserve compliance appears to be improving. For example, in early July 2005, the Navy reported that 88.6 percent of selected reservists were in a Dental Class I or II category, an increase over the 69 percent reported in the Dental Class I or II category in December 2002. We also reviewed MORDT results for two Marine Corps units during a site visit to a Marine Corps Reserve Battalion that had been mobilized. We found that test results for the first unit indicated that 85 percent were categorized as Dental Class I or II while 77 percent in the second unit were categorized as Dental Class I or II.

Analysis provided by the AFAA from its review, mentioned earlier, indicated that about 13 percent⁴⁵ of the Air National Guard and Air Reserve members who were eligible to be deployed between June 1, 2004, and August 31, 2004, were found to have discrepancies in their dental records. In addition to the AFAA review, in 2004 the Air Force Inspection Agency conducted health services inspections and found discrepancies in dental readiness classifications in 49 percent of the 37 installations reviewed.

Indications of Noncompliance
with Physical Fitness
Examination Requirement
Exist at All Reserve
Components

As with the other examination requirements, we also found indications of noncompliance with the physical fitness examination requirement at all six components.

During our review in April 2005 we also reviewed 29 physical fitness files of the Army National Guard unit that deployed to Iraq. Of the 29 physical fitness files we reviewed, only 18 members showed compliance with the physical fitness examination requirement during 2004. Of these 18 members, 11 passed the physical fitness test and 7 failed. According to the unit commander, some soldiers possess skills that are greatly needed for unit continuity and strength and usually outweigh the ramifications of having to separate the member due to physical fitness test failures. We also conducted a review in June 2005 of 227 physical fitness files of the Army Reserve unit that deployed to Afghanistan. Of the 227 physical fitness files we reviewed, only 117 members showed evidence of compliance with the physical fitness examination requirement during 2005. Of these 117 members, 89 passed the physical fitness test and 16

⁴⁵ We are 90 percent confident that the true percentage of medical discrepancies is within +/-6.1 percentage points of our estimate.

failed.⁴⁶ In group discussions held at this time, members stated that there were no repercussions for failing the physical fitness test. As previously reported in our 1994 report,⁴⁷ we also found that physical fitness scores had been inappropriately changed and servicemembers were not discharged even after repeated test failures, primarily because commanders placed more emphasis on maintaining unit strength.

While visiting a Navy Reserve Activity, we obtained a single unit's physical fitness test results to ensure data were properly maintained in the Physical Readiness Information Management System. However, when we asked the Navy Personnel Command to provide a copy of the required physical fitness report, we learned the report would be submitted to OSD late. According to a Navy official, the Navy had identified over 2,000 duplicate record entries and estimated that nearly 25 percent of the body fat scores were missing from the data totals. In its report to OSD, the Navy reported that it had not mandated separation processing for individuals who failed the physical fitness test since May 2001.

During a visit to a Marine Corps Reserve Center, we also obtained information that indicated individual Marine Corps reservists' physical fitness scores were recorded in the Marine Corps Total Force System. Subsequent to our visit, however, we learned that the Marine Corps also provided an unofficial "draft" physical fitness report to the OSD after the deadline. In order to review Marine Corps physical fitness statistical data, we requested a copy of the report on April 6, 2005. As of October 2005, the Marine Corps had not responded to our request.

The Air Force did not meet OSD's required due date in submitting its first annual report on its assessment of the physical fitness, body fat, and health promotion program for the active service, the Air National Guard, and the Air Force Reserve. The Air Force did not submit its annual report until May 4, 2005. Based on the data provided by the Air Force for the Air National Guard and the Air Force Reserve, only 83 percent of the force members were tested, with 13.2 percent of those tested falling into the

⁴⁶ At the time of our review, 110 members did not have an APFT on file. In addition, there were service members who did not take a physical fitness test for the record during 2005, nor did they have a temporary or permanent profile when completing the physical fitness test.

⁴⁷ GAO, *Reserve Forces: DOD Policies Do Not Ensure That Personnel Meet Medical and Physical Fitness Standards*, GAO/NSIAD-94-36 (Washington, D.C.: Mar. 23, 1994).

poor category. However, the Air Force's assessment of one of its reserve component's statistical data may not be entirely correct. In its reported statistical information of the numbers of members tested, those members testing in the poor category are higher than those numbers directly reported by the Air National Guard to the Air Force Medical Support Agency, which consolidated the respective components' data and in turn submitted the overall report to the Assistant Secretary of Defense for Force Management Policy. In addition, as discussed earlier, we were unable to determine that the data used from the Air National Guard and Air Force Reserve databases that generated these data are reliable.

DOD Lacks Visibility over the Health Status of Reserve Components after Being Called to Active Duty and the Extent to which Members with Preexisting Conditions Required Care during Deployment

DOD does not have complete visibility over the health status of reserve component members after they are called to duty and is unable to determine the extent of care provided to those members deployed with preexisting medical conditions. Despite the existence of various sources of medical information, DOD has incomplete visibility over members' health status when called to active duty, primarily because the reserve components vary in their ability to systematically identify, track, and report members' medical deployability and the DOD-wide centralized database cannot provide complete information—both of which hinder DOD's ability to accurately determine what forces remain for future deployments. In addition, DOD is unable to determine the extent to which reserve component members received care for preexisting medical conditions while deployed; however, evidence suggests that reserve component members did deploy with preexisting medical conditions that could not be adequately addressed in theater and that some of these conditions may have stressed in-theater medical capabilities.

Visibility over Health Status of Reserve Members after They Are Called to Active Duty Is Limited

Although DOD has some visibility over reserve component members after they are called to active duty or mobilized, this visibility is limited despite several potential sources of information. For example, the reserve components vary in their ability to systematically identify, track, and report information about members' medical deployability, which limits DOD's visibility over the health status of members. In addition, although medical information is captured on predeployment forms for all reserve component members and entered into a DOD-wide centralized database during mobilization, some data are still missing and information regarding the reasons why members were found nondeployable is not captured in a way that can be easily searched through the database. Moreover, medical referral data captured on the predeployment forms provide some insight into the care that members may have required during mobilization, but this care is not always related to why a member was determined to be

medically nondeployable. Some data on the medical reasons why Army Guard and Reserve members were not deployed after being activated can be obtained from an analysis of the Army's medical holdover database, but this information is insufficient to provide DOD with visibility over members' health status since it is only gathered on the numbers of Army reserve components held prior to deployment and this population is diminishing due to positive changes in Army's medical holdover policy. DOD's limited visibility over reserve component members' health status when they are called to active duty could affect planning for future deployments because the pool of available Guard and Reserve component members from which to fill requirements for certain skills and grades is dwindling, and members' health status is deteriorating following deployments.

Reserve Components Vary in Ability to Identify, Track, and Report Medical Nondeployable Members

The reserve components vary in their ability to systematically identify, track, and report members' medical deployability, and only three reserve components—the Navy Reserve, the Air Force Reserve, and Air National Guard—can currently identify and track members with both temporary and permanent conditions that limit medical deployability. This limited visibility over reserve component members' medical deployability status hinders DOD's ability to identify the pool of available Guard and Reserve members who are available for deployment.

The Navy Reserve uses the Medical Readiness Reporting System (MRRS) to track and report the status of reservists classified as Temporarily Not Physically Qualified for duty because of an illness, injury, or other medical condition that should be resolved within 6 months. This system is also used to track and report the status of reservists, classified as Not Physically Qualified for duty, with more serious medical conditions such as cancer or heart disease that will not be resolved in 6 months and may lead to a medical review or board retention decision. As the Marine Corps Reserve continues to fully implement the Navy's Medical Readiness Reporting System, it too will have these same capabilities. Both the Air National Guard and the Air Force Reserve's medical tracking systems—PIMR and RCPHA, respectively—can identify and track members with specific medical conditions that limit deployment; however, neither system can distinguish between temporary and permanent limitations. In addition, the Air Force has a system called Military Personnel Data System that captures information on all medical profiles and can report specific queries on specific categories such as temporary and permanent conditions. Although the Army tracks active, guard, and reserve members with medical profiles that limit deployment through their medical tracking system, MEDPROS, the active Army and Army Reserve do not presently

Centralized DOD-wide
Database Provides Some
Visibility over Health Status
During Mobilization, but Data
Could Be Further Improved

track members with temporary medical conditions that render them nondeployable. However, the Army National Guard is in the process of implementing a system, called the Medical Non-Deployable Tracking Module (MND-TM), that will track its members who have a temporary or permanent medical condition that renders them nondeployable. Army National Guard officials expect all states to use this system for its members by July 2007. Until all six reserve components are able to systematically identify and track members' medical deployability status, DOD will not have the most accurate information to centrally manage estimating the remaining available pool of guard and reserve members for future deployments.

DOD has some visibility over reserve component members' medical status during mobilization through the centralized DOD-wide database operated by the Army Medical Surveillance Activity (AMSA). All active and reserve component members are required to complete a medical predeployment form to document the member's medical deployability status, which is then forwarded to AMSA for entry into the database. Thus, information can be obtained from the centralized database on reserve and active component members who were determined nondeployable during mobilization due to medical reasons. The member also completes a health assessment form after deployment. However, we have noted in previous reports that the centralized database has missing and incomplete forms. In our last report issued in September 2004,⁴⁸ we found that for the required forms from reserve component members (1) not all of the forms had reached AMSA, (2) only some of the forms that had reached AMSA had been entered into the database, and (3) not all of the forms contained complete information, thus limiting analysis.

We also noted that while the components were not in complete compliance with the requirement to submit pre- and postdeployment assessments, the number of assessments had grown significantly. During this review, we found that DOD has continued to make progress toward collecting the pre- and postdeployment forms. According to AMSA officials, the database contained about 140,000 assessments at the end of 1999, grew to about 1 million assessments by May 2003, almost doubled at 1,960,125 by June 2004, and was at 2,241,177 by June 2005.

⁴⁸ [GAO-04-1031](#).

Further, DOD has established a centralized deployment health quality assurance program to improve data collection and accuracy.⁴⁹ Each service has also developed a deployment health quality assurance program. The department's first annual report, documenting, among other things, issues relating to predeployment health assessments, was issued in May 2005. The DOD quality assurance program includes (1) periodic site visits jointly conducted with staff from the Office of the Assistant Secretary for Health Affairs and staff from the military services to assess compliance with the deployment health requirements, (2) periodic reports from the services on their quality assurance programs, and (3) periodic reports from AMSA on health assessment data maintained in the centralized database. The report noted that centralized management of quality assurance had improved accountability of the preassessment forms on the part of the services.

For this review, we obtained predeployment information from AMSA officials based on over 1 million active and reserve component predeployment health assessment forms collected between November 2001 and June 2005. More than 5 percent of the reserve component and more than 6 percent of the active component predeployment health assessment forms did not record the servicemember's deployability status. Of the approximately 94 percent of forms that were complete, nearly the same percent of reserve component and active component members were found medically deployable, 94 percent of the reserve component members compared to 96 percent of the active component members. Unfortunately, the forms do not always capture information regarding the reasons why members were found medically nondeployable or do not capture that information in a systematic way. For example, although the form has an entry for a narrative explanation to explain why a member is medically nondeployable, an AMSA official informed us that these explanations are often incomplete or not decipherable, and can not be easily categorized. Furthermore, although the forms do provide space for the member's deployment destination, this information is not always filled in because, according to AMSA officials, deployment destination is often not known by the member or is classified. Therefore, the data presented here are for all worldwide deployments, including the United States, and

⁴⁹ This program was established following our 2003 review, GAO, *Defense Health Care: Quality Assurance Process Needed to Improve Force Health Protection and Surveillance*, GAO-03-1041 (Washington, D.C.: Sept. 19, 2003).

could change after the initial deployment, thus preventing an analysis by operation.

As seen in table 1, the total nondeployable rate for all six reserve components was more than 5 percent, while table 2 shows the total nondeployable rate for the active component was almost 4 percent. While the Army Reserve had the highest percentage of nondeployable servicemembers among the reserve components, at about 9 percent, the active Army had the highest percentage of nondeployable servicemembers among the active components, at almost 6 percent. According to medical officials, some of these nondeployable personnel, such as those who had suffered multiple heart attacks, should have been discharged prior to the time that they received their mobilization orders. Others had temporary conditions, such as broken bones and pregnancies, that did not warrant medical discharges but made the servicemember nondeployable at the time of the assessment.

Table 1: Service Decisions Concerning Reserve Components' Deployability, November 2001 through June 2005

Reserve Components	Deployable	Nondeployable	Deployable or nondeployable answer missing on form	Percentage with missing answer	Total number of predeployment health assessments completed	Percentage nondeployable
Army Reserve	100,286	9,842	5,578	4.82	115,707	8.51
Army National Guard	181,160	10,959	6,584	3.31	198,703	5.52
Navy Reserve	8,597	99	1,445	14.25	10,141	.98
Air Force Reserve	13,164	156	2,341	14.95	15,661	1.00
Air National Guard	35,025	243	3,335	8.64	38,603	.63
Marine Corps Reserve	3,886	31	763	16.30	4,684	.66
Total	342,118	21,330	20,046	5.23	383,499	5.56

Source: GAO analysis of AMSA data.

Table 2: Service Decisions Concerning Active Components' Deployability, November 2001 through June 2005

Active Components	Deployable	Nondeployable	Deployable or nondeployable answer missing on form	Percentage with missing answer	Total number of predeployment health assessments completed	Percentage nondeployable
Army	347,057	21,018	19,451	5.02	387,528	5.42
Navy	20,190	109	1,627	7.42	21,928	0.50
Air Force	150,045	1,477	14,544	8.76	166,066	0.90
Marine Corps	47,318	166	4,191	8.11	51,678	0.32
Total	564,610	22,770	39,813	6.35	627,200	3.63

Source: GAO analysis of AMSA data.

Medical Referral Data Provide Insight on Care Provided during Mobilization

The predeployment health assessment forms capture information on specific medical referrals given to members by the reviewing health care official during mobilization, which is useful in gaining some insight into the care that members may have required during mobilization. These data are not as helpful in determining why a member was not medically deployable since they are not always related to why a member was determined to be nondeployable. According to a senior OSD official, although any indicated referral may be related to a disposition of nondeployable, this is not always the case. Three common scenarios illustrate this relationship: (1) a member is found to be clearly nondeployable from a medical standpoint, and no referral is made; (2) a member is referred for further evaluation for a condition for which deployability is questionable, in which case there is a direct relation between the referral and the determination of deployable or nondeployable; or (3) a member is found to be deployable, but has a minor medical issue for which the health provider provides a referral for treatment. According to a senior OSD official, the last scenario is a fairly uncommon reason for a referral. Examples might include a referral for a routine preventive test, such as a Pap test in a gynecological clinic. The Pap test is a desired preventive medical test, but depending on the date and result of the last Pap exam and the individual's personal history and risk factors, it is not always necessary to perform one prior to deployment.

More than 50,000 referrals were made on the predeployment health assessments from November 2001 through June 2005 for both the active and reserve components. As shown in table 3, of the 21,000 forms with referrals for reserve component members, the referral rate averaged more than 5 percent. As shown in table 4, of the 24,633 forms with referrals for their active duty counterparts, the referral rate was about 4 percent.

Within the reserve components, the Army Reserve had the highest referral rate at nearly 8 percent, while the Air National Guard and Air Force Reserve had the lowest rates, both at less than 1 percent.

Table 3: Total Predeployment Referral Rate by Reserve Component, November 2001 through June 2005

Reserve component	Total number of predeployment events with referrals	Total predeployment referral rate
Army National Guard	11,609	5.84
Army Reserve	8,750	7.56
Air National Guard	201	0.52
Air Force Reserve	145	0.93
Navy Reserve	211	2.08
Marine Corps Reserve	84	1.79
Total	21,000	5.48

Source: GAO analysis of AMSA data.

Table 4: Total Predeployment Referral Rate by Active Component, November 2001 through June 2005

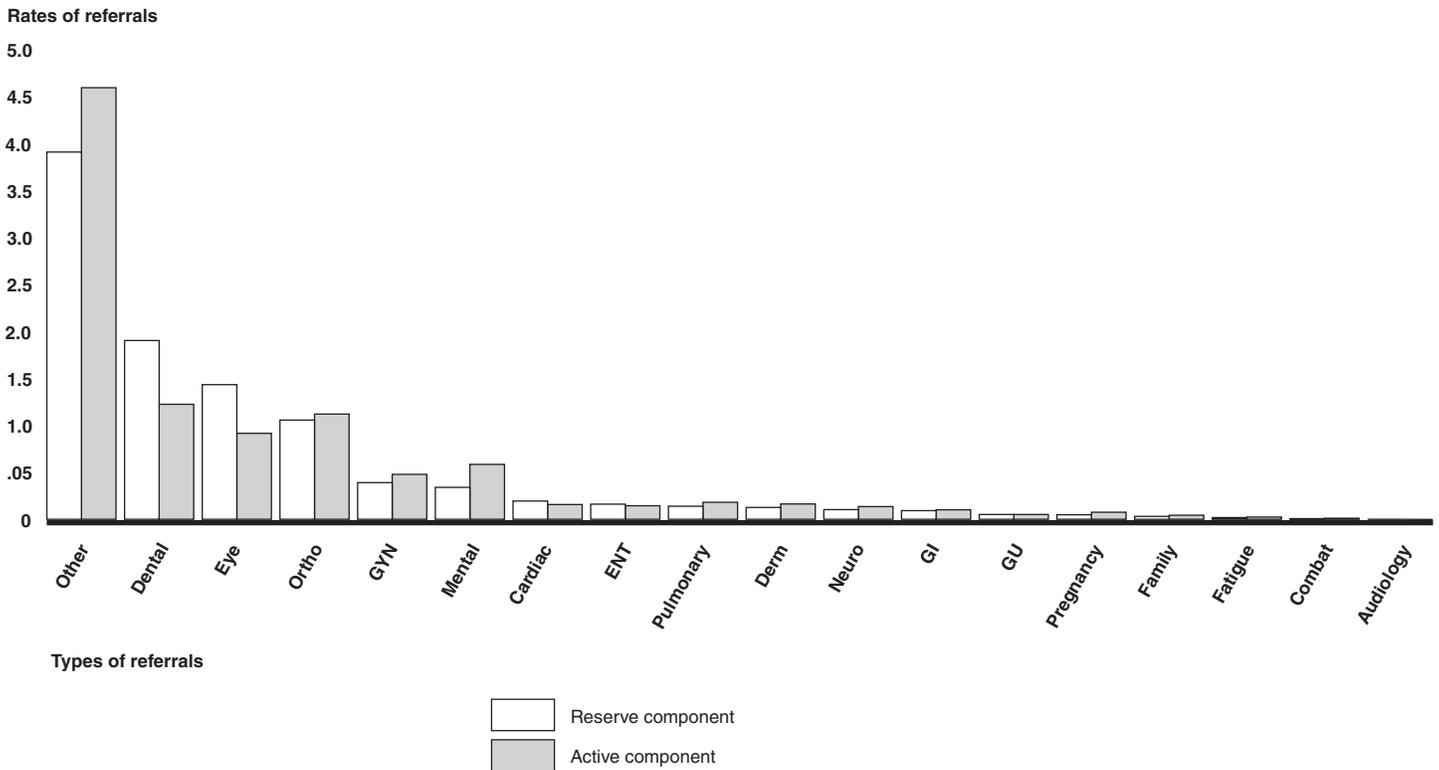
Active component	Total number of predeployment events with referrals	Total predeployment referral rate
Army	20,312	5.24
Air Force	3,047	1.83
Navy	572	2.61
Marine Corps	702	1.36
Total	24,633	3.93

Source: GAO analysis of AMSA data.

Note: Predeployment Health Assessment forms may contain no referrals, one referral, or multiple referrals per completed form.

There are 18 categories of referrals that can be checked on the predeployment form, of which 1 is “other” and does not provide any further detail. As seen in figure 1, the top 3 medical referrals for the reserve components were “other,” “dental,” and “eye,” whereas the top 3 referrals for active components were “other,” “dental,” and “orthopedics.” The rate of medical referrals for the reserve components was almost 40 percent and for the active components was almost 50 percent.

Figure 1: Rate of Medical Referrals by Type for Active and Reserve Components from November 2001 through June 2005



Source: GAO analysis of AMSA data.

Although the AMSA referral data do provide some insight into the medical care required during mobilization, the referral data are not detailed enough to determine the type of medical referral or determine the reason for nondeployment.

Army Medical Holdover Database Provides Data on Activated Members Who Were Not Deployed Due to Medical Problems

The Army’s medical holdover database, a module within the Medical Operational Data System (MODS), does provide DOD with a snapshot of data about the number of Army National Guard and Reserve members who were not deployed after being called to active duty because of medical problems and the medical reasons why they were not deployed after being activated. Although all of the services may keep reserve component members on active duty if they incur an injury in the line of duty following deployment, only the Army has held reserve component members in need of medical care at military treatment facilities prior to deployment. These

servicemembers are referred to as the medical holdover population. Because of the large numbers of activated Army National Guard and Army Reserve members placed in medical holdover by the Army in the early part of Operation Iraqi Freedom, the Army Office of the Surgeon General created a module in an existing database to track them. We examined the Army medical holdover data to obtain information about the possible reasons why servicemembers were found to be medically nondeployable. However, the data cannot provide complete visibility over members' health status because the population receiving medical care from the Army prior to deployment is diminishing due to changes in Army's medical holdover policy. Further, until January 2005, MODS was not used consistently by all case managers⁵⁰ responsible for servicemembers in medical holdover.

Between December 2002 and October 2003, 4,850 activated Army reserve component members were found medically nondeployable and kept on active duty until their medical problems had been resolved and they were returned to full duty or until they had been referred to a medical board and discharged from the Army. In October 2003, the Army changed its policy to allow the demobilization of personnel who were found to be nondeployable within the first 25 days of activation. In accordance with this policy, reserve component servicemembers identified in the first 25 days as having a medical condition that renders the individual nondeployable may be released from active duty immediately. As a result of this policy change, the Army was able to demobilize reserve component members who were found to be nondeployable within the first 25 days of their mobilization. The change also reduced the inflow of reserve component members on active duty with medical problems who were identified during the predeployment health assessment process. As of August 11, 2005,⁵¹ only 860 reserve component members⁵² were in a medical holdover status as a result of a medical condition found prior to deployment.

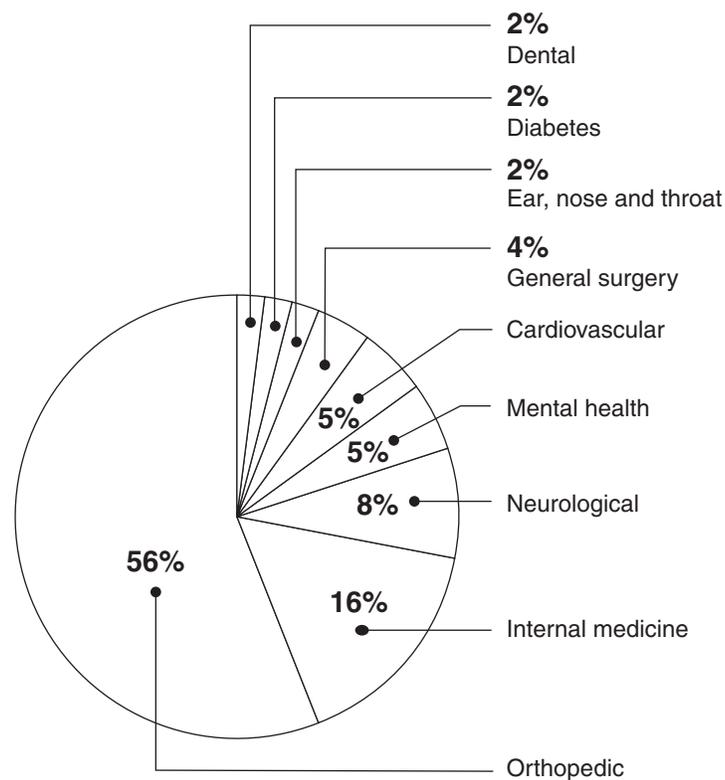
⁵⁰ Draft regulation for the Medical Holdover Case Management Program states that a case manager is normally a registered nurse who is assigned to manage the medical care provided each medical holdover soldier. The case manager implements the case management process with a focus on clinical evaluation and outcomes.

⁵¹ As of August 11, 2005, the total number in medical holdover was 4,866—860 of whom were placed there prior to deployment, and the remainder of whom were placed there due to a medical condition developed during deployment.

⁵² According to an Army official, 87 of these 860 have been in a medical holdover status for over a year due to complex medical conditions, such as cancer.

As shown in figure 2, the most common medical condition that has prevented a reserve component member from deployment⁵³ is orthopedic in nature—accounting for 56 percent of the 860 Army National Guard and Army Reserve members who were found medically nondeployable and placed in a medical holdover status—followed by internal medicine at 16 percent, and neurological problems at 8 percent.

Figure 2: Medical Conditions of Army National Guard and Army Reserve Members in a Medical Holdover Status as of August 11, 2005



Source: GAO analysis of Army data.

⁵³ Conditions that could disqualify a reserve component servicemember from deployment and would cause the member to be released if identified medically nondeployable during the first 25 days of activation include temporary and permanent conditions that do not meet medical deployment standards as outlined in AR 40-501, Chapter 3.

Lack of Visibility over Reserve Component Members' Health Status Could Affect Planning for Future Deployments

Despite the more specific information about medical status that can be obtained by reviewing these medical holdover data, the data are fairly new and limited to those held at medical treatment centers.

Although senior military officials at various levels of command told us that the health status of reserve component members did not affect deployment schedules, the extent to which unit commanders have had to find replacement members to fill in for members who were medically unqualified upon alert, the reasons why, and how, or if, this impacted planning of operations in Iraq and Afghanistan are unknown. However, DOD's lack of visibility over reserve component members' health status when they are called to active duty could affect planning for future deployments as the demand for troops for the Global War on Terrorism continues.

The Army has had to transfer reserve component personnel from nonmobilized units to mobilized units to meet mission requirements. For example, the Army Inspector General reported in February 2005 that with increasing frequency, Army units identified for alert and mobilization had previously provided members to other units. The report noted that frequently more than half of a deploying unit's personnel had been transferred into the unit to meet personnel requirements. This "ripple effect" is occurring across the Army reserve force, and each subsequent mobilization requires more and more personnel transfers to meet personnel requirements. The need for these personnel transfers is largely due to an outdated Cold War strategy that planned to use the reserve forces as a later deploying force and therefore did not give them full resources. As more units are used for this "cross-leveling", it becomes even more important that the Army have good visibility over the health status of the remaining reserve component members.

In addition, as shown in table 5, the health status has declined for active and reserve components after returning from deployment as shown by data from the pre- and postdeployment health assessments. The Army National Guard and Army Reserve had the highest percentage of servicemembers indicating their health as fair to poor on the postdeployment health assessment.

Table 5: Rate of Servicemembers' Health Status as Recorded on Pre- and Postdeployment Forms for Active and Reserve Components from November 2001 through June 2005

Military component	Predeployment: good to excellent	Postdeployment: good to excellent	Predeployment: fair to poor	Postdeployment: fair to poor
Reserve component:				
Army Reserve	95.77	87.05	2.70	12.30
Army National Guard	96.57	89.07	2.27	10.31
Marine Corps Reserve	98.36	89.90	0.99	8.95
Air National Guard	99.13	97.43	0.42	1.73
Air Force Reserve	99.00	96.49	0.40	2.16
Navy Reserve	98.60	93.67	0.64	5.08
Active component:				
Army	95.00	90.53	3.44	8.32
Marine Corps	97.51	93.49	1.74	5.59
Air Force	98.82	97.73	0.86	1.73
Navy	96.88	94.27	2.55	5.08

Source: GAO analysis of AMSA data.

As the pace of operations for the reserve forces continues to be high and the health status of returning members is diminished, it becomes even more important that DOD has good visibility over the availability of remaining units. Improved visibility and tracking of the health status and medical deployability of these members is a key component in the calculation of the members available for planning future deployments.

Extent to which Members with Preexisting Medical Conditions Required Treatment during Deployment Cannot Be Determined

DOD cannot determine the extent to which reserve component members received care for preexisting medical conditions while deployed in theater⁵⁴ because DOD has not determined what preexisting medical conditions may be allowed into specific theaters of operations. The purpose of examining members and properly screening them at the mobilization stations is to help ensure that members are medically and physically fit to deploy and do not have any condition that would adversely affect the mission. As noted in DOD guidance,⁵⁵ fitness specifically includes the ability to accomplish the task and duties unique to a particular operation, and the ability to tolerate the environmental and operational conditions of the deployed location. Specific medical deployment criteria for proper screening are essential for determining preexisting medical conditions that can not be adequately addressed in theater and could stress in theater medical capabilities. While evidence suggests that members did deploy with preexisting conditions, the total impact of this is unknown.

While Specific Deployment Criteria for Operations Enduring Freedom and Iraqi Freedom Continue to Evolve, Tracking of Known Preexisting Conditions Has Not Begun

Developing and updating medical criteria for a specific theater of operations are the responsibilities of the combatant commands—for Operation Enduring Freedom and Operation Iraqi Freedom this is U.S. Central Command (CENTCOM). The CENTCOM medical deployment criteria have been evolving over the course of these operations. CENTCOM has updated this guidance six times throughout these operations to include more specific guidance to the theater of operations; the last update was issued in January 2005. During the initial mobilizations for these operations, the services were dependent on CENTCOM general deployment criteria issued in May 2001, which did not identify medical conditions that would render a member medically unfit for these operations. In the absence of specific guidance early on during the operations, the services relied upon their own medical deployment criteria. For the Army, specific criteria did not exist until February 2005.⁵⁶

⁵⁴ For the purposes of this report, preexisting medical conditions refer to those medical conditions that were not identified during mobilization that may limit a member's ability to perform his or her mission and cannot be adequately addressed in theater.

⁵⁵ Minimal Standards of Fitness for Deployment to the CENTCOM Area of Responsibility, January 2005.

⁵⁶ Army Regulation 40-501 was updated to include standards for deployment in February 2005.

The original CENTCOM deployment criteria made a general statement that all personnel must be assessed and determined to be medically and psychologically fit for worldwide deployment to a combat theater and that the in-theater health infrastructure provides only limited medical care. Not until May 2004 did CENTCOM update its deployment criteria to include more specific guidance. This updated guidance stated that servicemembers who have existing medical conditions may deploy if all of the following conditions were met: (1) an unexpected worsening of the condition is not likely to have a medically grave outcome; (2) the condition is stable; and (3) any required ongoing health care or medications must be immediately available in theater in the military health system, and have no special handling, storage, or other requirements, such as electrical power. The criteria provided a list of conditions that may preclude medical clearance for DOD civilians and contractors (including current heart failure, history of heat stroke, and uncontrolled hypertension); however, according to CENTCOM officials, this list of conditions did not apply to servicemembers because they were already covered by service-specific guidelines. The most recent CENTCOM deployment criteria applicable to all servicemembers and DOD civilians and contractors were issued in January 2005, and update theater-specific immunization requirements and provide more detailed guidance on contact lens wear, among other things. As these policies are developed, the combatant command is to provide them to the services, which are then responsible for determining how they implement the screening requirements in terms of screening their deploying forces, including activated reservists.

Because DOD has not determined what preexisting conditions may be allowed into a specific theater of operations, it has not known what preexisting conditions to track. As noted, the medical deployment criteria for the current theater of operations have been evolving, but specific medical deployment criteria have not been developed for other potential theaters of operation. However, some preexisting medical conditions may be common to all theaters of operation. DOD has not determined this. Further, although DOD has a number of systems for tracking medical conditions in theater, the current databases have not been modified to capture data on known preexisting conditions for this specific operation. For example, the Joint Medical Workstation (JMeWS) provides medical treatment status and medical surveillance information, as well as tracks and reports patient location within a theater of operations and during evacuation from frontline medical units to stateside medical treatment facilities. The U.S. Transportation Command (TRANSCOM) utilizes the TRANSCOM Regulating Command and Control Evacuation System (TRAC2ES) to document patient movements, such as medical evacuations.

Evidence Suggests that Reserve Component Members Have Been Deployed into Theater with Preexisting Medical Conditions

The Joint Patient Tracking Application (JPTA) was initially designed for use within Landstuhl Regional Medical Center in Germany as a way to manage Operations Enduring Freedom and Iraqi Freedom patients. In 2004, the services were directed by the Assistant Secretary of Defense for Health Affairs to implement JPTA at military treatment facilities in theater and the continental United States to improve patient tracking and management. The Disease Nonbattle Injury (DNBI) rates for the services in Operations Enduring Freedom and Iraqi Freedom are tracked in the DNBI database by the Air Force Institute for Operational Health. We did not evaluate these systems since they do not distinguish care provided for preexisting medical conditions.

Although DOD does not systematically develop or report information about the extent of care that was provided in theater to reserve component members for preexisting medical conditions,⁵⁷ senior military medical officials who served in theater have provided examples of reserve component members who were deployed with preexisting medical conditions that could not be adequately addressed in theater. Some officials told us that such treatments strained in theater medical capabilities and infrastructure.

According to a senior military official in the surgeon's office of the commander in chief of the U.S. Central Command (CENTCOM), there were many instances of individuals, from all services, who deployed into the Iraq and Afghanistan theater of operations with conditions for which they should have been considered nondeployable. Also, medical officials from both the Army and Navy cited examples of conditions seen in theater that should have rendered members nondeployable. Among the examples cited were members with a history of heart attack, severe asthmatics (the desert conditions were not suitable for these members), severe hypertension, a woman 4 months into chemotherapy for breast cancer, and a man who had received a kidney transplant 2 weeks prior to deploying. Other examples included cases involving members deployed with sleep apnea requiring machines that are run by electricity, even though electricity was either unavailable or unpredictable. Another soldier, we were told, who arrived in theater was diabetic and required an insulin pump for treatment. We were also told of a number of psychiatric

⁵⁷ Although some systems exist to track various aspects of medical care provided in theater, we did not identify any system that tracks care provided to reserve component members for preexisting conditions.

patients who were suffering from conditions such as bipolar disorder who should not have been in the desert because the medications that they were taking caused them to sweat profusely. One Air Force Reserve medical official who served in theater preparing members to be medically evacuated estimated that of the approximate 2,000 reservists she helped to evacuate, 10 percent being evacuated were due to preexisting conditions such as diabetes and heart problems, with the most common condition being diabetes. The commander of an Army Guard unit deployed to Iraq told us about a member who had deployed with a preexisting knee problem for which he had to be returned to the United States to correct. The issue was eventually resolved and the member was allowed to redeploy with his unit.

According to a September 2004 Air National Guard Surgeon General memorandum,⁵⁸ unacceptable dental health should preclude a member from deploying under any circumstances because dental resources do not exist in theater. However, the Air National Guard's Surgeon General has noted that dental emergencies are historically and currently the most common preventable reason for loss of manpower in the wartime theater.⁵⁹ In addition, the Air Force's Air Surgeon Chief of Medical Services Directorate commented on January 17, 2003, in response to a case involving an Air National Guard member who had been sent into theater with an obvious major preexisting dental condition, that it is unreasonable to expect deployed doctors and dentists to perform remedial procedures and provide care that should have been accomplished at home because it takes too much time away from treating injured and ill in theater, and it results in lost man hours for the gaining unit that it needs to accomplish its war-fighting requirements. In our small group discussions with Army National Guard, one servicemember said that he was told that he would receive dental care in theater, although this care was never provided. At one Air National Guard unit command we visited, officials informed us of a member who was mobilized and subsequently deployed with preexisting dental problems in late 2003, because (1) the dental condition was not disclosed by the member and (2) the unit command did not have a current dental exam in his medical records to prove otherwise. The member would not have been deployed had his true dental condition been initially

⁵⁸ This is based on Dental Class III or IV classification standards. This is a servicewide standard.

⁵⁹ The Air National Guard issued the memorandum, via SG Log Letter 04-026, on September 27, 2004.

identified, but he received substantial dental work while deployed.⁶⁰ According to a unit command official, the member was subsequently returned to his unit command because his dental costs and related work downtime were excessive.

Other Reasons Members May Have Arrived in Theater with Preexisting Conditions

In addition to a lack of specific guidance from CENTCOM to the services early in the operations, military medical officials told us other reasons why members may have arrived in theater with preexisting medical conditions. First, military officials stated that in some cases members did not disclose their preexisting medical conditions because they wanted to serve their country. A Navy official, for example, stated that a Navy officer with hypertension did not disclose his medical condition in order to deploy to Iraq to support Operation Iraqi Freedom. Because the officer's medical condition worsened in Iraq, the Navy had to return him to his home unit and find a replacement to fill his position. We were also told of members who arrived in theater with preexisting conditions with the expectation that they would be taken care of while they were there. For example, a senior medical official stated that one servicemember arrived in theater with one kidney and in need of dialysis, which was not available in theater. Early in operations several servicemembers with hernias were deployed with the expectation that the surgery would be conducted in theater.

It is important to have up-to-date medical criteria specific to a theater of operations to alert members to changing condition in theater or new information on vaccinations, for example. Developing and updating medical criteria for a specific theater of operations is the responsibility of the commander in chief of the combatant command—in this case, CENTCOM. As these policies are completed and updated, the combatant command is to provide them to the services, who are then responsible for determining how they implement the requirements in terms of screening their deploying forces including activated reservists.

Conclusions

The findings we present in this report are not new. In the aftermath of the first Persian Gulf War, a number of DOD and GAO studies were issued that identified problems with guard and reserve personnel being medically and physically fit for duty. DOD agreed with many of the studies' findings and

⁶⁰ From November 2003 through January 2004, the reservist incurred a total of 20 dental office and clinic visits and received two fillings, two extractions, four root canals, and three crowns, at a cost of about \$5,200 to the military.

recommendations but never developed a plan with goals, time frames, and measurable results to improve visibility over reserve component members' health status. At times, Congress has stepped in and directed DOD to make a number of improvements, especially for quality assurance and tracking of health assessment data collected before and after a member's deployment. Congress recently directed OSD to develop and implement a comprehensive plan to improve management of the health status of the reserve component. The importance of such a plan has become even more important in the current environment, where the pool of guard and reserve members with the right skills from which to fill requirements for DOD's overseas and domestic commitments is dwindling.

Further, many of DOD's personnel policies, including its medical policies, are outdated, as they are based on Cold War strategy that allowed the reserve force more time to mobilize before deployment. Now the reserve force deploys with the active force and is expected to be medically and physically fit when called to duty. The lack of oversight of reserve members' health status, however, does not appear to be unique to the reserve component. Oversight, as seen in the area of enforcing DOD's reporting requirement on the status of physical fitness for both the active and reserve components, has not taken place. No repercussions exist if a service does not provide this report on time, nor are there any deadlines for the annual report to be submitted to OSD.

OUSD/P&R has the authority to set medical and physical fitness policy and processes to oversee this area; however, OUSD/P&R has not taken action to exercise its authority to address these long-standing problems.

Recommendations for Executive Action

As DOD proceeds to develop a comprehensive plan for improving management over the health status of the reserve components in response to the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, we recommend six actions.

To have visibility over reserve components' compliance with routine medical and physical fitness examinations, we recommend that the Secretary of Defense

- direct the Under Secretary for Personnel and Readiness, in concert with the Assistant Secretary for Health Affairs and the Principal Deputy to the Under Secretary, to establish a management control framework and execute a plan for issuing guidance, establishing quality assurance for data

reliability, and tracking compliance with routine medical and physical fitness examinations; and

- direct the Under Secretary for Personnel and Readiness, in concert with the Principle Deputy who oversees the Office of Morale, Welfare, and Recreation, to take steps to enforce the service reporting requirement on the status of members' physical fitness in conjunction with the actions taken in the first recommendation.

To improve DOD's visibility over reserve components' health status after they are called to duty, we recommend that the Secretary of Defense

- direct the Under Secretary of Defense for Personnel and Readiness, in concert with the Assistant Secretary of Health Affairs, to also oversee the development of the reserve components' tracking systems to identify and track members' temporary and permanent medical conditions that limit deployability; and
- direct the Under Secretary of Defense for Personnel and Readiness, in concert with the Assistant Secretary of Health Affairs, to modify the medical predeployment forms to better capture reasons for nondeployment and medical referrals.

To help prevent the deployment of reserve component members with preexisting medical conditions that could adversely affect the mission and strain resources in theater, and to provide visibility over those members deployed with preexisting conditions for which treatment can be provided in theater, we recommend that the Secretary of Defense:

- direct the Chairman of the Joint Chief of Staff to determine what preexisting medical conditions should not be allowed into specific theaters of operations, especially during the initial stages of the operation, and to take steps to ensure that each service component consistently utilizes these as criteria for determining the medical deployability of its reserve component members during mobilization; and
- direct the Chairman of the Joint Chief of Staff, in concert with the service secretaries, to explore using existing tracking systems to track those who have treatable preexisting medical conditions in theater.

Agency Comments and Our Evaluation

In written comments on a draft of this report, DOD did not concur with our first and fourth recommendations, partially concurred with our fifth recommendation, and concurred with our second, third, and sixth recommendations. DOD did not concur with our recommendation that it establish a management control framework and execute a plan for issuing guidance, establishing quality assurance for data reliability, and tracking

compliance with routine medical examinations. DOD did not state that it disagreed with our findings; however, DOD stated that it had initiatives underway that addressed our recommendation. DOD further noted that because policies, programs, and instructions are already in place or in process, it did not see the need for any additional action. We disagree with DOD's conclusion because, based on our review, we do not believe that DOD's initiatives are far enough along to dismiss further action, and we continue to believe that our recommendation has merit. We agree that the initiatives DOD cited in its written comments are positive steps toward correcting the identified problems, but management and planning remain a concern. We have not seen enough evidence to agree that DOD has put in place a management control framework that will enforce holding all responsible levels accountable, ensuring that all routine medical requirements are being met, and that complete and reliable data are being entered into the appropriate tracking systems. As noted in our report, the problems with determining the health status of the reserve force were revealed during Operations Desert Shield and Desert Storm, and in the decade that has passed since then DOD has made little progress to correct the identified problems. As a result, in 2004, Congress directed DOD to establish a Joint Medical Readiness Oversight Committee to oversee the development and implementation of a comprehensive medical readiness plan. As also noted in our report, the committee held its first meeting in February 2005, and a plan to improve medical readiness was being developed during this review. We do not believe that a committee can be held accountable for ensuring that such actions take place. Ultimately, the Under Secretary of Defense for Personnel and Readiness, in concert with the Assistant Secretary for Health Affairs, are accountable for enforcing the requirements for routine medical examinations.

Moreover, DOD stated that it has established a new quality assurance program that monitors electronic data with validation through medical record reviews of a wide range of force health protection measures. We did not find this to be true during our review. With the exception of the Navy Reserve, the reserve components do not monitor electronic data of routine medical examinations with validation through medical record reviews. Further, we found the data in the reserve components' tracking systems to be unreliable for purposes of determining compliance with routine medical examinations. As noted in our report, compliance with these routine medical examinations is the first step toward determining who is medically fit or ready for duty. DOD stated that its compliance-monitoring Individual Medical Readiness program regularly reports the overall medical readiness status for each servicemember. However, we found that the Individual Medical Readiness program's outcomes are

derived from data in the reserve components' tracking systems, which we have found to be unreliable, with the exception of the Navy Reserve, for the purposes of determining compliance with routine medical examinations. DOD stated that its Individual Medical Readiness program's data are being incorporated into overall unit readiness status reports, providing visibility of reserve component medical readiness throughout the line command structure. We believe that until top management at DOD ensures that complete and reliable data on routine medical examinations are being entered into its tracking systems, DOD and Congress will continue to have a false picture of medical readiness for the reserve components. We believe that our first recommendation still has merit.

DOD concurred with our recommendation that DOD take steps to enforce the services' reporting requirement on the status of their members' physical fitness. DOD stated that DOD instruction 1308.3, dated November 5, 2002, among other things, requires the active and reserve components to provide an annual report to the Principal Deputy of the OUSD/P&R not later than March 31. DOD stated that the Air Force, the Navy, and the Marine Corps have submitted their reports. DOD noted that exceptions to the reporting requirement for the Air Force and the Army had been approved. However, during our review we were told that none of the reports had been submitted to the Principal Deputy as required. We raised concerns in this report about the data reliability of the tracking systems for physical fitness. We found that the reserve components are unable to report complete and reliable data on compliance with routine physical fitness examinations on a componentwide basis due to incomplete and unreliable data. Just as we found with routine medical examinations, we also found that DOD lacked quality assurance of the data on compliance with physical fitness examinations in its tracking systems. We do not know what data reliability issues DOD will cite in its annual reports on physical fitness. We note that the responsible office for physical fitness oversight, the Office of Morale, Welfare, and Recreation, does not participate in the Joint Medical Readiness Oversight Committee that is directed to oversee improvements in medical readiness, nor are we aware of any DOD plans to include improvements in the oversight of physical fitness in its comprehensive medical readiness plan. Therefore, we have expanded our first recommendation to include routine physical fitness examinations in the actions to be addressed.

DOD concurred with our recommendation that DOD oversee the development of the reserve components' tracking systems to identify and track members' temporary and permanent medical conditions that limit deployability. DOD stated that it is already actively adapting existing

systems, and in some cases creating new ones, that can be used to track the medical status of active and reserve members, to include those known conditions that could limit an individual's deployability. DOD noted that it continues to pursue better integration between medical and personnel data systems to improve visibility regarding deployment-limiting medical conditions, whether temporary or permanent, but the overall effectiveness will continue to be limited by lack of access to civilian medical records of reserve component members.

DOD did not concur with our recommendation that DOD modify the medical predeployment form to better capture reasons for nondeployment and medical referrals. DOD stated that the best sources of accurate information about what medical reasons kept service members from deploying are the permanent medical records. This may be the case, but we continue to believe our recommendation has merit because DOD has no way to systematically analyze the information to determine why servicemembers are medically nondeployable. Because the predeployment form is used to document whether a servicemember is deployable, this existing form could be modified to better capture the reasons for determining why a servicemember is determined nondeployable. Although the form has an entry for a narrative explanation to state why a member is medically nondeployable, AMSA officials informed us that these explanations are often not decipherable, incomplete, and can not be easily categorized. DOD also stated that the existing predeployment form already includes a list of the most common referral categories to simplify the documentation process for the health care provider. In addition, DOD also noted that data from the forms are captured electronically and are readily available to monitor for trends in referral patterns, among other things. We do not believe that any meaningful analysis for referrals can be determined from these forms because we found that the top medical referral category for the reserve and active components was "other". This heavy use of the category "other" does not provide any insight as to what medical care a member is receiving after being called to duty. Given that the rate of medical referrals for the reserve components was almost 40 percent and for the active components was almost 50 percent, we continue to believe that DOD should modify the predeployment form to better capture reasons for nondeployment and medical referrals.

DOD partially concurred with our recommendation that DOD determine what preexisting medical conditions should be allowed into a specific theater of operations, especially during the initial stages of operations, and take steps to consistently utilize these criteria for determining medical deployability. DOD stated that certain conditions clearly should render a

member nondeployable, and the services have made strides in defining these conditions and incorporating them into their applicable policies and procedures. But DOD also noted that due to the ever-changing nature of a theater of operations and the inexact nature of medicine, a list of nondeployable preexisting conditions will never be fully comprehensive or fully enforceable. We agree that a list of nondeployable preexisting medical conditions can never be fully comprehensive; however, we still believe DOD could establish a list of what preexisting medical conditions should be allowed into specific theaters of operations, especially during the initial stages of operations, so that in future deployments DOD would not experience situations such as those that occurred with members being deployed into Iraq who clearly had preexisting conditions that should have prevented their deployment.

DOD concurred with our recommendation that DOD explore using existing tracking systems to track those who have treatable preexisting medical conditions in theater. DOD noted that refinements to medical tracking system are ongoing. We wish to note that before DOD's tracking systems can be used to track those who have treatable preexisting medical conditions in theater, DOD must determine what preexisting medical conditions should be allowed into a specific theater of operations as called for in our fifth recommendation.

DOD noted in its overall comments that the reserve and active forces use many of the same reporting tools within each service and face the same basic challenges in ensuring data quality. DOD stated that where tracking systems are shared, the reserve components depend on the active components to develop and fund those systems, and that priority for deployment of large systems has historically been given to the active component. DOD also pointed out that our report indicates that the health status of members deteriorates with multiple deployments and that the data we used are self-reported and should be taken with great caution and in the proper context. We used the self-reported data from postdeployment health assessments to help demonstrate the importance of good visibility over the reserve forces. We noted that the demand for reserve personnel, especially within the Army components, continues, and the pool of reserve members used to fill requirements is dwindling. Further, the health status of returning reserve and guard members is not as good as it was before deployment as our analysis of the pre- and postdeployment health assessments showed. Therefore, it becomes even more important that DOD have good visibility over the health status of remaining reserve force to help determine what is left for future deployments.

DOD's comments are reprinted in their entirety in appendix II.

We are sending copies of this report to the Secretary of Defense; the Secretaries of the Army, the Navy, and the Air Force; the Commandant of the Marine Corps; the Chairman of the Joint Chiefs of Staff; and the Director, Office of Management and Budget. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff has any questions concerning this report, please contact me at (202) 512-5559 or stewartd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.



Derek B. Stewart
Director, Defense Capabilities and Management

Appendix I: Scope and Methodology

To assess the Department of Defense's (DOD) ability to determine the reserve components' compliance with routine medical and physical fitness examinations, we reviewed federal statutes and Office of the Secretary of Defense (OSD) applicable directives and instructions to identify and understand the roles and responsibilities of the offices within DOD for management of the health status of the reserve components. We discussed these statutes and guidance with senior officials in the Office of the Under Secretary of Defense for Personnel and Readiness. We reviewed and discussed service policies and regulations for medical and physical fitness with military officials within the service surgeons' general offices and other service headquarters' officials responsible for physical fitness in the service personnel and operations functions. We also reviewed and discussed reserve component policies and guidance for medical and physical fitness examinations with officials within the reserve component surgeons' general offices and other reserve component officials responsible for physical fitness in the respective reserve component personnel and operations functions. We interviewed cognizant officials involved with policy development, administration, tracking, and reporting on compliance with medical and physical fitness examinations from the following offices or commands:¹

Office of the Secretary of Defense

- Assistant Secretary of Defense for Health Affairs, Deployment Health Support Directorate;
- Assistant Secretary of Defense for Reserve Affairs; and
- Principal Deputy Under Secretary of Defense for Personnel and Readiness, the Office of Morale, Welfare, and Recreation.

Army

- Assistant Secretary of the Army, Manpower and Reserve Affairs;
- U.S. Army Office of the Surgeon General and Commanding General, Army Medical Command;
- U.S. Army Reserve Command, Fort McPherson, Georgia;
- National Guard Bureau;
- Army National Guard;
- First U.S. Army, Fort Gillem, Georgia;
- U.S. Army Forces Command, Fort McPherson, Georgia;

¹ Unless otherwise noted, the officials listed in this appendix have their offices in the Pentagon or at locations in the Washington, D.C., metropolitan area.

- Army Fitness School, Ft. Benning, Georgia;
- Fifth U.S. Army, Fort Sam Houston, Texas;
- U.S. Army Medical Command, Fort Sam Houston, Texas;
- U.S. Army Dental Command, Fort Sam Houston, Texas;
- Army Audit Agency; and
- MEDPROS Program Office.

Navy

- Assistant Secretary of the Navy, Manpower and Reserve Affairs;
- Office of the Chief of Navy Operations;
- Office of the Chief of Navy Reserve;
- Bureau of Medicine and Surgery;
- Commander Navy Reserve Forces Command, New Orleans, Louisiana; and
- Navy Personnel Command, Millington, Tennessee.

Marine Corps

- U.S. Marine Corps Health Services, Headquarters;
- U.S. Marine Corps Manpower and Reserve Affairs, Headquarters, Quantico, Virginia; and
- Marine Forces Reserve, Headquarters, New Orleans, Louisiana.

Air Force

- Department of the Air Force, Headquarters;
- Assistant Secretary of the Air Force for Manpower and Reserve Affairs;
- Office of Air Force Reserve, Headquarters;
- Air Force Reserve Command, Robins Air Force Base, Georgia;
- National Guard Bureau;
- Air National Guard, Headquarters;
- Air National Guard Readiness Center; and
- Air Reserve Personnel Center, Denver, Colorado.

We also conducted medical and physical fitness file reviews with an Army National Guard unit from the Mid-Atlantic region and an Army Reserve unit from the Mid-west region. We chose units that had deployed for Operations Enduring Freedom or Iraqi Freedom. During these visits we

collected and analyzed information from available² medical and personnel files to assess the reserve component members' compliance with routine medical and physical fitness examinations. We also documented difficulties the units had in ensuring that all members complied with medical and physical fitness examinations. Finally, during the site visits, we conducted group discussions with unit members regarding their experience with routine examination requirements.

To gain a better understanding of how the components collect data about their members' compliance with routine medical and dental examinations and physical fitness assessments, we assessed the reliability of data produced by several services' databases. Assessing the reliability of the services' data included consideration of issues such as the completeness and currency of the data from the respective database system's program managers, administrators, and contractors; assurances that all members are included and the information is up to date; and examination of who is using the data and for what purposes, and the users' assessment of reliability. We also examined whether the data tracked through the services' systems was subjected to quality control measures, such as conducting periodic testing of the data against medical records, to ensure the accuracy and reliability of the data. In addition, we reviewed existing documentation related to the data sources and interviewed knowledgeable agency officials about the data. Overall, the reserve components' data we assessed regarding compliance with routine medical and dental examinations and fitness assessments did not accurately reflect the total population of service members, had limited data quality assurance, and were unreliable for the purposes of this report; however, we determined that the Navy Reserve's medical data were sufficiently reliable for our purposes. Data from the Navy Reserve's Medical Readiness Reporting System were found reliable because Readiness Commands conduct inspections that include examining the data for accuracy, Medical Department Representatives verify 10 percent of the updated medical records after each weekend drill, and the data are reported to the Commander, Navy Reserve Forces Command biweekly. Further, we did not assess the reliability of the Marine Corps Reserve's medical data because the Marine Corps was in the process of changing from the Shipboard Automated Medical System, a stand-alone non-Web-based

² We reviewed all available medical and physical fitness files during our visits to the units. Some files were not available because (1) members who had deployed with the unit had transferred to another unit or were no longer serving, (2) some files had been misplaced, and (3) some members were having a routine exam and their file was with them.

system, to the Navy Reserve's system. All reserve components' physical fitness data that we reviewed had missing or incomplete information, had limited data quality controls, or did not accurately reflect the total population of service members due to limited access to the database. Therefore, we determined the data to be unreliable for the purposes of assisting us in determining reserve component members' compliance with physical fitness examinations.

To assess DOD's visibility over reserve components' health status after they are called to duty and the care, if any, provided to those deployed with preexisting conditions, we collected and analyzed information from a variety of sources throughout DOD. We interviewed officials at the six reserve component headquarters and officials responsible for mobilizing the reserve components. We also observed the mobilization of Army National Guard and Army Reserve members at Fort Bliss, Texas, to obtain information on their health status during this process. We obtained and analyzed data provided on medical deployability from the DOD-wide centralized database on pre- and postdeployment health assessments, maintained at the Army Medical Surveillance Activity, and discussed available data with these officials. We also obtained and analyzed data on Army servicemembers who were held at mobilization stations for medical reasons from the Army's medical holdover database (Medical Operational Data System). Based on our review of databases we used, we determined that the DOD-provided data were reliable for the purposes of this report. To address the extent of medical care provided in theater for preexisting medical conditions, we reviewed the Joint Chiefs of Staff procedures for Deployment Health Surveillance and Readiness and information provided by the U.S. Central Command Surgeon's General office regarding medical deployment criteria for Operations Enduring Freedom and Iraqi Freedom. We also collected and reviewed the services' medical instructions, memoranda, policies, and medical data. We reviewed several databases for relevance regarding collecting in theater medical data on preexisting conditions. Specifically, we obtained information and discussed the following databases: Joint Medical Workstation, the U.S. Transportation Command Regulating Command and Control Evacuation System, the Joint Patient Tracking Application, and the Air Force Institute for Operational Health Disease Nonbattle Injury database.

However, we did not identify any databases used to collect information on members that may have had preexisting conditions when deployed. We also interviewed military medical officials who had served in theater to obtain information on preexisting conditions of reserve component members while deployed. In addition to those offices and commands

previously listed, we discussed reserve component medical deployment policies, medical and physical fitness policies and instructions, and data regarding medical and physical fitness issues with responsible officials from:

Department of Defense

- Joint Chiefs of Staff, J-4 (Logistics), Medical Readiness Division;
- U.S. Transportation Command, Scott AFB, Illinois;
- U.S. Central Command, MacDill, AFB, Florida; and
- Army Medical Surveillance Activity.

Army

- U.S. Army Office of the Surgeon General and Commanding General, Army Medical Command;
- U.S. Army Center for Health Promotion and Preventive Medicine-Europe;
- Army Reserve Unit, Mid-west region;
- Walter Reed Army Medical Center; and
- Soldier Readiness Processing, Medical Operations, Fort Bliss, Texas.

Navy

- Navy Reserve Readiness Command Southwest, California;
- Navy and Marine Corps Reserve Center, California; and
- Navy Branch Medical Clinic, Virginia.

Marine Corps

- Marine Corps Mobilization Command, Kansas City, Missouri; and
- 4th Combat Engineer Battalion, Maryland.

Air Force

- Air Force Institute for Operational Health;
- 142nd Fighter Wing Air National Guard, Portland International Airport, Oregon;
- 163rd Air Refueling Wing Air National Guard, March Air Reserve Base, California;
- 349th Air Mobility Wing U.S. Air Force Reserve, Travis Air Force Base, California; and
- 452nd Air Mobility Wing U.S. Air Force Reserve, March Air Reserve Base, California.

We reviewed Air Force audit and inspection reports. We interviewed officials with the Air Force Audit Agency regarding its report on the Air Force's Individual Deployment Process³ to obtain a better understanding of the report's scope and methodology to assess reserve components' compliance with medical and dental requirements. We assessed the reliability of the Air Force Audit Agency's analyses by (1) reviewing relevant documentation of their analyses, and (2) interviewing knowledgeable officials about the audit work and analyses. We determined the analyses were sufficiently reliable to use as one of the sources of evidence describing the extent of discrepancies in Air Force medical and dental records. We also reviewed the Air Force Inspection Agency's Health Services reports and its annual analysis reports for calendar year 2004.⁴

We also found DOD's Army Medical Surveillance Activity (AMSA) database and the Army's Medical Operational Data System (MODS) to be sufficiently reliable for the purposes of our report due to their data quality controls and currency. In addition, through our review of existing information about the systems and the resulting data and through discussions with cognizant agency officials, we found the data sufficiently reliable for the purposes of this report.

We interviewed the Chief of AMSA. We discussed the information in the DOD-wide centralized health assessment database and obtained selected data from all the reserve and active component members' pre- and postdeployment health assessments that were completed from November 2001 through June 2005. Assessments became mandatory for all mobilized reserve component members on October 25, 2001. The data we obtained contained predeployment health assessment records for 383,449 reserve component members and 627,200 for active members. We analyzed the data that we obtained to determine the categories of medical referrals and deployability status.⁵ We also analyzed data on the self-reported general

³ Air Force Audit Agency, Individual Deployment Process, Audit Report F2005-0005-FD3000 (June 13, 2005).

⁴ Air Force Inspection Agency, Health Services Inspection, ARC Inspection Results, ARC Element Results, Annual Analysis Calendar Year 2004 (as of June 20, 2005).

⁵The data represent deployment events. A deployment event is defined as a servicemember completing a pre- or postdeployment health assessment form with no recent history (within 6 months) of completing a separate pre- or postdeployment health assessment form.

health of the reserve component members and compared the data from predeployment assessments with the data from postdeployment assessments. All of our analyses compared data across the reserve components to look for differences or trends.

Further, we reviewed the Army's medical holdover data in MODS and found them reliable for our reporting purposes. The Office of the Army Surgeon General uses MODS to monitor and track the medical holdover population. The intended use of this system is for the MEDCOM and other command elements to track active and reserve component servicemembers in outpatient medical treatment, while still on active duty status.

We conducted our review from October 2004 through September 2005 in accordance with generally accepted government auditing standards.

Appendix II: Comments From the Department of Defense



RESERVE AFFAIRS

ASSISTANT SECRETARY OF DEFENSE
1500 DEFENSE PENTAGON
WASHINGTON, DC 20301-1500

OCT 13 2005

Mr. Derek B. Stewart
Director, Defense Capabilities and Management
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Stewart:

This is the Department of Defense (DoD) response to the GAO draft report, "MILITARY PERSONNEL: Top Management Attention is Needed to Address Longstanding Problems with Determining Medical and Physical Fitness of the Reserve Force", dated September 29, 2005, (GAO Code 350604/GAO-06-105). Written comments to each of the recommendations are attached.

Should you have any questions reference this response, please direct them to my point of contact, COL Priscilla Berry, 703-693-8104, Priscilla.berry@osd.mil

We appreciate the opportunity to comment on the draft report.

Sincerely,

A handwritten signature in black ink that reads "T. F. Hall".

T. F. Hall

Attachments:
As stated



**GAO DRAFT REPORT – DATED SEPTEMBER 29, 2005
GAO CODE 350604/GAO-06-105**

**“MILITARY PERSONNEL: Top Management Attention Is Needed
to Address Longstanding Problems with Determining Medical and Physical
Fitness of the Reserve Force”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE RECOMMENDATIONS**

RECOMMENDATION 1: The GAO recommended that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in concert with the Assistant Secretary for Health Affairs, to establish a management control framework and execute a plan for issuing guidance, establishing quality assurance for data reliability, and tracking compliance with routine medical examinations. (Page 66/GAO Draft Report)

DOD RESPONSE: Non-concur

The Department of Defense (DoD) remains committed to maximizing its visibility of medical readiness throughout the Reserve components (RC). New policies establishing a standardized management framework for a Force Health Protection Quality Assurance (FHP QA) program, and a compliance-monitoring program to measure Individual Medical Readiness (IMR), as called for in this recommendation, are already underway. Separate Department of Defense Instructions (DODI) establishing tracking and reporting policies for both programs are in the final phases of formal coordination. Because these policies, programs, and instructions are already in place or in process, we do not see the need for the Secretary of Defense to direct any additional action.

The FHP QA program subsumes and expands upon DoD’s Deployment Health QA program instituted in January 2004. The FHP QA program includes both DoD and Service level monitoring of electronic data with validation through medical records reviews of a wide range of force health protection measures. The IMR program monitors and reports regularly upon compliance with each of six critical IMR elements and the overall IMR status for each servicemember, at all levels, from unit to Service to DoD-wide. The IMR program will improve visibility and enhance reliability of Reserve component members’ health status by replacing the existing every 5-year physical examination with an annual periodic health assessment (PHA). The IMR is also being incorporated into overall unit readiness status reports, providing visibility of RC medical readiness throughout the line command structure. Many of the components have already started implementing these program improvements and are seeing results.

RECOMMENDATION 2: The GAO recommended that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in concert with the Principal Deputy who oversees the Office of Morale, Welfare, and Recreation, to take steps to enforce the Service reporting requirement on the status of their members’ physical fitness. (Page 66/GAO Draft Report)

DOD RESPONSE: Concur

Department of Defense Instruction 1308.3, "DoD Physical Fitness and Body Fat Programs Procedures," November 5, 2002, which assigns responsibility to the Principal Deputy Under Secretary of Defense for Personnel and Readiness (formerly the Assistant Secretary of Defense for Force Management Policy), requires the DoD Components to: 1) establish a data repository for their Military Service Physical Fitness and Body Fat Program; 2) maintain a data repository that provides initial or baseline statistics and a tracking mechanism that monitors physical fitness and body fat results as specified in this Instruction; and 3) provide an annual report to the Under Secretary of Defense (Personnel and Readiness), not later than March 31, that assesses Service physical fitness, body fat and health promotion programs. These first reports were due March 31, 2005. The Air Force, Navy, and Marine Corps reports have been received.

The Army requested a waiver to this reporting requirement until March 31, 2007, when the Army expects to be able to imbed reporting of this data within the Defense Integrated Military Human Resources System (DIMHRS). If reporting through DIMHRS is not on line by September 2006, the Army agreed to submit a manual report until DIMHRS becomes viable for reporting this data. The Principal Deputy Under Secretary of Defense (Personnel and Readiness) approved this request.

The Air Force Surgeon General requested two-year waiver to use abdominal circumference in lieu of the body fat measurement methodology described in DoDI 1308.3. The Principal Deputy Under Secretary of Defense (Personnel and Readiness) approved this request. At the end of this waiver period, March 31, 2006, the Air Force will provide a summary of findings and recommendations.

RECOMMENDATION 3: The GAO recommended that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in concert with the Assistant Secretary for Health Affairs, to also oversee the development of the reserve components' tracking systems to identify and track members' temporary and permanent medical conditions that limit deployability. (Page 66/GAO Draft Report)

DoD RESPONSE: Concur

The Assistant Secretary of Defense (Health Affairs) (ASD/HA), the Assistant Secretary of Defense (Reserve Affairs) (ASD/RA), and the Services are already actively adapting existing systems, and in some cases creating new ones, that can be used to track the medical status of Active and Reserve component members, to include those known conditions that could limit an individual's deployability. Many of these tools and systems are web-enabled to overcome IM/IT resource limitations common among RC units and to make it easier for RC members to provide medical information. Examples of these tools include the Health Assessment Review Tool (HART, used as part of the annual periodic health assessment), the DD Form 2900 (Post-deployment Health Reassessment questionnaire), Medical Protection System (MEDPROS, all Army components), Preventive Health Assessment and Individual Medical Readiness (PIMR, Active and Air National Guard), and the Medical Readiness Review System (MRRS, Navy and Marine Reserve Components). The DoD continues to pursue better integration between medical and personnel data systems to improve visibility regarding deployment-limiting medical

conditions, whether temporary or permanent, but the overall effectiveness will continue to be limited by lack of access to civilian medical records of Reserve component members.

Problems with the older processes that were meant to ensure medical readiness have been identified by Joint Forces Command (JFCOM) in its Lessons Learned Change Recommendation from Operation Iraqi Freedom. Currently, the Services are addressing these recommendations and are developing long-term strategic plans to improve RC medical readiness, to include making appropriate budgetary changes, as part of the Department's Comprehensive Medical Readiness Plan. Additionally, a RAND study to ascertain and describe those standards and systems used by the RC to track medical and dental readiness and the effectiveness of those systems is underway (sponsored by ASD/RA).

RECOMMENDATION 4: The GAO recommended that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness, in concert with the Assistant Secretary for Health Affairs, to modify the medical pre-deployment forms to better capture reasons for non-deployment and medical referrals. (Page 66/GAO Draft Report)

DoD RESPONSE: Non-concur

The Services are committed to improved reporting compliance which will enable better tracking of reasons for non-deployment of all members. The basic objective for the pre-deployment health assessments is, "... a quick confirmation and documentation of a service member's health readiness and to determine if there is a need for a clinical evaluation before deployment..." as specified in an OSD(HA) 6 October 1998 policy memo. These forms do not substitute for a complete entry in the medical record that would include a detailed history, the results of any pertinent physical examination or ancillary testing (lab, radiography, etc.), assessment, and plan. The existing Pre-Deployment Health Assessment Form (DD Form 2795) already includes a list of the most common referral categories to simplify the documentation process for the healthcare provider. The data from the forms is captured electronically and is readily available to monitor for trends in referral patterns, access to specialty care, timeliness of follow-up, and eventual diagnoses and outcomes. The Department has focused primarily on this type of analysis in the post-deployment setting. With the new requirement for annual health assessments across the total force, the need for a second, equally detailed, assessment as part of the pre-deployment health assessment process is unnecessarily disruptive to the deployment process.

Self-reporting tools like the DD Form 2795 are living documents. To ensure consistency and validity, these documents undergo periodic review and evidence-based revision. The best sources of accurate information about what medical reasons kept service members from deploying are the permanent medical records. Without civilian medical records to aid in our insight, the annual assessments of Reserve component members become critically important.

RECOMMENDATION 5: The GAO recommended that the Secretary of Defense direct the Chairman of the Joint Chief of Staff to determine what pre-existing medical conditions should not be allowed into specific theaters of operations, especially during the initial stages of the operation, and to take steps to ensure that each Service Component consistently utilizes these as criteria for determining the medical deployability of its reserve component members during mobilization. (Page 67/GAO Draft Report)

DoD RESPONSE: Partially Concur

Clearly, certain pre-existing conditions should render a member non-deployable to austere theaters of operations where appropriate medical care is not readily available. The Services, especially the Army, have made strides in defining these conditions and incorporating them into their applicable policies and procedures. However, due to the ever-changing nature of a theater of operations and the inexact nature of medicine, a list of non-deployable pre-existing conditions will never be fully comprehensive or fully enforceable. As it is today, a commander will always have to make a decision regarding the deployability of each individual service member within their command, based upon the recommendation of the medical community, their knowledge of the conditions that will be encountered in theater, and the unique aspects of the individual's situation.

RECOMMENDATION 6: The GAO recommended that the Secretary of Defense direct the Chairman of the Joint Chief of Staff, in concert with the Service Secretaries, to explore using existing tracking systems to track those who have treatable pre-existing medical conditions in theater. (Page 67/GAO Draft Report)

DoD RESPONSE: Concur

Refinements to medical tracking systems are on-going, utilizing lessons-learned with systems currently in place. Improvements in the documentation of medical conditions throughout the full continuum of military service, both active and reserve, will lead to better tracking and documentation of conditions that affect the health status of all military members.

COMMENTS NOT RELATED TO RECOMMENDATIONS:

Tracking compliance with routine medical examinations through electronic databases that contain reliable data is an important task for both the Active and the Reserve components, as both are held to the same standards of fitness and medical readiness. While, by design, this report did not focus on the health status of the Active forces, it is important to note that both Reserve and Active forces use many of the same reporting tools within each Service and face the same basic challenges in ensuring data quality. In situations where tracking systems are shared, the RC is typically dependent upon the Active component (AC) to develop and fund these systems. Priority for deployment of large systems, such as CHCSII, has historically been given to the AC. The RC has therefore been faced with developing component-specific programs or trying to accommodate data on their members in these department-wide systems.

The GAO report indicates that the health status of members deteriorates with multiple deployments. This is based upon answers provided by members on their pre-deployment and post-deployment health assessments. That assumption was not validated with evaluations conducted by health care providers. It is understandable that members would report a decline in their overall health status immediately after deployment due to the multiple physical stressors and rigors of combat experienced during their time in a theater of operations. However, a study to determine if their perception of health status improves with time after returning from deployment has not been done. Thus, such assumptions should be taken with great caution and in the proper context.

Differences in compliance between the Services often have to do with the geographically dispersed locations of their RC units. For example, Air Force RC medical units are typically located in the same location as the line units, thus giving them the ability to interact directly. Conversely, Army RC units are geographically dispersed, making it difficult for medical units to interact directly with non-medical units. In addition, the Air Force typically utilizes home-station mobilization, which means that the medical personnel conducting pre-deployment screenings are more likely to know the members they are screening and that the medical and command personnel have a greater opportunity to interact.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Derek B. Stewart (202) 512-5559 or stewartd@gao.gov

Acknowledgments

In addition to the contact named above, Brenda S. Farrell, Assistant Director; James Bancroft, Larry Bridges, Renee S. Brown, Sara Hackley, Kenya Jones, Ron La Due Lake, Karen Kemper, Julia Matta, Jen Popovic, and Nicole Volchko.

Related GAO Products

Defense Health Care: Improvements Needed in Occupational and Environmental Health Surveillance during Deployment to Address Immediate and Longstanding Health Issues. [GAO-05-632](#). Washington, D.C.: July 19, 2005.

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