

United States Senate National Guard Caucus

Report by Caucus Co-Chairs Senators Christopher S. Bond and Patrick J. Leahy
On National Guard and Army Reservists
On Medical Hold at Ft. Stewart, Georgia
October 24, 2003

Senators Kit Bond and Patrick Leahy, co-chairs of the U.S. Senate National Guard Caucus, dispatched their aides to Ft. Stewart to investigate reports that activated Guard and Reserve members were being poorly housed, with inadequate medical attention, while on “medical hold.”

Summary

Approximately 650 members of the National Guard and the Army Reserve who have answered the call-to-duty and in many cases were wounded, injured or became ill while serving in Iraq, are currently on medical hold at Ft. Stewart, Ga. Army base. As a result of an investigation by a reporter and expeditious follow-up by a veteran service organization representative it has come to our attention that these National Guard and Army Reserve soldiers have been receiving inadequate medical attention and counsel while being housed in living accommodations totally inappropriate to their condition. Of the roughly 650 injured soldiers currently awaiting medical care and follow-up evaluations, approximately one-third of these soldiers were found not physically qualified for deployment and therefore never deployed overseas. The remaining two-thirds deployed overseas and were returned to Ft. Stewart as a result of wounds or injuries sustained while serving or as the result of illness encountered either before or after deployment. Regardless of the nature of the medical malady, these soldiers have been enduring unacceptable conditions for as many as 10 months.

The return of the 3rd Infantry Division from the Middle East (18,000-strong which is permanently stationed at the base), has forced commanders to lease barracks from the Georgia National Guard that were designed as temporary quarters for National Guard soldiers undergoing annual training. They are not designed to accommodate wounded, injured or ill soldiers awaiting medical care and evaluation. The Army has designed a Disability Evaluation System that is purposely slow to ensure that National Guard and Army Reserve citizen-soldiers who are found not physically qualified for duty receive a fair and impartial review when undergoing a medical evaluation board. The process, similar in many respects to the workman's compensation process, requires that these soldiers be given every opportunity to recover. If full recovery is not possible, the system works to establish a baseline condition before the soldier is evaluated by a medical evaluation board.

The situation at Ft. Stewart unfortunately was, and remains, hampered by an insufficient number of medical clinicians and specialists, which has caused excessive delays in the delivery of care. Exacerbating the situation, was the Army's placement of wounded and injured soldiers in housing

totally unsuitable for their medical condition. Additionally, these soldiers were placed under the leadership of soldiers who were also injured, resulting in a situation where the sick and injured were leading the sick and injured. Furthermore, the perception among these soldiers is that the traditional active duty soldier is receiving better care, compounding an already deteriorating situation that had a devastating and negative impact on morale. Most of the soldiers in the medical hold battalion, which was established administratively to provide a military structure for the soldiers, have families living within hundreds of miles; yet they have been unable to join their families while awaiting the final deliberation of their cases.

In the short term, we must alleviate the unacceptable conditions at Ft. Stewart and determine if the problem is isolated to Ft. Stewart alone or part of a larger system wide problem.

Alleviating the problems at Ft. Stewart will require the immediate assignment of additional medical clinicians, specialists and medical support personnel and/or the transfer, where appropriate, of our National Guard and Army Reserve soldiers to facilities close to their families so they can continue to receive quality care and await further medical reviews if necessary in an environment conducive to healing. We must also ensure that the conditions at Ft. Stewart are not replicated elsewhere, while ensuring the fixes we install at Ft. Stewart are applied throughout the Army if necessary. In the long term, the Congress must address the physical readiness of the National Guard and the Reserve by passage of a pending bill, TRICARE for Guard and Reservists, to ensure that every member of the Guard and Reserves has adequate health insurance coverage and is medically ready to deploy.

Fundamental Problem

More than 650 members of the National Guard and Army Reserve, who have been activated and put on active duty (some of whom have already served in Iraq or Afghanistan) are currently on medical hold at Ft. Stewart, Ga. These numbers change almost daily as some soldiers are returned to duty, others receive medical evaluations for medical conditions that prohibit their continued service on active duty, while more soldiers are brought into the system (the result of sustaining injuries, wounds or falling ill overseas; or failing to qualify for deployment after being mobilized because of injuries or preexisting conditions).

About one-third of the citizen-soldiers currently in the disability evaluation system at Ft. Stewart could not originally deploy with their units because they were not medically fit, while approximately two-thirds were injured, wounded or fell ill while on deployment overseas and were returned stateside to receive special medical attention. When the 3rd Infantry Division, which is based at Ft. Stewart, returned from its deployment in Iraq, available housing was in short supply which resulted in those on medical hold being moved from one barracks to another in a form of musical housing. The U.S. Army resorted to leasing open-bay barracks with detached restroom facilities and no air conditioning in most cases, which are normally used to house Georgia National Guard troops during their two weeks of annual training.

These National Guard and Army Reserve soldiers have been kept in place at Ft. Stewart

according to standard Army policy while they await medical care and work-ups, which senior officials say is designed to protect their careers and ensure they receive the best medical care. The goal is to put these medically held Reserve soldiers in a holding pattern until they are healthy enough to return to duty and go back to their units or to prevent soldiers from being permanently discharged from service until the nature of their conditions have been fully assessed and optimal treatment regime prescribed. When soldiers cannot return to duty, a final determination about their status is made by a Medical Evaluation Board (MEB). The MEB process can take anywhere from an average of 42 days to 76 days after the soldier's treatment has been "optimized." That is when a sufficient diagnosis and treatment regime has been put in place to establish enough confidence to make a decision. Some troops have been on medical hold for more than 10 months.

The primary task of the Army Medical Department is to return these soldiers to duty. While undergoing medical care and reviews they can be assigned light duty around the post. Adequate convalescence requires a great deal of rest in most cases and cannot be properly pursued if there are unnecessary life stressors, such as placement in housing that is designed to house "healthy" National Guard forces on annual training — not injured, wounded or ill soldiers.

The barracks for these medically held National Guard and Army Reservists are totally inappropriate for soldiers injured, wounded or ill who are in need of quality care and are garrisoned in a stateside Army installation. The worst accommodations to which these medically challenged soldiers were subjected are 1950s-style, concrete-foundation barracks with no air-conditioning or insulation and detached toilets and shower facilities, though they do have heat. On a relatively cooler day in the area (October 22nd), the temperature in one of these huts was noticeably warm if not stifling. Bunks sit in open bays, no more three feet apart. In some cases, there are no footlockers for the troops to store their gear. In a few of the better barracks, for soldiers with more severe medical conditions, there is air conditioning, indoor-plumbing, and storage space.

The fundamental problem, as summarized colorfully by one of the base commanders, is that soldiers are going through a "go slow medical review system while living in 'get them the hell out of here barracks.'" Many of the medically held reservists—mostly from Southern states like Georgia, Alabama, and Florida—expressed frustration and anger over the duration of their medical hold and the quality of their housing while in this seemingly interminable holding pattern.

Complicating Factors

Feeding these justifiable frustrations are several real and perceived considerations regarding their medical care and treatment on the base.

There has been a shortage of clinicians and specialists to see the medically held Reservists and to accelerate the review and treatment process. At various points over the past several months there may have been only a handful of doctors to care for these hundreds of troops, as well as to assist with regular forces and their families. Most reserve doctors called to active duty were deployed

forward, and those remaining in the states can stay on duty for only 90 days before returning to their civilian practices. One soldier on medical hold said it took him almost three weeks to get a follow-on appointment necessary to optimize his care.

Further feeding the anger and frustration is inadequate leadership. Typically, a soldier will receive advice, counsel, and assistance in accessing the military's health system from the soldiers's unit or from upper echelon chain-of-command. The units of the medically held reservists, however, have deployed abroad in most cases, and their commanders are focused on their operational mission overseas. The Reservists at Ft. Stewart have been grouped together in a "medical hold" battalion for administrative purposes but the effectiveness of the unit chain of command is suspect.

Additionally, many of the battalion leaders—at the officer and NCO level—are sick themselves, raising the question of whether these leaders are capable to care for themselves, let alone hundreds of their comrades. Without a familiar advisor and leader, deployed away from home and their parent National Guard or Army Reserve commands, and lacking experience dealing with a huge bureaucracy like the Army, these Reservists were left without the leadership to which they were accustomed.

Moreover, many of the medically held Reservists perceive bias against them on the post. Whenever they go the hospital, PX, or dining hall, they are asked whether they are a Reservist or a traditional active duty service member. This question is made for accounting purposes, but it makes the Reservists—many of whom are likely disappointed about being on sick call in the first place—feel like they are being singled out. Similarly, many of the medically held Reservists, lacking sufficient knowledge of the military's medical bureaucracy, chalk up delays in treatment to preferential treatment for active forces.

An Avoidable Situation

This situation could have been avoided. In early June, medical and garrison staff realized that there would be a surge in housing needs when the 3rd Infantry Division returned from Iraq. The division was manned at over 115 percent authorized strength, which would force commanders to use triple bunks to accommodate 6500 troops in their barracks that usually hold about 4300. These commanders recognized then that these permanently assigned troops would have to take priority over the troops temporarily at the post on medical hold. Six weeks ago, medical staff submitted a request up the chain-of-command for 18 additional care providers who could help manage and accelerate the reviews of the medical holds. No action was taken on the request.

At about the same time, the garrison commander submitted a request to 1st Army Headquarters at Ft. MacPherson, Georgia, for additional funds to renovate the barracks that are leased from the Georgia National Guard. The command provided \$4 million, divided into two parts, but the prospective contractors could not begin work until this week. That project, which would have taken 90 days at the very least, was postponed pending the outcome of the investigations the Army has currently undertaken after media reports about the medical hold situation surfaced.

Additionally, it is reported that the Army had the opportunity in the initial stages of the mobilization process to provide for rear-detachment elements staffed by National Guard personnel. These elements are designed to provide stateside oversight and support to National Guard personnel and units deployed overseas. Had they been present it is possible the conditions described herein might have been identified and rectified before they reached a crisis point.

Medical Readiness of the Guard and Reserves

It is clear that part of the situation was created by the fact that some of the mobilized reservists were not as healthy as possible. Almost ten percent of Guard/Reserve personnel mobilized for duty at Ft. Stewart could not deploy because of a medical condition and were put on medical hold status for some period of time.

In the barracks visits, there were also troubling indications that a handful of Reservists were knowingly activated and sent to mobilize with medical conditions that would preclude them from actually deploying. Such an unjustified deployment might have been designed to take advantage of the fact that once soldiers are activated (put on active duty orders) they become the full-scale responsibility of the U.S. Army. The service is then charged with their care and feeding to include medical care and medical evaluations.

The hundreds of Reservists who could not deploy because they were medically unready raises a number of larger questions, which the caucus has already begun to address through its effort to ensure every member of the Guard and Reserves has adequate health insurance. The caucus will continue to address the issue in detail during its ongoing investigation of the medical readiness and mobilizations, examining questions like whether the resources and process for screening at the unit level within the National Guard and Army Reserve ranks are sufficient, and how to explain the recall of soldiers to active duty who are not fit for duty.

Recommendations

There are a number of actions that the Army must take to address this situation at Ft. Stewart and the larger issue of "medical holds," which will continue to arise as the country pursues the war against terrorism and sustains operations in Iraq, Afghanistan and other areas where military forces are operating.

In the short term, the Army National Guard and the Army Reserve must jointly provide for the leadership, guidance and medical care our Reservists require to operate at maximum proficiency. These dedicated and loyal soldiers need to know what to expect in the medical review process. They need to understand thoroughly the Army's health care system, warts and all. This strong, steady leadership must have the goal of reaffirming the Army's seamless support for the "Army of One" and the country's gratitude for their service and sacrifice, reassuring them that they are not forgotten despite the fact they are separated from their units.

To move the Reservists along to a Medical Evaluation Board if required, many more doctors need to be assigned to Ft. Stewart and, specifically, to these cases. The biggest delay in getting

the Reservists off medical hold is the wait to optimize care. Many soldiers are seeing a different doctor every time they enter the hospital, each of whom may prescribe a different remedy. Additional doctors and specialists, who could help coordinate care, would provide greater continuity-of-care, one of the central reasons to keep them at their mobilization station in the first place.

It is unacceptable to have these citizen-soldiers—every one of whom answered the call-to-duty--living in such inadequate housing. However, more adequate barracks cannot be completed quickly because it will take almost three months to complete any upgrades. Other 3rd Infantry Division barracks are unlikely to become available soon.

It would be far better to send these troops back home. They could be assigned to another Military Treatment Facility (MTF), a State Area Command (STARC) or possibly a VHA medical facility closer to their families. Liaisons from the TRICARE management authority could ensure that they are receiving adequate care and that they would be available to return to Ft. Stewart if they get better and can return to duty. The benefit to morale among the medically held Reservists would far outweigh any of the unlikely risks that might go along with moving troops away from their mobilization station. Current Army Regulation 40-501 directs medically held soldiers to remain near their mobilization post, but there is no statutory restriction against assigning them to another facility close to home.

In the longer-term, the Army, working together with the leadership of the National Guard and the Army Reserve, must ensure that our citizen-soldiers who are identified for activation are medically ready to deploy. Enactment of the cost-share TRICARE proposal for Reservists, currently attached to the Senate version of the Fiscal Year 2004 Supplemental Spending Bill for Iraq and Afghanistan, would ensure that every member of the Reserves has access to health insurance and would increase the likelihood that citizen-soldiers are medically and physically ready for duty.

Currently, reservists are required to complete a physical once every five years. The high percentage of reservists found to be physically unable to deploy raises the questions of whether this five-year interval is too long. Another question the Caucus may want to raise, is the Army's mobilization and demobilization policy sufficient in providing a housing standard for soldiers on medical hold? Furthermore, is the working relationship between the Army's medical department and the Veterans Health Administration (VHA) structured to allow for the transfer of soldiers on medical hold from Army military facilities to VHA facilities? Also, new medical case management software included in the second version of the military's Composite Health Care System (CHCS II) will permit continuity-of-care wherever a soldier accesses care. Guard and Reserve units across the country could assign liaisons to help manage a Reservists' care and maintain contact with their mobilization base at any point.

Lastly, it has been reported that architectural hardware and software exist that will allow the Army to equip its hospitals, dining halls, and commissaries with scanners that could read an ID that can show whether a member of the service is from the active component or the Reserves. Perhaps the Caucus should look at such systems as a means of addressing the perceived bias that exists when reservists are queried about their service status.
